OFFICE OF THE CITIZENS' REPRESENTATIVE

Citizens' Representative Investigation of Psychiatric Services in Provincial Correctional Facilities

March 25, 2011

Office of the Citizens' Representative
Province of Newfoundland and Labrador

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March 25, 2011

The Honourable Roger Fitzgerald
Speaker
House of Assembly
Confederation Building
St. John's, NL A1B 4J6

Dear Sir,

I am pleased to submit to you a Report titled *Citizens' Representative Investigation of Psychiatric Services in Provincial Correctional Facilities.* This submission is made pursuant to section 44 of the *Citizens' Representative Act.*

Yours truly,

Barry G. Fleming, Q.C.
Citizens' Representative

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Citizens' Representative Investigation of Psychiatric Services in Provincial Correctional Facilities

Summary

This is the Final Report of the Office of the Citizens' Representative (the "OCR") following a complaint initiated by the Citizens' Representative against the Department of Justice. The complaint focused on whether the Department treated inmates at the Province's correctional facilities fairly by continuing to retain a Psychiatrist with conservative prescription practices for psychiatric drugs. The Investigation was initiated after the Office of the Citizens' Representative received numerous contacts and complaints from inmates who alleged that their psychiatric prescription medications were eliminated or tapered after incarceration. The investigation of these individual complaints was complicated because of limits on the jurisdiction of the OCR. This Investigation focused primarily on the decision by the Department of Justice to continue to retain a psychiatrist who has well-documented conservative prescription practices.

The Investigation entailed a review of all complaints and inquiries received by the OCR from inmates and their families about this issue. Numerous interviews were conducted, as was general research about the problems associated with mental health in prisons. Three psychiatrists, including the Psychiatrist retained by the Department of Justice, were contacted for their opinions. After reviewing the evidence, the OCR recommends that the Department of Justice undertake a request for proposals for the provision of psychiatric services at the Province's correctional facilities. The goal of this process should be to find a psychiatrist who can provide psychiatric services, including the prescription of psychiatric drugs, in a manner more consistent with that available to the general population.

Introduction

1. This is the Final Report of the Office of the Citizens' Representative ("the OCR") into a complaint initiated by the Citizens' Representative pursuant to section 15 of the *Citizens' Representative Act*. The investigation focused on whether the Department of Justice (the "Department") treated inmates at the Province's correctional facilities fairly by continuing to retain a psychiatrist with conservative prescription practices for psychiatric drugs.

The Investigation

2. The OCR, over the past several years, has received numerous complaints from inmates and their families about the prescription practices of the Psychiatrist retained to provide services at the provincial correctional facilities. Specifically, the complaints alleged that the Psychiatrist withdrew or tapered the prescription of psychiatric medications which had previously been provided to inmates by physicians and psychiatrists prior to incarceration. The Citizens' Representative commenced this investigation in August, 2009 on his own initiative, as opposed to basing it on the individual complaints from inmates.

3. Prior to the initiation of this investigation the OCR had anecdotal evidence of the prescription practices of the Psychiatrist for the Province's correctional facilities. This evidence tended to suggest a conservative approach. It was difficult to make a definitive conclusion about those practices while investigating individual complaints. In 2008, the Department released a review of the prison system in Newfoundland and Labrador entitled *Decades of Darkness - Moving Towards the Light*. Chapter 10 of this Review dealt extensively with the provision of health services to inmates, and more specifically, with the provision of mental health care. The authors interviewed the Psychiatrist and he confirmed his conservative approach to prescribing psychiatric medications. This alleviated the need for the OCR to review inmates' medical files to definitely determine his prescription practices.

4. After some initial concerns about the OCR's jurisdiction to conduct this investigation, the Department fully cooperated throughout. Our investigation entailed an extensive review of what inmates and their families have alleged about the Psychiatrist's prescription practices. We conducted a number of interviews with medical personnel at her Majesty's Penitentiary (HMP) in St. John's. We spoke with the Superintendent of Prisons for the Department, along with the Assistant Superintendent for HMP. We had the benefit of the insights of three psychiatrists, including the Psychiatrist retained by the Department. Meetings with the John Howard Society provided us with a community perspective on this issue. We also undertook a literature review on the topic of mental health and prisons. We thank all of those who assisted us with this work.

5. To be clear, the focus of the Investigation is on the Department's decision to continue to retain the Psychiatrist after his prescription practices were widely known. While the practices of the Psychiatrist per se are not the subject of this Investigation, they are an integral part of this Investigation. In keeping with the provisions of the *Citizens' Representative Act* which requires that the work of the OCR is to be undertaken with as much confidentiality as possible, we have chosen to refer to witnesses by the positions they hold, or their initials, as opposed to their names.

Jurisdiction

6. For the past several years the OCR has received between 10 and 15 contacts and inquiries per year from inmates at provincial correctional facilities or their families about the prescription practices of the Psychiatrist retained by the Department. This Office was somewhat hampered in addressing those contacts and inquiries by virtue of the fact that the provision of psychiatric services, including prescription drugs, was a matter covered by the doctor and patient relationship. The standard position of the Department was exemplified in this response received by the OCR on December 8, 2008. It states in part;

> **"At this point, I would like to reiterate that any decision relating to treatment/diagnosis, including the appropriateness of medication, is left to the discretion of the medical practitioner providing the service. Non-medical staff including the undersigned, are not able or qualified to respond to complaints related to medical treatment. Typically, complaints about a specific medical treatment/planning between a physician and patient are referred, by the person with the concerns, to the College of Physicians. As you know, this independent governing body has the expertise and legislative authority to investigate and respond to such concerns/allegations. Having said that I also note, [the Psychiatrist] has exemplary qualifications and is a member in good standing with the College of Physicians. In addition to his duties with corrections, [the Psychiatrist] is an associate professor of psychiatry and program director of the psychiatry residency program at Memorial University.**

7. The position of the Department correctly points out the limitations of the OCR's jurisdiction in investigating individual complaints of this nature. The OCR and ombudsmen generally, do not have the jurisdiction or legal right to investigate the standards of practice of professionals. That is the responsibility of the profession's governing body.

8. The authors of the report *Decades of Darkness – Moving Towards the Light* noted that the Psychiatrist retained by the Department was known to have a conservative approach to the prescription of medications. The release of this report also coincided with numerous media reports highlighting the problems that inmates and their families were experiencing as a result of this conservative approach. This prompted the OCR to reassess how best it might review the fairness of the prescription practices performed by the Department's Psychiatrist.

9. By letter dated August 26, 2009, the OCR gave notice to the Department that it was undertaking its own review of the psychiatric services provided by the Department's Psychiatrist based on its own initiative as opposed to individual complaints. The OCR relied upon section 15 off the *Citizens' Representative Act*. It states;

> **15. The Citizens' Representative may, on a written complaint or on his or her own initiative, investigate a decision or recommendation made, including a recommendation made to a minister, or an act done or omitted, relating to a matter of administration in or by a department or agency of the government, or by an officer, employee or member of the department or agency, where a person is or may be aggrieved.**
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> *(Emphasis added)*

10. In its letter the OCR noted;

> **"We have reviewed the documented history of the prescription psychiatric drugs for some of the inmates that have contacted us and that review confirms a dramatic decrease in the prescription of drugs after incarceration. This anecdotal evidence of a general practice of reducing or eliminating the prescription of psychiatric drugs for inmates was confirmed by [the Psychiatrist] to the authors of *"Decades of Darkness – Moving Towards the Light; A Review of the Prison System in Newfoundland and Labrador*". (pp120-122)**
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> **. . .**
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> **The specific "decision or recommendation made...act done or committed, relating to a matter of administration"...is the Department of Justice's continued retention of [the Psychiatrist] for the provincial correction facilities in light of his acknowledged practice of eliminating or reducing the prescription psychiatric medications for inmates after incarceration. For me, it is an open question as to whether the alleged therapeutic benefits of reducing psychiatric medications upon incarceration are inexcusably mitigated by the physical**

condition of the sites in which the effects of these withdrawals take place.

11. On November 20, 2009 the Department responded by stating;

> **We do consider the Department's decision to engage professional services for inmates to be within the jurisdiction of the Citizens' Representative to investigate. In this regard, I can advise that the nature of the Psychiatrist's relationship with the department has not changed since our correspondence to you dated December 8, 2008, in which we provided that information to your Office. Also, in this instance you have identified the focus of your investigation as being on the Psychiatrist's prescription practices and the alleged therapeutic benefits associated with them. As these concerns are not a matter of administration by the Department, we therefore consider any investigation relating to or stemming from the medical options (including prescribing practices) to be a class of investigation beyond the jurisdiction of the Citizens' Representative.**

12. On February 10, 2010, the OCR responded to the Department's position by reasserting its jurisdiction and advising that it would make application to the Supreme Court of Newfoundland and Labrador to have it determined the jurisdiction of the OCR on this matter. Further discussions ensued and the Department, after giving the matter careful consideration, elected not to accept the offer of a court challenge for two reasons: (1) the Psychiatrist in question was willing to participate in our review; and (2) in challenging our jurisdiction, it did not want to leave the impression that the Department had anything to "hide" in relation to the prescription practices of the Psychiatrist concerned. While the Department remained of the view that this investigation was beyond the jurisdiction of the OCR, it provided document and testimonial evidence.

The Complaints

13. What follows is a sample of complaints received by the OCR from inmates at HMP prior to the start of this Investigation. The OCR receives between 10 and 15 similar complaints per year about this issue. This sample reflects the nature of the complaints received and gives context to this Investigation. It is important to note that the complaints are allegations and the content of each has not been proven.

14. One complainant provided the following written complaint;

> **"I'm writing you this letter about a problem I have with my medication. Five years before I came to HMP my family doctor**

and psychiatrist had me on 300mg of Welbutrin which is an antidepressant to manage my depression. When I entered HMP in March of 2008, [the Psychiatrist] kept me on my meds for the first six months, now he has cut me off my meds. Without my medication I'm depressed all day long and I can't cope around people, I can't function or concentrate and I am always mad. I'm bouncing off the walls. I feel like I'm going crazy the way I'm feeling without my meds. I would not want to be released into society. There is no point. I don't feel normal anymore. I can't even think straight. Without my meds I will not be responsible for my actions. I thought that jail was supposed to be about rehabilitation, not in this jail. All I'm learning is how to hate more. Something has to be done about [the Psychiatrist] before it is too late. How many more inmates do we have to loose before someone takes this serious. I've seen three suicide attempts in the last month. So far this year there have been two deaths and it's getting worse. I ask you to please help me before it's too late."

15. Another complainant alleged that he was being prescribed methadone for pain after having a partial shoulder blade removed because of a tumor. Upon his admission to HMP the Psychiatrist cut the dosage of 190 mg of methadone to 85 mg and discontinued his Rivotril. He alleged that he has been prescribed this medication for a number of years and is currently in a lot of pain and suffering from depression. Despite providing HMP's Psychiatrist with a copy of his medical files from his physician in Ontario which was compiled prior to incarceration, his medications have been reduced or eliminated.

16. Another complainant provided this written account;

I have been an inmate at the HMP for almost five months and [the Psychiatrist] took me off medication that myself and my Doctor on the outside took over six years of trying different combinations to perfect so that I could function properly in society. But since I have been here I have been laughed at by [the Psychiatrist] and told that he would watch my process! My mental state dwindled to the point of not being able to cope with the everyday ins and outs of prison life as structured as it is. I started picking up stupid institutional charges that has in fact thanks to [the Psychiatrist's] supervision, or lack there of should I say, that my parole is in fact in jeopardy and at this juncture in life I need to be stable and not some experiment to see how I cope with the hardened conditions of prison life. I would have been put up more of a struggle in the system to get my meds stabilized but I have been continually threatened with segregation or the hole to be watched. This frightens me

because I have talked to many different inmates that have spent up to 40 days in segregation which I don't see the point. The process to cut people off from reality put in a box and feed. Something like a hamster in a cage but without the wheel. It is just a tactic to frighten inmates into medical submission. It has changed my life for the worst in a bad situation and I wonder how many more people will get caught up in the revolving door syndrome because they are not fit to be released back into society in a non rehabilitated state."

Superintendent of Prisons/Assistant Superintendent of Prisons

17. The Superintendent of Prisons for the Province and the Assistant Superintendent of Prisons gave their impressions of the prevalence of, and problems caused by, illegal prescription drug use in our prison system. They also discussed some new programs to address the problems. They have 26 and 27 years experience, respectfully, working in the prison system.

18. They indicated that the characteristics of the prison population have changed remarkably from when they first started working in the system. In the past, inmates tended to be in their late 30s or early 40s and if they presented with any addiction problems at all, it tended to be the abuse of alcohol. This was a much easier prison population to deal with. Today the prison population at HMP is generally comprised of young men in their early 20s. They can be addicted to a variety of substances but prescription drug use and abuse is by far the most problematic.

19. Illegal prescription traffic at HMP poses a persistent and significant security concern. There is a constant effort by some inmates and their families and friends to smuggle illegal prescription drugs into the prison. During a recent weekend, staff had intercepted a package containing over 200 prescription pills, needles, and other drug paraphernalia which had been thrown over the outside wall of the institution. People who are addicted to prescription drugs will resort to all sorts of intimidating tactics to acquire those drugs. They will bully, strong-arm, intimidate and harass those who are in possession of those drugs. It is not uncommon to hear new inmates being asked numerous times, "what pills are you on".

20. The hoarding of prescription drugs is a serious problem at HMP. Medications are dispensed on the unit where the inmates reside. Those medications are dispensed four times a day. It is impossible to distribute these drugs in a one-on-one environment. Inmates who hoard drugs can have them stuck to the roof of their mouth. They can find other creative ways not to consume drugs once administered to them. It is a serious security concern that inmates who may

properly require these drugs will be intimidated into hoarding them by those wishing to satisfy an addiction or otherwise profit in their distribution.

21. Continuous monitoring of inmates occurs in the bottom unit of HMP. The unit is divided into two parts with a control room in the middle. Each part contains five cells. One part is dedicated for inmates assigned to segregation. A stay in segregation is used to punish serious breaches of the prison's rules. The other part comprises a special handling unit which is used to house inmates who are threatening suicide, are difficult to deal with, are drug traffickers, or the Psychiatrist feels are not ready to go back into the general prison population. Unlike segregation, the special handling unit has an area outside the cells with a television and showers. The control room permits correctional officers to monitor both parts 24 hours per day.

22. When the Superintendent and Assistant Superintendent provided their information there was currently an inmate in the special handling unit who would have been there for several weeks. The inmate's behaviour gave an indication of the type of challenges prison officials face when dealing with the current inmate population. There was absolutely no where else to house this individual. He would constantly cover himself and the walls of his cell in feces. He would flood the toilet by filling it with towels and attack the correctional officers when they attempted to fix the problem. A psychiatric assessment took a long time to be completed. He now attends court by video conference because the last four of his court appearances ended with Sheriff's officers having to forcefully restrain him.

23. The Superintendent and Assistant Superintendent gave examples of recent improvements in the programming available for inmates at HMP. Many of these improvements were the result of the release of the prison review *Decades of Darkness*. One of the most notable of these was the Justice Project undertaken by the Canadian Mental Health Association. Initially established as a one-year program, it has been extended for a second year. The caseload for the program is a maximum of 25 inmates. There is currently a waiting list to enroll. The Project has three employees who are responsible for connecting with inmates and assisting them when they transition to civilian life. They assist the inmate with finding housing, attending medical appointments, and more generally, integrating into society. Only those who have a diagnosed mental illness can partake in the Project. The Assistant Superintendent indicates that from all feedback he's received, the Project is a success. The best evidence of this is the fact that there is a waiting list for the project. He cites the example of one offender who, over the past three years, has only been free for one month. He currently has been on the streets for three months and is doing relatively well. These anecdotal examples illustrate the potential of the Project.

24. The John Howard Society currently operates at HMP a moderate intensity management of substance abuse project. The program is of eight week

duration. Inmates can start the program at any time. The program is also available to inmates by the John Howard Society once they leave HMP. Within HMP there are normally eight inmates enrolled at any given time. Additionally, an addictions counselor has been hired.

25. Since the *Decades of Darkness* review all correctional officers have been provided with a mental health awareness training program offered by Living Works. This program is recognized worldwide and gives correctional officers training in understanding and identifying symptoms of mental disorders and addictions. The goal of the program is not to enable correctional officers to make mental health diagnosis, but rather to be sensitive to and aware of the manifestations of those disorders.

26. Irrespective of the security concerns held by the Superintendent and the Assistant Superintendent about the prevalence of prescription drugs at HMP, they have no say or influence in the authorized prescription of those drugs. That is the responsibility of HMP's Psychiatrist.

The Psychiatrist

27. The Psychiatrist has been a duly trained, certified and practicing psychiatrist in Newfoundland and Labrador since 1987. He is a tenured associate professor of psychiatry at Memorial University of Newfoundland. He currently has practicing privileges with Eastern Health and maintains a small fee-for-service practice. The Psychiatrist provided a full and frank account of his history of providing psychiatric services to inmates in this Province, his perception of the incidence of mental health disorders among inmates, the process by which psychiatric services are provided to inmates and, most germane to this Investigation, his theory on how psychiatric prescription drugs should be administered to a prison population.

28. The Psychiatrist provides psychiatric services to a number of correctional facilities. He started providing psychiatric assessments for young offenders attending Youth Court in 1989. He continued to perform these assessments until 2006 when a child psychiatrist was persuaded to take over this function.

29. In 1989, the Psychiatrist was approached by the then Director of Corrections for the Department with a request to provide psychiatric services at HMP. The previous psychiatrist had left on short notice and the Director of Corrections knew of the current Psychiatrist's conservative approach to the prescription of pharmaceutical agents because his wife was a nurse at the Health Sciences Centre where the Psychiatrist worked at the time. The Psychiatrist currently works one day a week at HMP. On average, he has to return to HMP once a week to deal with unexpected issues which may arise.

30. In 2002, the Psychiatrist started to provide psychiatric services at the Newfoundland and Labrador Correctional Centre for Women (NLCCW) in Clarenville one full day a month and, occasionally, he can deal with issues that may arise using video conferencing. Around this time, the Psychiatrist started providing regular services to the Labrador Correctional Centre (LCC) and currently provides a full day of practice per month.

31. The Psychiatrist referenced a study by Dr. Roger Bland when discussing the prevalence of various mental health disorders among inmates. While Dr. Bland's study focused on provincial inmates in Edmonton, Alberta, the conclusions were somewhat applicable to this Province. Dr. Bland concluded that 93% of prison inmates had an identifiable mental disorder including addiction, and 87% of that group had a fully diagnosable substance abuse or dependence disorder. He also concluded that 57% of provincial inmates have an antisocial personality disorder; 25% had an affective (mood) disorder; and 2% suffered from a psychosis.

32. With respect to inmates in this Province, the Psychiatrist's impression was that Dr. Bland's percentages were accurate except for the following:

- The percentage of inmates suffering from a mood disorder is between 5 – 10% which is about the same for the general population. Mood disorders tend to be diagnosed too frequently.

- The percentage of provincial inmates suffering from psychotic disorders is about 4 – 5%.

33. The Psychiatrist noted that the general life in prison can affect an inmate's mood rather than the inmate presenting with an actual mental disorder. That life entails a realization that one has broken the law; there is little to do in an unpleasant environment and one is stuck with a bunch of other people one doesn't trust or would associate with but for the incarceration.

34. The Psychiatrist discussed the effect of incarceration on the types of mental disorders that inmates present with upon entering prison. With inmates suffering from a psychosis, stress – including the stress from incarceration - can exacerbate the condition. Fortunately, incidents of this occurring are rare. If an inmate experiences a psychotic episode they will be transferred to a hospital.

35. Inmates with antisocial personality disorders frequently respond in two ways upon incarceration. The structured environment of a prison tends to improve behaviour because there are immediate consequences for a breach of the prison rules. However, they may respond as well to the "unofficial rules" of the prison as determined by the inmates. These "unofficial rules" reflect norms such as an inmate should not "rat" on another.

36. Inmates suffering from substance abuse disorders upon incarceration often engage in drug seeking behaviour. This can lead to a situation where the strong will prey upon the weak in order to acquire the substances needed to immediately satisfy an addiction.

37. The prescription for anti-depressants can assist an inmate who suffers a relapse of a mood disorder upon incarceration. This doesn't happen very often. The far more common scenario arises when inmates have been inaccurately diagnosed as having mood disorders prior to incarceration. The Psychiatrist provided the following example. A person incarcerated for domestic violence is in jail, may face a loss of the love or affection of the victim and a loss of his opportunity to be gainfully employed. The inmate may perceive himself as being stressed and unable to sleep. These conditions are not due to a true mood disorder. These are a consequence of the events which led the inmate to be incarcerated.

38. The Psychiatrist discussed the ways in which inmates would contact him. All new inmates will be seen by a nurse practitioner for an initial screening and then referred to the Physician. Inmates would see the Psychiatrist if they:

- are on psychotropic medication including benzodiazepine or sleeping pills;
- have a psychiatric illness or have been seen by a psychiatrist;
- are perceived by prison officials as strange, weird or odd;
- are perceived to be suicidal or declare that they wish to harm themselves; or
- request to see the Psychiatrist for a psychotropic medication.

The Psychiatrist estimates that he probably sees 50% of the prison population.

39. The Psychiatrist stated that the addition of a psychologist to the HMP staff has worked out well. More psychology help would be beneficial along with more social workers and addictions therapists. More specifically, the Psychiatrist believes a more prevalent use of twelve step programs such as Alcoholics Anonymous will assist inmates suffering from addictions. More involvement from faith based organizations and pastoral care would also be helpful. The Psychiatrist stated he didn't know the use of twelve step programs in other prisons in Canada. He noted that the lack of opportunity to discuss issues with other prison psychiatrists was unfortunate.

40. The Psychiatrist acknowledged that the characterization by the authors of *Decades of Darkness* that his prescription practices were conservative was accurate. He made no apologies for this approach. There is an overwhelming drive to find pharmacological solutions to non-pharmacological problems, or in the vernacular, "Prozac won't bring my girlfriend back". The Psychiatrist acknowledges the seriousness of bipolar disorders, but states that the

diagnosis locally is very common and often unwarranted. Some of those diagnosed have no history of mania or depression. The Psychiatrist acknowledges that the standard of practice for psychiatry can contemplate a more liberal approach to prescribing medications, but he strongly argues for a conservative approach. This argument is based on the adverse effect of some drugs on patients and the fact that reliance on a drug required to treat a mental disorder often diverts an inmate from addressing and solving his problems.

41. In July 2007, the Psychiatrist wrote the then Superintendent of Prisons outlining his theory as to what drugs, and in what circumstances, should be prescribed in prison. He was urged to do so because the Director of Corrections wanted to have the theory reduced to writing in case someone else might benefit from it. A copy of that letter is attached as Appendix A. The Psychiatrist advised that the letter still reflects his approach to prescribing drugs in prisons.

42. The Psychiatrist still maintains a practice which consists of a complement of four inpatient beds at the Health Science Centre and the conduct of three half-day clinics a month. He mainly sees patients he has been seeing for some time. He is also on call at the hospital. The Psychiatrist states that the biggest difference in prescribing drugs for patients in the community versus inmates is that it is difficult to get patients in the community off these drugs in non-controlled settings. These patients will tend to get their drugs elsewhere. He generally does not start these patients on prescriptions and if he does, it is for a short period of time. He prefers to find other solutions for those patients who have not yet started prescription drugs. The Psychiatrist does acknowledge that he has some patients who have been on benzodiazepine for long periods of time. He certainly would not increase the dosage for them, but would rather attempt to keep the dosage stable or lower. If these patients were incarcerated, he would at least try to reduce or eliminate the dosage. In a prison setting, you can try and see what happens without these prescriptions. The Psychiatrist states that he promotes a conservative approach to prescribing drugs while teaching at Memorial University.

43. In June 2008, the Psychiatrist wrote the Newfoundland Medical Board to outline an agreement he has with the other medical staff at HMP with respect to the delineation of the various doctors' responsibilities. A copy of the letter is attached as Appendix B. He states that the letter reflects the historical assignment of tasks at HMP. It was written to the Medical Board in response to a number of complaints to that Board from inmates about his conservative prescription practices.

44. While the January 2008 letter reflects the delineation of responsibilities at HMP, the Psychiatrist expressed some frustration with the prescription practices of a physician at the West Coast Correctional Facility. That physician

prescribes medication for sleeping and anxiety much more liberally than the Psychiatrist.

45. The authors of *Decades of Darkness* noted that there had been approximately 20 complaints filed with the Newfoundland Medical Board by inmates concerning the Psychiatrist's prescription practices. He states that the number has not risen significantly. He stated that after a complaint has been filed each party has an opportunity to discuss in writing their position with respect to the complaint. Once each party's position is settled, the complaint and responses are reviewed by the Board. If the complaint is dismissed, the complainant (patient) is given a rationale for that decision. If a complaint was found to have some merit, a quasi-judicial hearing before a tribunal would determine if the complaint can be proved. The Psychiatrist points out that of all the complaints filed with the Board by inmates none have gone to a hearing. They have all been dismissed prior to that point in the process.

46. Given the stress associated with incarceration and the physical limits of HMP, the Psychiatrist has no concerns about the withdrawal of drugs from inmates that have previously been prescribed. He states that drugs interfere with the various rehabilitative functions that are practiced in prison and more generally, with the inmates' ability to learn, listen and pay attention. Drugs make the environment worse.

47. The Psychiatrist indicated that when he first sees an inmate, he routinely takes a history from him, but does not normally look for past medical records for that patient. His initial visits are regularly twenty minutes and he makes his own diagnosis. That is a shorter visit than would occur in the community. This is so because of a code of silence that exists within a prison which results in an inmate not voluntarily disclosing information about himself other than as absolutely necessary. The follow-up sessions are very quick. The Psychiatrist states he would take as long as required to make a diagnosis and address an inmate's concerns.

The Nurse Practitioner

48. The Nurse Practitioner works at HMP five days a week. He begins his day by seeing individuals who have been placed on a list of those wishing to see him during the previous evening. He is responsible for distributing medications at lunch. Contract nurses are responsible for the distribution of medicines at other times during the day and on weekends.

49. When an inmate arrives at HMP and indicates that he is on prescribed medication, a check is made with his pharmacy to verify the prescription. If a medication has been prescribed, it will be continued. If the prescription is for a psychiatric drug, it will be continued by the Physician until the Psychiatrist can

see the patient. Contrary to what some inmates may state, they are never taken off their medications by the Psychiatrist abruptly; a weaning process is involved. The Nurse Practitioner notes that many inmates do quite well once they are off the psychiatric medications they were taking prior to incarceration.

50. There are more referrals for medical follow-up on an inmate's file for the Physician than for the Psychiatrist. It was the Nurse Practitioner's perception that the Physician has more contact with other practitioners who have seen the inmate prior to incarceration than the Psychiatrist.

The Physician

51. The Physician indicated that she works at HMP one day a week and is responsible for seeing all new inmates that come to the prison. Upon admission, a patient profile is completed and attached to the patient's chart. If an inmate is being treated for a chronic condition, the Physician will consult with the treating physician for their medical history. The medical files for inmates are shared by the Physician, the Nurse Practitioner and the Psychiatrist.

52. Shortly after starting work at HMP, the Physician met with a person from administration and the Psychiatrist concerning the division of labour between the Physician and the Psychiatrist. The agreement was written by the Psychiatrist and clearly outlines his responsibility for providing psychiatric care including the prescription of drugs.

53. If an inmate sees the Physician about depression, she will complete the normal consultation about depression or anxiety and then inquire if the inmate is on the list to see the Psychiatrist. If an inmate has seen the Psychiatrist and feels that they can't connect with him, their interview with him was too short, or they are otherwise unhappy about the consultation, the Physician will refer him to the Psychologist.

54. The Physician believes that HMP needs a medical unit. She was alarmed when one inmate's sense of self-dignity and self-respect did not prompt him to request clean paper on an examination table. He was prepared to sit and lie down on used paper that was soiled and bloodied. Generally, the space where she practices is not clean. Coffee stains can exist for weeks. The Physician often cleans the area where she practices herself. She brings all of her procedural trays to her private practice for sterilization.

The Psychologist

55. In order to see the Psychologist an inmate would notify a guard. The guard would complete a form to be reviewed by the Nurse Practitioner who would

determine whether the inmate should be referred to him, the Psychologist or the Psychiatrist.

56. The Psychologist noted that research generally suggests that a combination of psychotherapy and medication is often the best approach to addressing mental illness. Once a patient has been seen and the Psychiatrist has not made a diagnosis, the Psychologist will work with what records can be retrieved from other institutions to assist the inmate. The Psychologist, Physician and the Psychiatrist meet as needed, but the Psychologist would prefer more consultation.

57. A session with the Psychologist lasts one hour with follow-up sessions occurring bi-weekly. The Psychologist has access to a private room that ensures confidentiality. The Psychologist will approach the Psychiatrist to act on behalf of an inmate, but the ultimate decision to prescribe medications rests with him.

58. Inmates often consult the Psychologist about sleeping disorders. The Psychologist's approach is to start with counseling and relaxation techniques. These techniques do not always work. There is still a place for the use of prescription drugs in treating these disorders but that is the responsibility of the Psychiatrist.

Dr. L

59. Since 1980, Dr. L has been in continuous practice in this Province as a General and Forensic Psychiatrist. He is an Associate Professor of Psychiatry at Memorial University of Newfoundland. He has appeared as an expert witness in over 500 legal proceedings and has been called upon to give evidence for both the Crown and the defense bar. While he has visited patients at HMP, he does not practice prison psychiatry.

60. Generally, Dr. L is of the view that a psychiatrist has to formulate his or her own diagnosis of a patient. The determination as to whether the patient shall continue with a medication is made after an assessment of the success of that medication. While psychiatry is a science, the ultimate diagnosis of a patient entails the exercise of a psychiatrist's judgement. Dr. L sites a study which found that psychiatrists in Great Britain were more likely to diagnose bipolar disorders than schizophrenia, while psychiatrists in the United States made more diagnosis of schizophrenia than bipolar disorders. One of the reasons for this was that psychiatrists in the different countries were trained differently and, therefore, were inclined to make different diagnosis.

61. Dr. L notes that drugs are a big problem in prison populations. Illegal drugs are bartered and drug seeking behaviour can result in hoarding and bullying.

There is still, however, a place for the proper prescription of drugs in prisons. Dr. L cited an example where he had a patient stable for many years. The stability was the result of a very simple, straight forward, cheap drug - Ritalin. When this patient was incarcerated, Dr. L made a special request of the Psychiatrist at HMP to keep the patient/inmate on Ritalin. The Psychiatrist agreed and the patient/inmate was stable when Dr. L next saw him in court.

Dr. N

62. Dr. N has been practicing medicine in this Province since 1975 and general adult psychiatry since 1985. He was on staff of the Health Sciences Centre for twenty years and now has a general psychiatric practice. Dr. N has experience dealing with the corrections system. He has assessed individuals at the St. John's Lock-Up under the *Mental Health Act*. He has also been retained to determine if accused are fit to stand trial. He has been to HMP many times to visit patients.

63. There is a serious risk of taking inmates off prescription drugs like benzodiazepine too quickly. The patient may experience psychosis as a result of having these medications tapered too rapidly. There was a rash of suicides at the Health Sciences Centre in the 1990's. An external review was conducted by independent consultants from Nova Scotia. One of the contributing factors for the suicides was the stoppage, or abruptly tapering, of benzodiazepines.

64. While it is preferable that patients be on benzodiazepine for short periods of time, Dr. N stated that most adult psychiatric practices have people on these drugs for extended periods of time.

65. Dr. N noted that it is important for each psychiatrist to make his or her own diagnosis of a patient. He was of the opinion, however, that if a person has been prescribed a medication for an extended period of time, a new psychiatrist should consult with the psychiatrist who prescribed the medication before tapering that drug. With advances in modern communications, this task is not onerous. Most psychiatrists are willing to send you at least the patient's last chart notes or information gathered on admission to hospital.

66. Dr. N does not believe that a blanket prohibition against the prescription of medications to address insomnia is warranted. He estimates that 20% of people with mental disorders have problems with sleeping. Sleeping difficulties present as one of the first indications of a manic episode among bipolar patients. Most people have sleep problems when faced with significant stress.

67. Dr. N attended a forensic psychiatric conference in Montreal which had speakers promoting the idea that the highest level of psychiatric care in any society should be within the prison and legal systems. Mental illness is

frequently a life-long illness. A society that can properly address the mental illnesses and disorders of inmates can achieve social and economic dividends as realized by lower rates of recidivism.

68. Dr. N recalls being at HMP to assess an inmate and the supervisor at the facility advised Dr. N not to see the inmate unless he was in shackles. The inmate was exhibiting violent outbursts. After the assessment, a correctional official poignantly stated, "Doc, if this guy had a broken leg, he would be in hospital".

The John Howard Society

69. Officials from the John Howard Society indicated that their organization works to reduce crime by providing rehabilitation opportunities for offenders. It works in the community by providing education and advocacy opportunities. It has been in this Province since 1951. It is the position of the John Howard Society that inmates entering correctional facilities throughout the Province should have the same right to access medical treatment as other citizens of the Province. An inmate's incarceration is not coupled with a sentence of diminished medical care.

70. The John Howard Society often has access to an inmate's case file after they leave HMP. Offenders who have acquired a number of institutional charges are often the same ones who suffer from mental illnesses and disorders. Those illnesses and disorders can manifest in behavioural issues which cause the offender to break the rules and regulations of the institution.

71. The John Howard Society has encountered many offenders who state they had their psychiatric prescriptions terminated or tapered after incarceration. They are advised they can complain to the Newfoundland Medical Board. This is often not realistic. The offender at this point may be facing a number of important issues including re-establishing relationships within the community. They may also be dealing with the effects of having their medications tapered or discontinued while in prison. They often lack the stamina, insight and confidence to pursue a complaint.

72. Officials of the John Howard Society were able to give examples of the plight of offenders who suffer from mental disorders and are in and out of the HMP. They may also suffer from addictions. Once convicted, they will go to the HMP where their medications are eliminated or tapered. Upon release, they reconnect with their community physician or psychiatrist and are prescribed medications. If arrested or convicted again they experience the effects of having those medications eliminated or tapered. An offender can be in a real mess after experiencing the cyclical effects of having prescription drugs and the denial of these drugs while incarcerated.

73. Inmates who have physical disabilities, disorders and illnesses are much more likely to get proper attention and care. This fact is also reflected in the population at large, but the consequences of this for those incarcerated are far more severe.

The Reasonable Expectations of Inmates

74. The reasonable expectation of inmates with respect to their access to psychiatric drugs prescribed after incarceration can be ascertained by reviewing a number of various sources. Accreditations Canada is a non-profit independent organization that provides various health organizations with the benefit of peer reviews to assess the quality of their performance. Their assessments are based upon evidence and focus on patient safety, ethics, staff training and community partnerships. Its 2010 Provincial Correctional Health Services Standards has the following purpose; [1]

> Accreditation Canada's provincial Correctional Health Services Standards are intended for health services delivered in correctional facilities other than at the federal level, that have different security levels (minimum, medium, maximum) and diverse inmate (or prisoner, or offender) populations (including youth, women, Aboriginal, seniors). "Health services" is defined as including nursing assessments and interventions, diagnostic services, physician clinics, health promotion and prevention, emergency care, dental services, psychiatric and psychological services, special programs (e.g. Methadone), and dialysis. Correctional health services are planned, designed, delivered, modified, and evaluated to fit the needs of inmates while considering local and organizational security protocols.

75. The following excerpts from those standards are germane to this Investigation;

> **9.1. The health care team conducts a health assessment for inmates in accordance with applicable policy upon admission or transfer to the correctional facility.**
>
> **Elements of psychosocial health include functional and emotional status, including inmate's communication and self-care abilities; previous mental health problems; mental health status, including personality and behavioural characteristics;**

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risk-taking behaviour, including alcohol, drug use, and lifestyle choice; socio-economic situation; spiritual orientation; and cultural beliefs.

9.4. The health care team gathers an inmate's medical history with input from the interdisciplinary health care team and external consultants or service providers and in compliance with applicable legislation.

76. A Senate Committee report authored by Senator Kirby entitled *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* has the following to say about its goal with respect to the provision of mental health services in correctional facilities;

> **The Committee has one primary goal for federal offenders – and by extension, for provincial correctional populations – it wants the standard of care for adult mental health within correctional institutions (and in post-release settings) raised to be equivalent to that available to "non-offender" members of the general community.**

77. Rule 22 of the Department's policy and procedure manual dealing with inmates' rights states;

> **(1) At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of Psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include psychiatric services for the diagnosis and, in proper cases, the treatment of states of mental abnormality.**

The Test

78. Section 37 of the *Citizens' Representative Act* sets out the test, or the prerequisites which must exist, before the Citizens' Representative can make recommendations following an investigation. Section 37 states;

> ***37.***
>
> *(1) Where, after making an investigation under this Act, the Citizens' Representative is of the opinion*
>
> *(a) that a decision, recommendation, act or omission that is the subject matter of the investigation appears to be*

(i) contrary to law,
(ii) unreasonable,
(iii) unjust,
(iv) oppressive,
(v) improperly discriminatory,
(vi) in accordance with a practice or procedure that is or may be unreasonable, unjust, oppressive, or improperly discriminatory,
(vii) based wholly or partly on a mistake of law or fact, or
(viii) wrong;

(b) that in making a decision or recommendation, or in doing or omitting an act, a power or right has been exercised

(i) for an improper purpose,
(ii) on irrelevant grounds, or
(iii) on the taking into account of irrelevant considerations; or

(c) that reasons should have been given for a decision, recommendation, act or omission that was the subject matter of the investigation, the Citizens' Representative shall report his or her opinion and his or her reasons and may make those recommendations that he or she considers appropriate to the appropriate minister and to the department or agency of the government concerned.

(2) In making a report under subsection (1), the Citizens' Representative may recommend

(a) that a matter should be referred to the appropriate authority for further consideration;

(b) that an omission should be rectified;

(c) that a decision should be cancelled or varied;

(d) that a practice on which a decision, recommendation, act or omission was based should be altered or reviewed;

(e) that a law on which a decision, recommendation, act or omission was based should be reconsidered;

(f) that reasons should be given for a decision, recommendation, act or omission; or

(g) that other steps should be taken.

Observations and Conclusions

79. The following observations and conclusions flow from a thorough review of the evidence collected throughout this Investigation.

80. The existence of illicit prescription drugs in this Province's correctional facilities, particularly HMP, poses a persistent and serious threat to the security of inmates, staff and the facilities. The Superintendent of Prisons and the Assistant Superintendent of HMP gave compelling examples of the problems associated with drug seeking behavior by inmates addicted to prescription drugs. The problem poses a daily safety concern for prison officials and correctional officers. These problems are also well documented in the literature dealing with prisons and prescription medications. Despite these concerns, the Superintendent of Prisons and the Assistant Superintendent of HMP indicated that the decision to prescribe medications rests solely with the Psychiatrist. Throughout our Investigation, officials from the Department have maintained that Departmental officials do not have access to the medical records of inmates. In the OCR's conduct of this Investigation, as well as the investigation of hundreds of individual complaints from inmates, we have found no evidence that the details of inmates' medical files are shared with Departmental or prison officials. Thus, while prison officials have a well-founded concern for eliminating or reducing prescription drugs in the Province's correctional facilities, we have found no evidence that this concern influences how or why individual inmates receive psychiatric drugs prescribed by the Psychiatrist. More generally, however, the Psychiatrist indicates he was recruited because of his conservative approach to prescribing medications. This approach is congruent with the Department's concern about the prevalence of prescription drugs in correctional facilities.

81. Inmates should have the reasonable expectation that they will receive the same type and level of medical care which is available to all citizens. The deprivation of many of the rights and privileges experienced by inmates upon incarceration does not extend to differential psychiatric care. Some have suggested, including Dr. N, that the best possible psychiatric care should be provided in our correctional institutions. The suggestion is compelling. Too often we perceive our prisons as foreign, intimidating and menacing institutions when in fact, they are part of a well-functioning, modern society. They not only house those who have violated societies' norms, but they are institutions where our family and friends work. Often, after short periods of incarceration, inmates are back in society. In light of this, it is important that the psychiatric services

provided at our correctional institutions be, if not superior, then at least similar and equivalent to that available to all citizens.

82. We conclude that the reasonable expectations of inmates with respect to the prescription of psychiatric drugs are not being met by the Department for the following reasons: The Department is fully aware of the conservative prescription practices of the Psychiatrist. According to the Psychiatrist, it was his conservative practice which brought him to the attention of the then Superintendent of Prisons for the Department. The March 12, 2007 letter (Appendix A) from the Psychiatrist to the then Superintendent of Prisons outlines in great detail the conservative nature of the Psychiatrist's prescription practices. Those conservative prescription practices were confirmed and fully discussed in the Department's *Decades of Darkness* review.

83. While the Psychiatrist is a duly trained, licensed and well-experienced practitioner operating within the standards of practice for his profession, inmates under his care do not receive the same care which is available to the general public. The Psychiatrist has indicated that one of the differences between treating inmates and patients in the general population is the level of control available in the prison setting. Patients in the community who are unhappy with his conservative prescription practices are free to seek authorized prescription drugs elsewhere. He indicated that he does have fee-for-service patients who have been on some prescription drugs, such as benzodiazepines, for extended periods of time. This does not occur with inmates. He indicated that if one of those patients was incarcerated he would eliminate or taper their drugs in an effort to see what would happen in the prison setting. Thus, the control made possible by incarceration is a distinguishing feature in how inmates versus patients are treated.

84. The Psychiatrist indicated that he makes his own diagnosis of inmates once first seen by him after incarceration. All three psychiatrists that we interviewed indicated that it was the prerogative, if not the responsibility, of a psychiatrist to make his or her own diagnosis. This prerogative/responsibility does not mean that a psychiatrist cannot benefit from contacting the former physicians and psychiatrists who have treated inmates. Indeed, the Correctional Health Services Standards drafted by Accreditations Canada contemplates that medical personnel operating in correctional facilities will consult with the treating physicians of inmates prior to incarceration. The Psychiatrist does not appear to undertake this practice.

85. It is also clear that the Psychiatrist's consultations and follow-ups with inmates are of a shorter duration than those which occur for his fee-for-service patients. He indicated that this was so because of an unofficial prison norm that inmates should not disclose more information than necessary to prison officials and medical staff. It is an open question as to whether this norm exists because of a perceived currency for private information among inmates or a breakdown in

the therapeutic relationships between inmates as patients, and the Psychiatrist because of his widely known prescription practices.

86. Dr. L gave the example of a long-time patient who had experienced stability after being treated with Ritalin. Upon the patient being incarcerated, Dr. L made contact with the Psychiatrist to ensure that the prescription would be maintained. When Dr. L next saw the patient in court he was stable and doing well. What of those patients who would benefit from this drug after incarceration, but do not have the benefit of Dr. L's initiative?

87. In conclusion, the reasonable expectation of inmates with respect to their access to prescription psychiatric drugs is not being met. This is so because the control associated with imprisonment permits the Psychiatrist to use a somewhat different approach to prescriptions than he uses with his other patients. For whatever reason, the length of consultations between an inmate and the Psychiatrist are shorter than those experienced by his fee-for-service patients. Additionally, contrary to the Correctional Health Services Standards and the practices of the other medical professionals at HMP, the Psychiatrist does not routinely consult with the treating physicians and psychiatrists of inmates prior to incarceration. The Department has been aware of the conservative prescription practices of the Psychiatrist. We conclude that to continue to retain him to provide psychiatric services for the provincial correctional facilities is unreasonable, unjust and oppressive to inmates, as contemplated by section 37 of the *Citizens' Representative Act*.

Recommendations

88. The Psychiatrist has consistent and strongly held views about how prescription psychiatric medications should be administered in correctional facilities. There is little prospect of those views being changed. In light of this, and pursuant to section 37 of the *Citizens' Representative Act,* we recommend that the Department undertake a request for proposals for the provision of psychiatric services at the Province's correctional facilities. Respondents to the request should outline their general philosophies with respect to the prescription of psychiatric medications. We further recommend that the Department accept a request which will ensure that inmates have the same access to properly prescribed prescription drugs as citizens in the community. Pursuant to section 38 of the *Citizens' Representative Act*, we request that the Department, within 30 days of the release of this Report, provide us with notification of the action it will take in respect to this recommendation.

Barry Fleming, Q.C.
Citizens' Representative

March 25, 2014
Date

Appendix 1.

March 12, 2007

[redacted]
Superintendent of Prisons
c/o Her Majesty's Penitentiary
St. John's, NL

Dear Mr [redacted]

Re: Prescription of Psychotropic Medications to Inmates

I would like to note the following:

1. According to a study done by [redacted] the lifetime prevalence of substance-use disorders among inmates of provincial prisons is approximately 87%. My experience would suggest that [redacted] figure is about right for prison inmates in Newfoundland and Labrador.

2. Insomnia is either a symptom of another medical condition or mental disorder or a self-correcting condition, not an illness in its own right. There is no need to treat insomnia pharmacologically and "sleeping pills" lose their effectiveness within days of being started. Therefore there is no need to prescribe any medication to prison inmates for the purpose of helping them to sleep. Most commonly-used "sleeping pills" also have abuse potential.

3. Anxiety may be a normal response to external stressors, a symptom of another medical or mental disorder or symptomatic of an anxiety disorder. While benzodiazepines ("Valium-like" drugs) are effective in relieving anxiety symptoms in the short term, like "sleeping pills" they soon lose their effectiveness. In the long term, benzodiazepines probably make anxiety disorders and mood disorders worse, not better. All benzodiazepines have abuse potential. The indications for long-term use of benzodiazepines are therefore few and far between, the one major exception being the use of a benzodiazepine, usually either clobazam or clonazepam, as an anticonvulsant.

   On the other hand, short term use of benzodiazepines is often indicated for patients who are undergoing withdrawal from either alcohol or other sedative drugs. In practice, a number of physicians seem to prescribe benzodiazepines for patients who are undergoing withdrawal from other drugs, such as cocaine and other stimulants or from opiates (morphine-like drugs such as OxyContin). The use of benzodiazepines under these circumstances should be short-term, that is no longer

than, at most, two to three weeks, including the time needed to taper and stop the benzodiazepine. Tapering of patients from chronic benzodiazepine use may take up to several weeks to complete, depending mainly on the total dose of benzodiazepines which they were previously taking.

4. For practical purposes, with rare exceptions, there is no justification for simultaneously prescribing more than one antidepressant agent or more than one antipsychotic agent to anybody at any one time. The only exception is that of an "overlap" period, during which one is changing a patient from one antidepressant to another or one antipsychotic agent to another, during which it is reasonable to increase the dose of one antidepressant or antipsychotic agent while simultaneously decreasing the dose of the other. This overlap period should not exceed six weeks at a maximum and in most cases should not exceed four weeks.

The one partial exception to this rule is that the tricyclic antidepressants imipramine and amitriptyline are useful in the treatment of certain types of chronic pain. In these circumstances, it is probably reasonable for someone to prescribe either imipramine or amitriptyline for back pain and another antidepressant for either an anxiety disorder or a mood disorder. However, it would usually be preferable to simply prescribe either amitriptyline or imipramine for both conditions.

5. Local experience and, I understand, experience across the country strongly suggests that the antipsychotic agent quetiapine (Seroquel) elicits drug-seeking behaviours among prison inmates. A recent letter in the January 2007 issue of the American Journal of Psychiatry strongly suggests that quetiapine has abuse potential. In addition to its use as an antipsychotic agent, quetiapine is sometimes used as a mood stabilizer for people suffering from bipolar disorder. Quetiapine also seems to be used to reduce behaviour outbursts, as an anti-anxiety drug and as a "sleeping pill". The use of quetiapine as an antipsychotic agent or as a mood stabilizer for patients suffering from bipolar disorder is clearly acceptable. Its use to modify behaviours is probably acceptable. However, its long-term use as an anxiety-reducing drug or as a "sleeping pill", in my opinion, is more likely to do harm than good. In any event, quetiapine is not a first-line treatment for either anxiety or insomnia.

6. The prescription of psychostimulants (i.e. various preparations of methylphenidate and/or dextroamphetamine), while widely accepted as a treatment for children suffering from attention deficit hyperactivity disorder, remains controversial as a treatment for adults suffering from attention deficit hyperactivity disorder. Both methylphenidate and dextroamphetamine have very high abuse potential. This makes their use particularly problematic among people with substance use disorders, especially in an environment such as a prison with a high risk of diversion of prescribed drugs with abuse potential. Alternative treatments for attention deficit hyperactivity disorder include treatment without medications, atomoxetine, antipsychotic agents in small to moderate doses, and a number of antidepressants including imipramine, desipramine, venlafaxine and bupropion.

The occasional patient suffering from HIV/AIDS may be prescribed either methylphenidate or dextroamphetamine for the treatment of AIDS dementia. Such treatment should not be interfered with without discussing the matter with the inmate's community psychiatrist.

7. Buspirone was initially marketed as an anxiolytic (anxiety-reducing drug) in the mid-1980's. As was acknowledged by the manufacturer when buspirone was initially marketed, buspirone does not appear to be of any benefit to anyone who has previously been exposed to benzodiazepines. This would exclude virtually the entire inmate population. My subsequent clinical experience and that of my colleagues has been that buspirone is devoid of both beneficial effects and adverse effects. In other words, buspirone is effectively an expensive form of water.

In light of the above, I would respectfully recommend the following:

1. The use of any medication for the sole purpose of inducing or maintaining sleep should be strongly discouraged. Inmates complaining of insomnia should be assessed, first to determine whether or not they have insomnia and second, if they have insomnia, whether or not their insomnia is due to an underlying medical illness or mental disorder. Inmates suffering from an underlying medical illness or mental disorder should receive appropriate treatment for the underlying disorder, not for insomnia itself. Inmates suffering from insomnia without an underlying medical illness or mental disorder should be educated about sleep hygiene. No new prescription should be written for any medication for the primary purpose of inducing or maintaining sleep, regardless of whether that medication is primarily marketed as a treatment for insomnia or as a treatment for some other condition.

Inmates entering custody who are already regularly prescribed medications for the purpose of inducing sleep should undergo medical and psychiatric assessments. Any underlying medical illness or mental disorder should be appropriately assessed and treated. Medications being prescribed for the induction or maintenance of sleep should be tapered and stopped, normally at a rate of approximately 1 standard "sedating dose" (e.g. temazepam 15 mg, methotrimeprazine 25 mg) per day approximately once per week until the medication has been stopped. Prescriptions of relatively short duration may be safely and appropriately be tapered at a faster rate.

2. The long-term use of benzodiazepines should be discouraged, except for inmates suffering from epilepsy for whom a benzodiazepine is being prescribed as an anticonvulsant. New prescriptions for benzodiazepines should normally be restricted to those inmates who are suffering from acute withdrawal from alcohol, other sedatives or possibly stimulants and/or opiates. The maximum duration of these prescriptions should not typically exceed 2 weeks, except in very unusual circumstances. New prescriptions for benzodiazepines for the use of relieving anxiety should be discouraged and should never exceed four days in duration.

   Inmates entering custody who are already regularly prescribed benzodiazepines, other than for the purpose of treating epilepsy, should undergo medical and psychiatric assessments. Any underlying medical illness or mental disorder should be appropriately assessed and treated. Benzodiazepines being prescribed for purposes other than the treatment of epilepsy should normally be tapered and stopped at a rate of approximately 1 standard "anxiolytic dose" (e.g. diazepam 10 mg, clonazepam 0.5 – 1 mg) per day approximately once per week. Prescriptions of relatively short duration may be safely and appropriately tapered at a faster rate.

   Inmates who are being prescribed a benzodiazepine for the treatment of epilepsy should undergo a medical and/or psychiatric assessment to determine the appropriateness of the use of the benzodiazepine for that purpose. Whether the benzodiazepine should be continued, tapered and stopped or otherwise changed should depend on the outcome of this assessment.

There being no indication for the use of more than one benzodiazepine at a time, the simultaneous prescription of more than one benzodiazepine to an inmate should be strongly discouraged. Inmates who are being prescribed more than one benzodiazepine should either be switched to monotherapy (treatment with only one benzodiazepine) or have all benzodiazepines tapered and stopped, whichever is appropriate.

3. The simultaneous prescription of more than one antidepressant or of more than one antipsychotic agent to any one inmate should be strongly discouraged. The only exceptions to this rule should be 1) during "overlap" periods as described above, during which the dose of one antidepressant or antipsychotic is being increased while that of the other is being decreased, and 2) the simultaneous use of either imipramine or amitriptyline for pain relief and another antidepressant for treatment of either a mood disorder or an anxiety disorder. The "overlap" periods should not exceed six weeks in duration and, in most cases should not exceed four weeks. Consideration should be given to treating inmates who are suffering from both an anxiety or depressive disorder and chronic pain with either imipramine or amitriptyline for both disorders whenever it is appropriate to do so.

   Inmates entering custody who are already simultaneously being treated with more than one antidepressant or antipsychotic agent should undergo a psychiatric assessment to determine the appropriateness of these prescriptions. In most cases it will be appropriate to taper and discontinue all but one of the antidepressants or antipsychotic agents. This may or may not require an adjustment in the dose of the remaining antidepressant or antipsychotic agent. This tapering may take up to several weeks to complete.

4. Caution should be exercised in the prescribing of quetiapine for indications other than the treatment of psychosis or bipolar disorder. Its use for either of these indications is acceptable. The initiation of prescriptions for quetiapine for the purpose of reducing behavioural outbursts should be approached with caution. The initiation of prescriptions for the purposes of reducing anxiety or inducing or maintaining sleep should be discouraged.

   Inmates entering custody who are already being prescribed quetiapine should undergo a psychiatric assessment to determine the appropriateness of their prescription for quetiapine. Inmates who are being treated for either psychosis or bipolar disorder with quetiapine should normally be continued on quetiapine at the

originally prescribed dose unless a change is clinically indicated. Inmates who are being prescribed quetiapine for problematic behaviours may or may not need to be continued on quetiapine. Inmates who are being prescribed quetiapine for either anxiety or insomnia should normally have their dose of quetiapine tapered and stopped. This tapering may take up to several weeks to complete. Depending on the underlying cause of their anxiety, inmates being treated for anxiety with quetiapine may or may not benefit from a therapeutic trial of an antidepressant.

5. The pharmacological treatment of adults suffering from attention deficit hyperactivity disorder is problematic in prison settings, particularly if these adults have a history of a substance use disorder, especially if the substance(s) abused include one or more stimulants and/or cocaine. The initiation of a prescription for either methylphenidate or dextroamphetamine should be discouraged unless the inmate ~~clearly suffers from attention deficit hyperactivity disorder and has either failed to respond~~ to an alternative to the psychostimulants or has unequivocally responded to either methylphenidate or dextroamphetamine in the past. This should be particularly the case for inmates with a history of a substance use disorder, especially if the substance(s) abused included one or more stimulants and/or cocaine.

Inmates suffering from attention deficit hyperactivity disorder entering custody who are already currently being prescribed either methylphenidate or dextroamphetamine should undergo a psychiatric assessment to determine the appropriateness of their prescription for the psychostimulant. Depending on the outcome of that assessment, it may or may not be appropriate to continue the psychostimulant for the duration of their incarceration. Alternatively, it may be appropriate to begin a therapeutic trial of a drug other than a psychostimulant or with no drug.

Inmates who are being treated for AIDS dementia with either methylphenidate or dextroamphetamine should not normally have their prescription for either methylphenidate or dextroamphetamine altered without first discussing the matter with their community psychiatrist.

Inmates other than those suffering from AIDS dementia who are caught hoarding, diverting/attempting to divert or otherwise misusing their prescriptions for either

methylphenidate or dextroamphetamine should normally have these prescriptions stopped immediately.

6. Prescriptions for buspirone should not normally be initiated for inmates. Inmates entering custody who are already currently being prescribed buspirone should undergo a psychiatric assessment to determine the appropriateness of their prescription for buspirone. In the vast majority of cases, they will not have any valid indication for buspirone, in which case buspirone can and should be stopped immediately.

7. With the above provisos, I would respectfully recommend that the formulary of psychotropic medications for inmates be the same as that of the Newfoundland and Labrador Prescription Drug Program.

Yours respectfully,

[redacted]
Psychiatrist

cc: [redacted] Director of Corrections
[redacted] RN

Appendix 2.

Eastern Health

[redacted]

January 30, 2008

[redacted]

The College of Physicians and Surgeons of Newfoundland and Labrador
139 Water St., Suite 603
St. John's, NL
A1C 1B2

RECEIVED
FEB 6 2008
H.M. Penitentiary

Dear [redacted]

Re: **Understanding concerning the Division of Medical Services Provided to Inmates/Patients at Her Majesty's Penitentiary (HMP) and at Other Correctional Facilities in Newfoundland and Labrador**

I apologize for the lengthy delay in getting this letter to you.

As per your request of approximately October 16, 2007, the following is the informal agreement about the division of medical services to inmates/patients at HMP into psychiatric services and non-psychiatric services respectively. While I have never seen this agreement in written form, it has, to my knowledge, existed since well before I began providing psychiatric services to inmates at HMP. This agreement has followed the extension of specialty psychiatry services to other correctional facilities in Newfoundland and Labrador.

Rationale

Populations of inmates in provincial correctional facilities are characterized by extremely high prevalences of substance-use disorders and personality disorders as well as other major mental disorders. By nature, patients suffering from many of these disorders are prone to drug-seeking and other manipulative behaviors which, if unchecked, would lead to therapeutic chaos. In order to keep these behaviors in check, it is vital to divide and clearly demarcate services provided by physicians to inmates/patients and HMP into psychiatric services, which are provided by a psychiatrist, and non-psychiatric services, which are provided by a family physician or general practitioner. This is particularly necessary in the prescription of pharmaceutical agents.

Division of Services by Symptoms/Complaints

Complaints of a psychiatric nature, including complaints of anxiety, insomnia, irritability, depression, or mood instability, suicidal ideation or behavior or complaints suggestive of psychosis, should normally be addressed by a psychiatrist until such time as a non-psychiatric basis for these symptoms is suspected, at which point the inmate/patient should be referred to the family physician/general practitioner for further diagnosis and treatment. Conversely, all other symptoms or complaints should normally be addressed by the family physician/general practitioner until such time as a psychiatric basis for the symptom/complaint is suspected, at which point the inmate/patient should be referred to the psychiatrist for further diagnosis and treatment. In cases of uncertainty about a psychiatric or non-psychiatric basis for a symptom/complaint, the psychiatrist and family physician/general practitioner should collaborate in the assessment and management of the inmate/patient's complaint.

Substance Abuse/Substance Withdrawal

The assessment and management of inmates/patients with substance-use disorders will normally be the responsibility of the psychiatrist. In urgent or emergency situations, the assessment and management of the inmate/patient, including the prescription of any drugs, whether psychotropic or non-psychotropic in nature, will be undertaken by the first available physician, regardless of whether he/she is a psychiatrist or a family physician/general practitioner, until such time as the psychiatrist can appropriately assume responsibility for the further assessment and treatment of the inmate/patient.

Emergency Situations

Depending on the nature, seriousness and urgency of the situation and the availability of the appropriate personnel, inmates suffering from urgent or emergency medical conditions, regardless of whether they are of a psychiatric or a non-psychiatric nature, will, depending on what is most appropriate, be addressed by either the psychiatrist or the family physician/general practitioner, the nursing staff with or without emergency referral to the most appropriate emergency department or other resource or directly by correctional staff, usually by emergency referral to the most appropriate emergency department or other resource. When in doubt, "common-sense" should prevail. Follow-up

care of the inmate/patient, once the urgent or emergency situation has been resolved, will normally be undertaken by the most appropriate individual.

Use/Prescription of Psychotropic versus Non-Psychotropic Drugs

The intended use of the drug administered/prescribed, rather than its classification as a psychotropic or non-psychotropic medication, should normally determine whether it is administered/prescribed to an inmate/patient by a psychiatrist or a family physician/general practitioner. While, in most cases, the intended use and the pharmacological classification of a drug are identical, numerous exceptions apply. To cite some examples, a number of tricyclic antidepressants, particularly amitriptyline, are used in the management of certain types of pain and certain mood stabilizers have uses in the management of epilepsy and/or of chronic pain. Conversely, a number of non-psychotropic agents, such as antihistamines, have psychotropic uses, particularly in the induction and/or maintenance of sleep.

Decisions regarding the prescription/administration of medications or other treatments for psychotropic purposes, including the management of insomnia, anxiety, non-emergency substance-withdrawal states, and major mental disorders will normally be the responsibility of the psychiatrist, regardless of whether the medications prescribed or administered are conventionally classified as "psychotropic" or "non-psychotropic" agents. Conversely, decisions regarding the prescription/administration of medication or other treatments for non-psychotropic purposes will normally be the responsibility of the family physician/general practitioner, regardless of whether the medications or treatments prescribed or administered are conventionally viewed as "non-psychotropic" or "psychotropic" agents.

[redacted] the family physician currently responsible for the provision of general medical services to inmates/patients at HMP will have had input into and approved of the contents of this letter by the time it is signed and sent to you. [redacted] Manager of Institutional Programs, will also be aware of the contents of this letter by that time.

I hope that the above is helpful in clarifying the division of medical responsibilities between the psychiatrist and the family physician/general practitioner at HMP.

Yours truly

[redacted]

Psychiatrist

[redacted]

cc: [redacted] Manager of Institutional Programs, c/o Her Majesty's Penitentiary

Appendix 3.

Reading List
Mental Illness and Prisons

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