# EXTERNAL PEER REVIEW OF PSYCHIATRIC SERVICES IN NEWFOUNDLAND CORRECTIONS

**September 19, 2012**


**Philip E. Klassen, M.D., FRCP(C)**
**Practice in Forensic Psychiatry**

***Vice-President, Medical Affairs***
***Ontario Shores Centre for Mental Health Sciences***
***Assistant Professor, Departments of Psychiatry and Medicine***
***University of Toronto***

TABLE OF CONTENTS

1. Executive Summary.....page 3
2. Review of Documentation .....pages 4-8
3. Interview Findings .....pages 9-13
4. Overview of Chart Review.....page 14
5. Conclusions and Recommendations.....pages 16-18
6. Appendices……...pages 19-25

## EXECUTIVE SUMMARY

The provision of psychiatric services in Newfoundland Correctional Facilities, offered by Dr. David Craig, was peer-reviewed. The peer reviewer worked as an independent physician with a practice in forensic psychiatry, for this purpose. Documentation was provided in advance. Twenty-three charts were randomly selected for review. A number of parties were interviewed.

Overall, Dr. Craig meets the standard of care, where that standard is comparable service provision in other provinces.

That being said, correctional mental health services can be improved, in Newfoundland and Labrador and elsewhere. Psychiatrists function within a health care delivery system and within teams; recommendations for improvement are made.

## REVIEW OF DOCUMENTATION

I had made available to me a document entitled **Department of Corrections Section 16 Healthcare Services**, dated April 1st, 1986. This document indicates that the objective of the Department of Corrections is that "...all offenders in custody have access to comprehensive system of quality healthcare services governed by standards comparable to those applied in the community." It's indicated that inmates should be transferred to receive healthcare services, if necessary, and/or should be given access to their own physician, if necessary. Wherever possible, psychiatric referrals should be made by the family practitioner or a general practitioner working in the correctional setting. It's indicated that nursing staff are to screen inmates for possible mental health difficulties, that a family practitioner is to assess the inmate within five days (including a mental health and addictions history). In dissociation cells, inmates are to be seen daily by the nurse, and at a minimum every five days by the physician. Further, inmates are to be seen by the family physician prior to transfer.

It's indicated that access to psychiatrists or other mental health programs should be provided "...where there's a demonstrated need", and the inmate "...should receive appropriate care and treatment while in custody".

This document indicates that where possible, inmates with mental health or addictions difficulties are to be referred for specialized treatment, including with respect to psychosis, mental retardation, organic difficulties, personality disorders, and substance abuse problems, using existing community services, and transfer if necessary, including to a forensic unit. It is indicated that this is necessary as some inmates "....will require special attention to prevent...deterioration of the inmate's health."

Further, it's indicated that there is to be a psychiatric evaluation of any inmate who is suicidal, homicidal, or "....extremely inappropriate". The document indicates that there is a collective, correctional, responsibility for suicide prevention.

The document further indicates that the mental health unit at Her Majesty's Penitentiary, (HMP) offers nursing, psychology, and psychiatry services, for preventive segregation, and individualized treatment of inmates with special needs, along with consistent case management.

All inmates are to have access to medical clinics. All inmates in segregation or dissociation cells are to be seen at each clinic. For inmates who require specialized healthcare services, individual treatment plans "...shall be developed...". The Medical Officer is to develop a treatment plan, including with respect to some or all of medication treatment, referral, or other interventions. The decision to transfer is the physician's, but the treatment is not to be limited to that available in Corrections.

With respect to prescribing practices, medications are not to be crushed, unless the inmate presents with a history of "persistent drug abuse", or there is reasonable apprehension of hoarding, albeit this is seemingly based on the notion that crushed medications are often

unpalatable, and may "...damage internal digestive systems". As well, it's said that crushed medications may not achieve their optimal affect, or may anesthetize the tongue.

It's further indicated that "the long-term use of minor tranquilizers and analgesics subject to abuse will be discouraged unless clinically indicated"; this is to be a medical decision, albeit with institutional surveillance.

I subsequently had made available to me a **Corrections Policy Manual** regarding healthcare, dated **April 1st, 2010**. There are 45 sections to this policy Manual, but not all sections were made available; the only possibly relevant section omitted was a section of pharmaceuticals.

The Policy Manual indicates that correctional officers are to ensure that release planning and follow-up are available for inmates. It's said that inmates exhibiting indicia of distress, or with a history of mental health care, are to be referred for assessment. The philosophy of treatment references professional standards, and availability of treatment is to be "equivalent in quality" to that in the community, including "medical rehabilitation" of the inmate. Access to essential services is to be "...in keeping with generally accepted community practices", or "governed by standards comparable to those applied in the community".

I had made available to me **A Review of the Prison System in Newfoundland and Labrador dated October 1st, 2008** [some blacked out]

It's indicated that the Adult Custody Section manages five facilities and approximately 281 inmates [elsewhere Dr. Craig indicates that 80% of these inmates are serving sentences and 20% are on remand approximately].

The themes of this review include:

- Organizational requirements (particularly dynamic security)
- Resourcing requirements
- Labour relations
- Legislative recommendations
- Policy recommendations
- General health recommendations
- Mental health recommendations
- Programming recommendations (identified as the most significant issue to inmates)
- Continuity of service to the community

The report suggests a more rehabilitative atmosphere, and notes difficulties among staff, with low morale and trust. It's indicated that there's generally little programming available.

The report indicates that inmates at Labrador Correctional Centre are 94% Aboriginal, and notes the need for cultural competence.

It's indicated that resourcing needs to follow a plan.

I had made available to me the **Letter of Dr. David Craig to Dr. John Scoville dated March 12th, 2007 [with updated July 5th, 2011].** Dr. Craig indicates that there's no need to treat insomnia pharmacologically; insomnia is either a symptom of another mental disorder, or a self-correcting difficulty. He indicated that sleeping pills lose their effectiveness within days, thus there is "no need" to prescribe these, and many sleeping pills have abuse potential.

Dr. Craig indicates that benzodiazepines soon lose their effectiveness and in the long term "...probably make anxiety and mood disorders worse, not better." A taper takes place over several weeks. Dr. Craig indicated that there's rarely an indication for more than one antidepressant or antipsychotic. He indicates that Seroquel may have abuse potential. He indicates that psychostimulant use for ADD in adults is controversial, and these agents have high abuse potential.

There's no indication in this letter of discussions with inmates about some of the foregoing issues, or offering inmates choices with respect to symptom management.

I had made available to me the **Letter of Dr. David Craig to Dr. R. Young dated January 30th, 2008** Dr. Craig indicates that inmates may display drug-seeking and manipulative behaviours which, if unchecked, would lead to therapeutic chaos. He indicates that it's necessary to keep these behaviours in check by partitioning prescribing of some medications between the family physician and the psychiatrist.

I had made available to me the **Letter of Dr. David Craig to Greg Brown/Simonne Poirier dated May 5th, 2008 [with update July 5th, 2011]** Dr. Craig indicates that he began providing service to Corrections in 1999. He indicates that his conservative approach has led to less coercion on the range(s) and better inmate alertness, without behavioural deterioration. On page 7 it's indicated "...I make a working diagnosis and initiate whatever treatment I feel is appropriate." On page 9 it's indicated that inmates tend to be primarily interested in medication during psychiatric contacts, and tend to be "…reluctant to say anything more than necessary...", presumably due to fear of being perceived as "rats". Dr. Craig indicates that he provides psychotherapy when the inmates permit this. He sees 25 to 30 patients per day.

I had made available to me the **Letter of Dr. David Craig to Terry Carlson dated November 14th, 2008.** Dr. Craig suggests that he too should receive critical incident stress management training, suicide prevention training, and training as regards Aboriginal mental health issues. He agreed that there should be family involvement, and communication between healthcare providers at the institution, and in the community. Additional letters to Terry Carlson dated January 12th, 2009, and to Heather Yetman dated July 14th, 2011, are not additionally contributory.

I had made available to me a document entitled **Citizen's Representative Investigation of Psychiatric Services in Provincial Correctional Facilities, dated March 25th, 2011**. This followed a complaint initiated by the Citizen's Representative, about the Department of Justice,

regarding whether inmates are treated fairly, by virtue of the Department retaining a psychiatrist with "...conservative prescription practices for psychiatric drugs". Inmates have reportedly indicated that medications that they received in the community were eliminated or tapered off. It's suggested that the Department of Corrections should have a psychiatrist to prescribe "...in a manner more consistent with that available to the general population". It's said that ten to fifteen complaints were received from inmates, or their families, per year. It's said that inmates experienced a dramatic decrease in access to prescription drugs after incarceration, reportedly confirmed by the psychiatrist in question..

By means of example, it's indicated that the antidepressant bupropion (Wellbutrin) was discontinued, and methadone, for treatment of pain, was tapered from 190 mg per day to 85 mg per day. It's indicated that a benzodiazepine was discontinued. Concern was expressed about distress, reintegration, and behavioural difficulties. Correctional administrative staff, expressed concern about drug trafficking and the effect of access to medication on inmate culture, including hoarding. It's indicated that medications are dispensed on the unit.

It's indicated that the Canadian Mental Health Association (CMHA) is active in Corrections, assisting with reintegration, albeit there is a wait list. The John Howard Society is involved regarding substance abuse treatment; 8 weeks of treatment are available, in the institution, and as well treatment is available in the community. Correctional officers have reportedly been trained as regards mental health and addictions.

With respect to psychiatrist Dr. Craig, it's indicated that Dr. Craig became a psychiatrist in 1987, and is associated with Memorial University Newfoundland (MUN). He began work in Corrections in 1999, and attends at Her Majesty's Penitentiary weekly. Dr. Craig attends at the correctional facility in Clarenville one day per month, and at the Labrador Correctional Centre one day per month as well. Dr. Craig opined that mood disorders were perhaps over-diagnosed in custody, influenced by situational factors. He noted drug-seeking behaviour and intimidation. He noted a distinction between mood and adjustment disorders.

Dr. Craig indicates that inmates are seen by the nurse practitioner, and referred by the general practitioner. The availability of a psychologist was helpful, and an increase in mental health and addictions staff complement was suggested.

Dr. Craig further indicated that bipolar disorder, while a common diagnosis, is often unwarranted, in inmates. He endorsed the contents of his letter dated July, 2007. He indicated that he tends to decrease the dose of, or discontinue, use of benzodiazepine medications, in jail. He indicated that such medications impair learning.

Dr. Craig indicated that he did not obtain inmate's medical records from the community. He indicated that typically a consultation visit is a 20 minute visit, attributed to inmates' unwillingness to disclose in greater detail.

When interviewed, the nurse practitioner indicated that medications are not discontinued abruptly, rather are tapered, and that inmates typically do well off the medications so managed.

The family physician indicated that she is at times in contact with the inmate's physician in the community. If the inmate is unhappy with service received from Dr. Craig, the inmate is referred to a psychologist.

The psychologist interviewed indicated that information is at times obtained from community contacts.

Other psychiatrists interviewed suggested that they might be less rigid about medication management than Dr. Craig. One psychiatrist expressed concern about benzodiazepine medications discontinued too quickly. It's indicated that a short course of benzodiazepine medication is preferred, albeit long-term benzodiazepine treatment is at times seen. It's suggested that there should be communication with outside care providers, and that there should not be a blanket prohibition regarding use of sedative-hypnotics (sleep aids).

## INTERVIEW FINDINGS

*All parties who were interviewed were apprised of the limited confidentiality of our contact. It was indicated that my report was anticipated to become a public document, and anything that they said could be included in my report, and thus could enter the public domain. Each person was advised that they had the right not to speak with me, and even if they chose to speak with me, could decline to respond to specific questions. All parties consented to proceed. They were interviewed on February 22nd and 23rd, 2012, in Newfoundland.*

I had the opportunity to interview an RN, and nurse practitioner, at the HMP site. They're present Monday through Friday. It's indicated that the family physician is present one day per week, as is the psychiatrist. They've been at HMP for three and two years respectively. It's indicated that all of the inmates are screened, for mental health and addictions (or other) difficulties by the NP, or the family physician. Both the NP and the nurse do intake. Any individuals with a psychiatric history will be referred to Dr. Craig, directly.

HMP healthcare staff indicated that theirs is a provincial facility serving, at any one time, between 140 and 165 inmates, albeit they were uncertain how many of these were on remand, as opposed to serving sentence. In an average week, they will assess 15 to 20 new inmates, with approximately one quarter of these being referred to Dr. Craig. Dr. Craig schedules follow-up visits. Dr. Craig sees approximately 20 to 25 inmates per week. He begins at approximately 0900 hours, and completes his clinical work between 1300 and 1500 hours, depending on volume [I was advised that Dr. Craig then spends several further hours in dealing with paperwork]. Meetings of the staff serving inmates with mental health and addictions difficulties take place four to five times per year, are generally clinical, and are generally informal. A psychologist (with a Master's degree) is available to provide counselling, and Dr. Craig refers to the psychologist, Mr. Martin. They were uncertain of the proportion of the inmates with mental health or addictions difficulties so referred. Inmates are not referred for treatment at external facilities save and except for the forensic unit at the Waterford Hospital; they estimated that two to three inmates per year are sent to the Waterford Hospital. There's typically little communication with the families of inmates, unless the family is called, albeit it's indicated that the family physician quite frequently calls outside service providers. They indicated that it is "rare" that they receive mental health or addictions information about inmates, from outside providers.

The pharmacy will verify medications individuals were receiving in the community. Medication dispensing is outsourced to an external provider who is at the institution three to four times per day, albeit nursing staff do some dispensing. Medications are dispensed on the unit. They are dispensed from a blister pack which is opened, and the medications are placed in cups. Methadone maintenance treatment is provided in the multi-purpose room, in liquid form, and inmates have to remain in the room for 15 minutes post-ingestion.

Healthcare staff indicated that medications are only very rarely crushed; this is done when inmates are known to have previously hoarded or diverted medication. They've not encountered any particular issues with crushed medications, albeit dispensing of medication in crushed form

is somewhat more time consuming. They indicate that there are concerns about hoarding, or diversion, with respect to narcotics, bupropion (Wellbutrin), benzodiazepines, quetiapine (Seroquel), and methylphenidate (Ritalin). The hypnotic zopiclone (Imovane) is on the formulary.

If an inmate expresses suicidal or homicidal ideation, or is inappropriate, they are referred for psychiatric evaluation. Inmates in segregation are seen weekly by Dr. Craig. They're monitored by means of a camera. They are seen daily by healthcare staff.

It's indicated that when inmates experience distress, they are referred to Dr. Craig and are not typically treated pharmacotherapeutically, rather are referred to the psychologist. At times inmates are treated pharmacotherapeutically, but this is after efforts at psychological care. They noted that for one patient/inmate an antidepressant (amitriptyline) was identified for treatment of back pain, to avoid the medication being discontinued by Dr. Craig.

Healthcare staff further indicated that staff at HMP are relatively familiar with prescribing patterns of family physicians and/or general practitioners in the community, and to an extent respond to that. It's indicated that there are some general practitioners that dispense Ritalin with considerable frequency, and without good assessment *a priori*, and it was indicated that healthcare staff are aware of who those physicians are, and take particular care with respect to medication management of inmates who were treated by those physicians, in the community. They indicated that inmates are known to double and triple doctor. It's indicated that there are rarely behavioural difficulties when medications from the foregoing list are tapered and discontinued in custody. It's indicated that benzodiazepines are ubiquitously tapered and discontinued; methylphenidate is at times treated similarly. Inmate complaints about medication discontinuation typically centre around use of benzodiazepines, methylphenidate, and/or other sedatives.

Healthcare staff offered, with respect to the report of the Office of the Citizen's Representative, that many of the inmates who complained had a history of hoarding, selling, or otherwise misusing medications.

With respect to prescribing, they indicated that Dr. Craig never prescribes a hypnotic, never prescribes quetiapine for agitation, albeit may maintain people on medication prescribed in the community if their period of time in custody are short.

Healthcare staff indicated that monitoring, as regards metabolic syndrome, takes place at times.

Healthcare staff indicated that Dr. Craig appears knowledgeable about the literature in his area. There have not been discussions about formalization of medication management procedures.

Healthcare staff also indicated that it's not uncommon for inmates to receive medications from community contacts, who might throw them over the wall at HMP. They indicated, in response to my question, that difficulties in the institution, regarding drug misuse, reflect a mixture of use of street drugs, and misuse of prescribed medications.

I had the opportunity to speak with healthcare staff at the Clarenville Institution, specifically spoke with the healthcare coordinator and deputy coordinator (both Correctional Officers). They indicated that the women at Clarenville Institution (facility for female inmates) are both on remand, and serving sentences. Inmates tend to present with addictions difficulties, predominantly, and are typically at the institution for approximately six to eight months. They have access to a physician once weekly, in the evenings, and to Dr. Craig one day per month. They also have access to a Master's level psychologist for approximately 1.5 days every two weeks. Staff indicated that Dr. Craig is very available, and will use telepsychiatry if necessary, up to four to five times per month. When Dr. Craig comes he is present for approximately four hours. Dr. Craig manages all prescribing of psychotropic medications. At any given time, there are 10 to 20 inmates in this facility. Dr. Craig will typically see between 8 and 13 inmates per clinic. Parenthetically, as per at HMP, staff indicated that Dr. Craig makes a handwritten chart entry quickly, then provides the full consultation note soon thereafter, typically the next day.

Staff indicated that they will obtain information about inmates' community care when requested by Dr. Craig. They will not typically call family, albeit they recalled in one case there was contact with family through the Case Management Team. Inmates typically arrive with medication prescribed in the community, and there may be contact with their pharmacy.

Staff stated that a lieutenant will typically assess the health status of a new inmate, initially, then a classification officer who is a social worker provides more in-depth assessment. Inmates in dissociation or segregation are seen daily by staff, and by Dr. Craig at each visit. Medications are not administered on the unit, rather are distributed in the healthcare area (unless the inmate is segregated). Medication arrives in blister packs. Staff check for compliance; at times medications are administered crushed. There are some difficulties at the institution with hoarding for recreational use, albeit, as was the case at HMP, overdoses are rare. Occasionally medications are used as currency, between inmates. In terms of misuse of medications, staff identified benzodiazepines and opiates. They indicate that new inmates are immediately asked "what are you on" by other inmates. Methylphenidate is administered crushed and other techniques are also employed to limit the opportunity for hoarding.

In terms of referral of inmates with mental health difficulties, it's indicated that they will communicate with correctional officers, then be referred to see the family physician, or the psychologist; almost all inmates have contact with the psychologist, who offers approximately 12 hours of care per week.

It's indicated that anxiolytic or sedating medications are typically discontinued by Dr. Craig, for example benzodiazepines, trazodone, or zopiclone. Inmates at times request medication from the general practice physician; Dr. Craig recently asked that psychotropics not be prescribed by the family practice physician, and it's indicated that the general practice physician will defer to Dr. Craig. Staff indicated that while inmates are initially upset, they often present better behaviourally, afterwards. With respect to methylphenidate, few inmates receive this medication. Dr. Craig may continue the medication, if it was prescribed *a priori*, or may wean them off it. Staff do not sit with Dr. Craig during visits; he will at times have medical students with him.

I asked healthcare staff whether the inmates understood, to the best of their knowledge, the rationale for medication discontinuation and they responded "a lot of times" they did not. Inmates are frequently angry, and wonder why medication was discontinued, and will complain to the general practice physician, or correctional officers.

Staff indicated that there is a good deal of programming available to inmates, at the institution.

I had the opportunity to speak with **Barry Fleming, the Citizen's representative**. Mr. Fleming reiterated, as per his document, that he's concerned about the issue of choice; he offered that it's not fair to inmates that they cannot choose their psychiatric practitioner. He indicated that fourteen inmates agreed to release of their records, both pre-incarceration and incarceration-related records, and these were reviewed for the preparation of his report. Mr. Fleming indicated, however, that in the main he relies on self-report of the inmates, and the relative consistency of their self-report, to establish the basis for veracity of systemic concerns. Mr. Fleming expressed concerns about poor quality of the HMP facility, lack of withdrawal support, and modest programming.

Mr. Fleming also expressed concerns about Dr. Craig's practice, in a prison context, in relation to treatment available in the community.

I had the opportunity to speak with **Dr. David Craig**. His counsel was present.

Given that Dr. Craig provided a good deal of information on his practice previously, I chose to ask Dr. Craig about specific areas of practice.

With respect to adjustment disorders, Dr. Craig indicated that these respond primarily to psychotherapy. Dr. Craig indicated that as in the community, he will listen to the concerns of inmates with adjustment difficulties. He acknowledged that there can be a role for medication in the treatment of adjustment disorders, including use of various antidepressants, and benzodiazepines. With respect to adjustment disorders in custody, Dr. Craig acknowledged that these are not often identified for intervention. He stated that inmates typically do not want to discuss their adjustment difficulties, largely because they're in custody, but rather will ask for medication, informing that they're depressed. Dr. Craig opined that adjustment disorders may receive less active identification and management in custody as they are so common, akin to personality difficulties, in the inmate population.

When asked, Dr. Craig indicated that he does give inmates information as regards his management strategies [albeit this does not appear to be documented in the patient record]. He indicated that complaints about him have all centered around medication management issues, in particular regarding benzodiazepines, and latterly methylphenidate. He stated that these complaints are not the product of lack of communication.

When asked, Dr. Craig stated that he tends to see inmates for 20 minutes for new consultations, and for five minutes in follow-up.

With respect to attention deficit disorder, or attention deficit hyperactivity disorder, Dr. Craig indicated that if inmates present having been started on psychostimulant medication in the community, this is continued in custody, otherwise he will wait and watch, and may use bupropion. He expressed concern about diversion, and the potential for conflict in custody, when methylphenidate prescribing rates increase (adding that there are similar difficulties with bupropion). Dr. Craig stated that these inmates typically do well, off medication.

Dr. Craig agreed that more collateral from community care providers would be of benefit, but time constraints are an issue. He stated that he would be pleased to change his practice in this regard.

Dr. Craig expressed concerns that he's the only psychiatrist at the Detention Centre, and lacks a community in which to share experiences. He indicated that he was not particularly well versed in the specifics of Recovery model. Dr. Craig estimated that he sees approximately 50% of the inmates, at HMP, who've been there for more than three months.

Dr. Craig indicated that there is a drug-seeking group of inmates, and that other inmates want those medications. He stated that there's been an increase in oxycontin and cocaine use.

I asked Dr. Craig if he sought particular authorities with respect to correctional psychiatry, and he indicated that he'd not. He was certainly well versed in the roles of a psychiatrist, as articulated by the Royal College of Physicians and Surgeons of Canada.

In addition to the General and Mental Health and Addictions Services already articulated, it's my understanding that programs and services available at HMP include concurrent disorders programming, moderate intensity substance abuse programming, various addictions programs, methadone maintenance treatment, a violence prevention program facilitated through the John Howard Society, sex offender interventions facilitated through the John Howard Society, a pre-release group, pastoral care, adult basic education, National Employability Skills Program, construction safety courses, Alcoholics Anonymous, ACOA, and recreation, along with various other spiritual/pastoral care services.

It's further my understanding that at Clarenville there is anger treatment, addictions treatment, empowerment treatment, a pre-release group, life skills treatment, the NESP, adult basic education, AA, a mindfulness group, and other pastoral and recreational services available.

## OVERVIEW OF CHART REVIEW

Allergies are documented and the chief complaint is clearly stated.

Generally speaking, consultation notes are thorough and are typed and reportedly on the chart quite quickly; this is helpful, as Dr. Craig's handwriting is difficult to read. Progress notes are also quite comprehensive, albeit they are not in a SOAP or SOAPE format. Diagnoses are not rendered according to a multi-axial format, but Dr. Craig's diagnostic reasoning, and plan, are clear. Treatment recommendations meet the standard of care.

Information from community providers is sometimes present. Dr. Craig sometimes provides information to community providers.

It does not appear that health maintenance is periodically discussed, or that education has been given regarding the diagnosis, and management options. The quality of the psychiatric thinking certainly is to standard. When patients require follow-up, follow-up is provided.

A more detailed review of chart findings is provided in Appendix II.

## CONCLUSIONS AND RECOMMENDATIONS

You've asked me to perform a voluntary external peer review with respect to the professional judgment and clinical prescribing practices of Dr. Craig, focusing on his psychiatric care in the correctional context only. The Terms of Reference are provided in Appendix I, below.

### Are inmates in correctional institutions receiving appropriate psychiatric treatment from Dr. Craig?

Dr. Craig is clearly practicing to an acceptable standard, as a psychiatrist/medical expert; his understanding of diagnosis, and medication management, is good, and he is familiar with unique aspects of prescribing in correctional settings. His documentation is good. His availability is good. There is a collaborative feel to his work with the other care providers. In other respects, Dr. Craig is practicing in a fashion very much typical of correctional psychiatric practice; the time spent with inmates tends to be limited, transfer of information to and from community care providers is also limited, and there is at times a somewhat adversarial feel to the contact between the provider and the patient/inmate. This is likely in part due to the fact that inmates may at times dissimulate, and the fact that the prison culture tends to be one of hostile engagement between the patients/inmates and staff.

Dr. Craig's practice, as is typically seen in correctional settings, tends to focus on issues that are potentially medication responsive. Dr. Craig has indicated that inmates often prefer not to talk about their difficulties; while this of course may at times be true, communicating one's appreciation of the inmates' distress, and clearly articulating the treatment options available remain important parts of psychiatric care, and should be provided in correctional settings, as elsewhere. To reiterate, Dr. Craig's practice is very typical of correctional psychiatry in Canada; I would submit that correctional psychiatry, generally speaking, could be improved in this regard.

The time that Dr. Craig spends with inmates is very typical of correctional practice, but is dissimilar from practice in the community, generally speaking.

Dr. Craig's prescribing practices are very typical of the prescribing practices seen in correctional settings. A number of commonly used psychotropic medications have potential for abuse, in correctional settings, with possible health and security consequences for inmates, and the institution. These include methylphenidate, bupropion, quetiapine, and benzodiazepines. To greater and lesser degrees, physicians in correctional settings tend not to prescribe these, or limit their prescribing. Whether these agents are prescribed, or not, is often the product of a number of forces, including the psychiatrist involved, whether the medications were started in the community, the patient's presentation and history, and perhaps the culture of the institution; the empirical basis for correctional prescribing practices is limited, and further research would be of value. The same may be said, generally speaking, for prescription of medications for the treatment of distress, and insomnia. The controlled setting of corrections can provide an opportunity for re-evaluation of the need for certain medications, and the opportunity to discontinue unnecessary treatment. There is disagreement even amongst eminent correctional

psychiatrists as regards exactly how to manage certain medications in correctional settings[1,2], but generally speaking Dr. Craig practices in accordance with correctional psychiatry standards.

Dr. Craig has indicated that he is committed to providing quality care, and that he is prepared to make changes to his practice, if necessary.

**Are standard of quality patient focus [sic] care being met?**

Patients of Dr. Craig, and of the correctional system, are being provided with psychiatric diagnosis and treatment that meets the typical correctional standard. The key elements of screening, segregation and specialty care for at-risk groups, and community linkages for follow up are in place.[3]

That being said, mental health professionals not only need to work as an inter-professional team, but need to work within a system of care. A system of care includes a mission and vision statement, and a value statement or a value proposition; these are articulated by the administration, with input from health care staff, as well as other stakeholders.

> **Recommendation #1: Formally extend the Recovery model of care to correctional mental health care**

I recommend that, if this is not already the case, Newfoundland and Labrador corrections formally adopt the Recovery Model, in terms of their mental health value statement. This, if practiced well, would have a significant impact the nature of the relationship between inmates, and care providers. The Recovery model is supported by the Mental Health Commission of Canada (MHCC) and is in widespread use in outpatient settings, inpatient settings, forensic settings, and even correctional settings, in North America, and elsewhere[1,4,5]. While containment and security are central to the mission of corrections, and while correctional health care staff are a part of that mission, a clear statement of ideology for health care services is both necessary, and not incompatible with the correctional mission. A statement of patient-centered values helps the correctional clinician avoid adversarial attitudes. The Recovery Model, put parsimoniously, is a model where the patient or client is supported and facilitated by care providers, with respect to goal setting and goal attainment; this places the patient at the centre of the process. The principles of Recovery are hope, empowerment, and connection; they promote patient choice, responsibility, and self-determination. Viewing inmates through the lens of the Recovery philosophy would assist the care provider in appreciating that individuals in correctional settings are likely to have experienced abuse and trauma, have little social capital, are frequently homeless and lack vocational skills, and that their motives or adaptation (or maladaptation) are the product of antecedent events and limited personal resources. Such awareness can move the clinician-patient engagement beyond a “contest” of wills regarding whether or not they receive a certain medication, and toward discussion of the range of treatment options available.

**Recommendation #2: Provide guideline driven services**

Provision of psychiatric care should not be subject to substantial variability; often the best way of delivering a service has been established, albeit not always for correctional settings. Clinical practice guidelines should be implemented wherever possible. Use of guidelines mitigates the issue of inmate choice of provider; the guidelines should help direct the provision of care irrespective of the provider. There are guidelines for mental health care in correctional settings; a number of organizations have prepared guidelines, including the American Public Health Association, the American Medical Association, the American Correctional Association, the (American) National Commission on Correctional Healthcare, and the US Department of Justice (National Institute of Corrections) [1,6]. Referencing clinical practice guidelines is helpful in communicating with inmates/patients. At the same time it should be noted that new evidence will promote new interventions, and clinical practice guidelines need to be updated periodically; there is recent research suggesting that individuals, under particular conditions, who are treated with methylphenidate in custody, show improved outcomes [7,8].

I would parenthetically also recommend that there be metabolic monitoring of individuals being prescribed atypical antipsychotic medications.

**Recommendation #3: Enhance communication with inmates/patients and community stakeholders**

Written information could be made available to inmates to assist them in understanding common diagnoses, and treatment options; issues with communication are often at the root of patient/inmate concerns. I would further recommend that Dr. Craig consider using a SOAP or SOAPE format, as well as multi-axial diagnostic formulation. Use of these templates would assist in reminding the healthcare professional that psychosocial issues should be noted, and that patient education is an important component of care.

The time that Dr. Craig spends with inmates is very typical of correctional practice, but is dissimilar from practice in the community. I would recommend that the practice of 20 minute consultations, and 5 minute follow-up visits, be re-evaluated, given my aforenoted recommendation(s). Changes to inmates' medication regimen on entry to a facility has an impact on their well-being and on their relationships with healthcare professionals and others, even if the changes are in the best interests of the patient/inmate, and the institution[9]. Preconceived notions of inmates' objectives can be mitigated by time spent with patients/inmates, and explaining the treatment options clearly.

It's recognized that good flow of information is essential to the provision of high quality mental health care. Consistent transfer of information to and from community providers is helpful in this regard, and should be promoted.

**Recommendation #4: Contract for service provision with an academic mental health service**

Dr. Craig has indicated that he would benefit from working within a community of correctional mental health service providers. I very much support this. I would recommend that Dr. Craig become a member of the Canadian Academy of Psychiatry and the Law and avail himself of resources that can be found, there. I would further recommend that psychiatric services in corrections be provided not through contracts with individual service providers, but rather through contracts with academic institutions, such as the MUN Department of Psychiatry; this should not be understood to suggest that I would recommend that someone other than Dr. Craig provide those services, as he meets the standard of care. Rather, I feel that Dr. Craig is quite correct in suggesting that he should not work within a professional vacuum in terms provision of psychiatric services in a correctional setting. An academic health sciences centre can not only provide linkages to community mental health supports, but can support evidence-based practice within the correctional setting, and can provide support to the psychiatry or mental health service provider, as work in correctional settings can offer many challenges, and coverage and turnover issues could be mitigated. This is consistent with the recommendation of the Canadian Psychiatric Association in their position statement on treatment of mental illness in correctional settings, approved on November 23rd, 2011[3]. Engagement with others in an academic setting could also support implementation of guidelines with respect to the mental health standards that might be unique to Newfoundland and Labrador (for example aspects of cultural competence).

**Recommendation #5: Consider adding mental health services to the correctional Balanced Scorecard**

Adding mental health services to the correctional Balanced Scorecard would help align the service, and would articulate clear goals for the service, in terms of quality improvement, along with identifying the metrics necessary to measure improvement in processes and outcomes. Whether the issue is suicide prevention, training for cultural competence, number of overdoses, inmate satisfaction/complaints etc, a Balanced Scorecard could be of value. The benchmarking that typically accompanies such a process could also add value. The correctional psychiatrist, and the mental health care team, are important parts of such a process.

## APPENDIX I: Terms of Reference

The peer review is to:

- Ensure that inmates in correctional institutions are receiving appropriate psychiatric treatment from Dr. Craig;
- Ensure that quality of patient focus [sic] care is being met; and
- Maintain public confidence in the healthcare system in the Eastern Region.

Dr. Craig, as per the Terms of Reference, read a draft of the Peer Review, and had the opportunity to respond.

## APPENDIX II: File Review

Typically approximately 20 charts are used for a peer assessment. Eighteen charts were randomly selected at HMP for review. Five charts were randomly selected at the Clarenville Correctional Centre, for review. Patient identifiers and summaries were provided to Dr. Craig for the purpose of facilitating his review of this summary, as per the Terms of Reference. The patient information has been removed but could be made available, if circumstances warrant and privacy concerns allow, upon request.

## APPENDIX III: References

1. Scott, C. L. (2010). *Handbook of Correctional Mental Health* (2d ed.). Washington, D.C.: American Psychiatric Publishing.

2. Reeves, R. (2012). Guideline, Education, and Peer Comparison to Reduce Prescription of Benzodiazepines and Low-Dose Quetiapine in Prison. *Journal of Correctional Health Care., 18*(1), 45-52.

3. Chaimowitz, G. (2012). The Treatment of Mental Illness in Correctional Settings. *Canadian Journal of Psychiatry, 57(1),* preceding p. 60.

4. Piat, M., & Sabetti, J. (2012). Recovery in Canada: Toward social equality. *International Review of Psychiatry, 24* (1), 19-28.

5. Simpson, A. I. F., & Penney, S. R. (2011). The recovery paradigm in forensic mental health. . *Criminal Behaviour and Mental Health, 21* (5), 299-306.

6. Peters, R.H., Sherman, P.B., & Osher, F.C. (2008). Treatment in Jails and Prisons. In: *Clinical Handbook of Schizophrenia*. New York: The Guildford Press.

7. Ginsberg, Y., & Lindefors, N. (2012). Methylphenidate treatment of adult male prison inmates with attention-deficit hyperactivity disorder: randomised double-blind placebo-controlled trial with open-label extension. *British Journal of Psychiatry*, *200*(1), 68-73.

8. Ginsberg, Y., Hirvikoski, T., Grann, M., & Lindefors, N. (2012). Long-term functional outcome in adult prison inmates with ADHD receiving OROS-methylphenidate. *European Archives of Psychiatry and Clinical Neurosciences*. Retrieved from doi:10.1007/s00406-012-0317-8,

9. Bowen, R. A., Rogers, A., & Shaw, J. (2009). Medication management and practices in prison for people with mental health problems: a qualitative study. *International Journal of Mental Health Systems, 3*(1), 24.