The Correctional Investigator
Canada

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L'Enquêteur correctionnel
Canada

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April 19, 2010

SEP - 2 2010

Don Head
Commissioner
340 Laurier Avenue West
Ottawa, Ontario
K1A 0P9

Subject: Independent Expert Review of Forced Medical Injections Administered to Ms. Ashley Smith on July 22, 23 and 26, 2007 at Joliette Institution

Dear Mr. Head:

In my Office's *Interim Report* on the Death of Ashley Smith (dated December 20, 2007), we noted that there was a need to determine whether medical injections that were administered to Ms. Smith at Joliette Institution between July 22 and July 26, 2007 complied with the *Corrections and Conditional Release Act*.

On July 23, 2008, the Office received the Service's Section 20 *Board of Investigation Regarding Allegations of Inappropriate Injections Administered at Joliette Institution between June 27 and July 26, 2007*. Our *Preliminary Review* of the Section 20 Board of Investigation (dated August 19, 2008 and shared with the Service on December 5, 2008) noted several discrepancies between the BoI findings and the use of force reviews conducted at the Institutional, Regional and National (Women Offender and Health Care Sector) levels. The findings of the BoI were also inconsistent with our detailed review of the video evidence.

Confronted with an irreconcilable interpretation of the events under scrutiny, my Office commissioned Paul Beaudry, MD, FRCPC to conduct an independent expert review of the treatment received by Ms. Smith, specifically the forced medical injections administered on July 22, 23 and 26, 2007 at Joliette. Dr. Beaudry's report is attached in both official languages, noting that the original was produced in French.

Given the concerns noted in the Beaudry report and those raised in the Service's own use of force reviews, it is disturbing that the Section 20 Board of Investigation into these matters could be so dismissive and deficient.

In providing Dr. Beaudry's report, and mindful of our concerns about informed consent and consistent with the concerns documented in the reports and reviews noted above, I find it necessary to make five recommendations:

1. That the Service accepts the findings of the Beaudry report.

2. That a detailed Action Plan with timeframes, including but not limited to referral of the Beaudry report to the appropriate professional regulatory colleges in Quebec, be prepared to respond to the ethical, clinical and equipment-related shortcomings in the way the events of July 22, 23 and 26, 2007 were managed at Joliette Institution.

3. That the Commissioner appoints an independent reviewer to examine and explain discrepancies and inconsistencies between the Service's internal use of force reviews and the National Board of Investigation report and processes as they relate to the medical injections administered to Ms. Ashley Smith between July 22 – 26, 2007 at Joliette Institution.

4. Consistent with our earlier recommendations, the Service should never use chemical restraints (medical injections) when an offender is physically restrained in Pinel-like equipment for health or security purposes, unless the offender has been certified under applicable mental health legislation.

5. That the Service's Health Care Advisory Committee be engaged to provide models for enhanced oversight and accountability of clinical treatment practices and guidelines, inclusive of patient advocacy, in the correctional setting.

I am available to discuss the Service's response to the Beaudry report and next steps in addressing these critical issues.

Sincerely,

Howard Sapers
Correctional Investigator of Canada

Attachment: (1)

The Correctional Investigator
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August 24, 2010

Mr. Don Head
Commissioner
Correctional Service Canada
Sir Wilfrid Laurier Building
340 Laurier Avenue West
Ottawa, Ontario
K1A 0P9

Dear Mr. Head:

On April 19, 2010, I provided you with a copy of a report I commissioned to examine the treatment received by Ms. Ashley Smith, specifically the forced medical injections administered on July 22, 23 and 26, 2007 at Joliette Institution. My correspondence forwarding the report contained five (5) key recommendations. In response to this correspondence, you have informed me that you have convened a National Board of Investigation pursuant to section 20 of the *CCRA*, to be chaired by Mr. Mario Dion and to be completed by September 7, 2010.

While I have concerns regarding the lack of acceptance of my Office's recommendations and the perceived need for CSC to conduct yet another review of these matters prior to responding to Dr. Beaudry's findings, I am surprised that we have yet to be contacted and consulted by Mr. Dion about our report.

We remain open to meet with Mr. Dion to ensure that our concerns are taken into consideration before he concludes his work. We look forward to a timely and comprehensive response from CSC on this significant issue.

Sincerely,

Howard Sapers
Correctional Investigator

c.c.: Marc-Arthur Hyppolite, SDC
Ian McCowan, AC
Ivan Zinger, OCI

Canada

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August 31, 2010

Kim Pate
Canadian Association of Elizabeth Fry Societies (CAEFS)
#701, 151 Slater Street
Ottawa, Ontario
K1P 5H3

Dear Ms. Pate:

In response to your request and consistent with the provisions of the *Privacy Act*, enclosed please find the following documents:

- A redacted copy in both French and English of the report entitled *Ms. Ashley Smith: Psychiatric Opinion Based on Record Review* conducted by Dr. Paul Beaudry and dated January 2010.
- Correspondence dated April 19, 2010, from Mr. Howard Sapers, Correctional investigator of Canada, to Mr. Don Head, Commissioner of Corrections related to the above report.
- Correspondence dated August 24, 2010, from Mr. Howard Sapers, Correctional investigator of Canada, to Mr. Don Head, Commissioner of Corrections related to the above report.

Consistent with the recent Order of the Federal Court in *CAEFS vs. Minister of Public Safety and the Correctional Service of Canada* (T-1040-09; August 23, 2010), I would ask you that you be cognizant of the sensitive nature and personal information contained in the Beaudry Report and protect the information accordingly.

Sincerely,

Howard Sapers
Correctional Investigator

Encl.: (3)

Canada

Ms. Ashley Smith

Psychiatric opinion based on record review

Paul Beaudry, MD, FRCPC
Psychiatrist

Translation – check against French original

JANUARY 2010

Brunet
Guérin
Beaudry
Psychiatrists - Medico-Legal Experts

TABLE OF CONTENTS

Robert Brunet, *MD, CSPQ*
Marc Guérin, *MD, FRCPC*
Paul Beaudry, *MD, FRCPC*

Brunet
Guérin
Beaudry
Psychiatrists Medico-Legal Experts

CONFIDENTIAL

January 31, 2010

Mr. Ivan Zinger
Executive Director and General Counsel
Office of the Correctional Investigator
Government of Canada
PO Box 3421, Station D
Ottawa Ontario K1P 6L4

Name: **Ms. Ashley Smith, deceased**
DOB: January 29, 1988

PSYCHIATRIC OPINION BASED ON RECORD REVIEW

I reviewed the late Ms. Ashley Smith's case on the request of Maître Ivan Zinger, Executive Director and General Counsel, Office of the Correctional Investigator, Government of Canada.

The content of this review is strictly confidential. Under the legislation currently in effect, unauthorized persons are strictly prohibited from reading this report and in particular to make any use of it whatsoever.

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Identification

Ms. Ashley Smith was 19 years old when she died on October 19, 2007, while she was in custody at the Grand Valley Institution for Women, a secure federal facility. Ms. Smith had spent the last four years of her life in custody. She was 13 when she first became involved with the youth criminal justice system.

In December 2003, Ms. Smith was sentenced to secure custody at the New Brunswick Youth Centre, where she spent considerable time in the Therapeutic Quiet Unit (in segregation). While serving her sentence at the New Brunswick Youth Centre, Ms. Smith incurred several charges related to various incidents where correctional or health professionals were attempting to prevent or stop her self-harming behaviours. In January 2006, when she was 18, it was agreed that any criminal conviction she incurred from that point forward would result in an adult sentence.

In October 2006, Ms. Smith was convicted to a custodial sentence as a result of new offences against the custodial staff involving her challenging behaviour. In October 2006, she was transferred to Nova Institution for Women, a federal facility. During her 11.5 months in federal custody, Ms. Smith continued to present disruptive and maladjusted behaviours primarily involving attempts at self-harm, namely self-strangulation with ligatures, head-banging and superficial cuts to her arms. Over this period, Ms. Smith was involved in approximately 150 security incidents.

During her incarceration in federal institutions, Ms. Smith was transferred seventeen times in less than one year from one to another of three federal institutions, two treatment centres, two external hospitals and a provincial correctional facility. These transfers were related to administrative issues such as cell availability, incompatible inmates and staff fatigue. Ms. Smith often refused to consent to or cooperate with assessments. She was certified four times under the Saskatchewan *Mental Health and Services Act* and four times under the Ontario *Mental Health Act* as a result of her maladjusted, disruptive, and self-harming behaviours.

Purpose of the psychiatric opinion based on record review

The purpose of this work is to provide a medical opinion on the treatment received by Ms. Smith while she was in custody at Joliette Institution (Quebec) from June 27, to July 26, 2007, more specifically, on July 22, 2007, and July 23, 2007, when Ms. Smith was physically restrained and received medication following a self-injury attempt, and on July 26, 2007, when she received medication prior to an inter-institutional transfer.

Documents consulted

1. Canadian Charter of Rights and Freedoms;

2. Charter of Human Rights and Freedoms;

3. Civil Code of Québec;

4. Corrections and Conditional Release Act (CCRA);

5. Corrections and Conditional Release Regulations (CCRR);

6. An Act respecting health services and social services (R.S.Q. c. S-4.2, section 118.1);

7. An Act to amend the Act respecting health services and social services as regards the safe provision of health services and social services (S.Q., 2000, c. 71);

8. An Act to amend the Professional Code and other legislative provisions as regards the health sector (S.Q., 2002, c. 33);

9. Professional standards documentation on the use of physical handling and chemical control measures:

   9.1. Cadre de référence – utilisation exceptionnnelle des mesures de contrôle: contention et isolement [Terms of reference – exceptional use of control measures: restraint and isolation], prepared by the Association des hôpitaux du Québec, revised edition, 2004;

   9.2. Mesures de contrôle: contentions physiques, isolement et contentions par médication psychotrope, directives médico-nursing administratives [Control measures: physical restraints, isolation and restraint through psychotropic drugs, medical and nursing administrative guidelines], Centre hospitalier Pierre-Janet; Protocole interprofessionnel relatif à l'utilisation de contention physique la moins contraignante possible [Interprofessional protocol on the use of the least restrictive physical restraint], McGill University Health Centre (MUHC), 2008.

10. The Ashley Smith Report: June 2008 report of the New Brunswick Ombudsman and Child and Youth Advocate;

11. A Preventable Death, paper prepared by Mr. Howard Sapers, Office of the Correctional Investigator, dated June 20, 2008;

12. Final report on Ms. Smith's psychiatric assessment and stay at the Institut Philippe-Pinel in Montreal from April 13 to May 8, 2007, prepared by

13. Commissioner's Directives – Correctional Service of Canada: Management of Security Incidents (567), Use of Force (567-1), Use of Restraint Equipment for Health Purposes (844) and Recording and Reporting of Security Incidents (568-1);

14. Documents produced concerning the treatment received at Joliette Institution, Quebec, from June 27 to July 26, 2007:

    14.1. Report produced by Canada's correctional system concerning the use of force on Ashley Smith;

    14.2. Correctional Investigator's preliminary report on the incidents of June 27 to July 26, 2007;

    14.3. Reports on the incidents of July 22, 23 and 26, 2007, produced by Joliette Institution, the regional level (Institutional Operations, Quebec Region) and Health Services, Mental Health Sector;

    14.4. Videos of use of force during injections administered to Ashley Smith on July 22, 23 and 26, 2007;

All reference documents, with the exception of the documents related to the psychiatric opinion were shared and handled according to their level of sensitivity/confidentiality.

15. Review of relevant scientific literature.

Summary of documents consulted

The legal framework surrounding the use of restraints and isolation emphasizes respect for the individual and his or her basic rights and most personal values. Everyone's right to life, liberty and security of the person and to the protection of this right against any treatment not consistent with the principles of fundamental justice is at the heart of the various charters and legislation.

1. Canadian Charter of Rights and Freedoms

The following are sections from the *Canadian Charter of Rights and Freedoms*:

"7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

"9. Everyone has the right not to be arbitrarily detained or imprisoned."

"12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment."

2. Charter of Human Rights and Freedoms

The following are sections from the *Charter of Human Rights and Freedoms*:

"1. Every human being has a right to life, and to personal security, inviolability and freedom."

"5. Every person has a right to respect for his private life."

"10. Every person has a right to full and equal recognition and exercise of his human rights and freedoms, without distinction, exclusion or preference based on race, colour, sex, pregnancy, sexual orientation, civil status, age except as provided by law, religion, political convictions, language, ethnic or national origin, social condition, a handicap or the use of any means to palliate a handicap."

3. Civil Code of Québec

The following are three articles from the *Civil Code of Québec*:

"10. Every person is inviolable and is entitled to the integrity of his person. Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent."

"11. No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent. If the person concerned is incapable of giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation of his incapacity may do so in his place."

"13. Consent to medical care is not required in case of emergency if the life of the person is in danger or his integrity is threatened and his consent cannot be obtained in due time. It is required, however, where the care is unusual or has become useless or where its consequences could be intolerable for the person."

4. Corrections and Conditional Release Act (CCRA)

The CCRA section relevant to this case is the section related to health services. It includes, but is not limited to, the following elements:

4.1. Section 86 sets out that "(1) The Service shall provide every inmate with
(a) essential health care; and

(b) reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community [Obligations of Service].

(2) The provision of health care under subsection (1) shall conform to professionally accepted standards [Standards]."

4.2. Section 88 sets out that "(1) [...]

(a) treatment shall not be given to an inmate, or continued once started, unless the inmate voluntarily gives an informed consent thereto; and
(b) an inmate has the right to refuse treatment or withdraw from treatment at any time. [When treatment permitted].

(2) [...] an inmate's consent to treatment is informed consent only if the inmate has been advised of, and has the capacity to understand,

(a) the likelihood and degree of improvement, remission, control or cure as a result of the treatment;

(b) any significant risk, and the degree thereof, associated with the treatment;

(c) any reasonable alternatives to the treatment;

(d) the likely effects of refusing the treatment; and

(e) the inmate's right to refuse the treatment or withdraw from the treatment at any time.

[...]

(5) Where an inmate does not have the capacity to understand all the matters described in paragraphs (2)(*a*) to (*e*), the giving of treatment to an inmate shall be governed by the applicable provincial law."

In the case at issue here, article 13 of the *Civil Code of Québec*, as previously mentioned, states the following: "Consent to medical care is not required in case of emergency if the life of the person is in danger or his integrity is threatened and his consent cannot be obtained in due time."

5. Corrections and Conditional Release Regulations (CCRR)

The incidents under review were specifically considered under the following sections: Placement and Transfers, Security Classification, Administrative Segregation, Search and Seizure and Use of Force.

6. An Act respecting health services and social services (R.S.Q. c. S-4.2, section 118.1)

Under this Act:

"Force, isolation, mechanical means or chemicals may not be used to place a person under control in an installation maintained by an institution except to prevent the person from inflicting harm upon himself or others. The use of such means must be minimal and resorted to only exceptionally, and must be appropriate having regard to the person's physical and mental state.

Any measure referred to in the first paragraph applied in respect of a person must be noted in detail in the person's record. In particular, a description of the means used, the time during which they were used and a description of the behaviour which gave rise to the application or continued application of the measure must be recorded.

Every institution must adopt a procedure for the application of such measures that is consistent with departmental orientations, make the procedure known to the users of the institution and evaluate the application of such measures annually."

In the process of developing their protocols for the application of control measures, Institutions must be guided by six guiding principles, set out in the departmental orientations [*Orientations ministérielles*], including the principle outlining that "[c]hemical substances, restraints and isolation are used as control measures purely for ensuring safety in situations where risk is imminent."

7. **An Act to amend the Act respecting health services and social services as regards the safe provision of health services and social services (S.Q., 2000, c. 71)**

   This Act is intended to increase safety in the delivery of health services and inform individuals and their families of the consequences of any accident that that could happen, or has happened, to the individual within the institution.

8. **An Act to amend the Professional Code and other legislative provisions as regards the health sector (S.Q., 2002, c. 33)**

   This Act came into effect on June 1, 2003, and introduced a new provision setting out that the physician is no longer the only professional with the right to authorize the use of restraints. The physician shares this power regarding restraints with nurses, occupational therapists and physiotherapists.

9. **Professional standards documentation on the use of physical handling and chemical control measures**

   9.1. Cadre de référence – utilisation exceptionnnelle des mesures de contrôle: contention et isolement [Terms of reference – exceptional use of control measures: restraint and isolation], prepared by the Association des hôpitaux du Québec, revised edition, 2004.[1]

   In 2004, the Association des hôpitaux du Québec published terms of reference intended to define the boundaries surrounding the adoption of protocols to apply restraint and isolation measures by health network institutions. These terms of reference take into account the ethical, legal and clinical dimensions that guide the decision-making process concerning the use of restraint and isolation.

   This document underlines the risks associated with using isolation rooms, namely the deterioration of the mental state of segregated patients, exacerbation of their psychiatric symptomatology, their feelings of helplessness and their feelings of violation of personal integrity and freedom.

   The document focuses on planned and non-planned interventions, among others.

   A planned intervention takes into account the person's history, the likelihood of re-occurrence of a problem situation and the recent use of a control measure with a person at risk of self-harm or of harming others. A decision is then made to identify an intervention protocol to resolve the problem experienced by the

individual, including the use of restraint and isolation as a last resort. To participate in the planned intervention, the person involved must provide voluntary and informed consent.

An unplanned intervention is carried out in response to behaviour that is unusual and unexpected and that places the safety of an individual or others in imminent danger. In such circumstances, the control measures have not been provided for in the intervention plan and must be followed up by a post-mortem analysis.

The document outlines the following five criteria to help assess an individual's capacity to give consent:

- Does the individual understand the nature of the illness for which treatment is being given?
- Does the individual understand the nature and goal of the treatment?
- Does the person appreciate the risks and benefits of the treatment, if treatment is given?
- Does the person appreciate the risks of not undergoing the treatment?
- Does the illness affect the person's capacity to understand?

9.2. Mesures de contrôle: contentions physiques, isolement et contentions par médication psychotrope, directives médico-nursing administratives [Control measures: physical restraints, isolation and restraint through psychotropic drugs, medical and nursing administrative guidelines], Centre hospitalier Pierre-Janet;[2] Protocole interprofessionnel relatif à l'utilisation de contention physique la moins contraignante possible [Interprofessional protocol on the use of the least restrictive physical restraint], McGill University Health Centre (MUHC), 2008.[3]

These documents are intended to define in detail the protocol for use of control measures at the Centre Hospitalier Pierre-Janet and at the McGill University Health Centre in accordance with the legislation and departmental orientations presented earlier and with the values of these health centres.

The documents describe the three control measures, as follows:

1. Physical restraints

   Control measure that consists of preventing or limiting the freedom of movement of a person using human strength, mechanical means or of depriving the person of a device used to compensate for a handicap.

2. Isolation

Control measure that consists of confining a person for a set amount of time in a given place the person cannot freely leave.

3. Restraint through psychotropic drugs

Control measure that consists of limiting a person's capacity to act by giving this person psychotropic medication without his/her consent. The single exception to this principle consists of medication administered as part of a court-authorized treatment order.

According to these documents, in the context of a planned intervention a person must give free and informed consent to the exceptional use of the relevant control measures to be able to participate in the intervention plan. If the person refuses to consent to the wording of the intervention plan and an emergency arises, unplanned intervention conditions will apply.

In an unplanned intervention situation, the exceptional use of control measures may be carried out without the person's consent if this person poses a risk of placing him/herself or others in serious and imminent danger.

10. The Ashley Smith Report: June 2008 report of the New Brunswick Ombudsman and Child and Youth Advocate

The document entitled "The Ashley Smith Report" prepared by the New Brunswick Ombudsman and Child and Youth Advocate in June 2008 provides a detailed account of the emergence of Ms. Smith's disruptive and oppositional behaviour around the age of 13 in 2001-2002, her difficulties at school, and her involvement with the youth criminal justice system after being charged with assault and disturbance in a public place under the *Criminal Code of Canada*. Ms. Smith was imprisoned for over three years from 2003 to 2006 in two provincial correctional facilities, the New Brunswick Youth Centre in Miramichi and the Saint John Regional Correctional Centre. On the basis of an analysis of Ms. Smith's experience in the youth criminal justice system and analyses of similar cases, the report issues several recommendations organized into five broad themes:

10.1. the importance of tailoring the educational system to the needs of youths suffering from mental illness or severe behavioural disorders.

10.2. the availability of mental health services to children and youths who are sentenced to serve custodial time.

10.3. the use of segregation at the New Brunswick Youth Centre. The use of segregation, for whatever purpose provided by policy or legislation, must be made in accordance with more stringent legislative provisions and policies that will avoid the deteriorating impact this form of prolonged solitary confinement may have on a young person's mental health.

10.4. the legal implications, namely the legal representation provided to youths faced with the prospect of being involved or those who are already involved in the youth criminal justice system.

10.5. the establishment of a more stringent policy regarding the use of section 92 of the *Youth Criminal Justice Act* concerning the transfer of an 18-year-old youth to an adult facility.

11. A Preventable Death, paper prepared by Mr. Howard Sapers, Office of the Correctional Investigator, dated June 20, 2008

As indicated in the preface, this report was "restricted to a close review and analysis of the operational environment and the documentation produced by the Correctional Service of Canada (CSC) prior to and after Ms. Smith's death." The report highlights the broader issues that contributed to the conditions and decisions that resulted in Ms. Smith's tragic death on October 19, 2007, while she was under the care and custody of the Correctional Service of Canada. The Investigator arrived at the following three key conclusions:

- Ms. Smith's death was preventable;
- Ms. Smith's death was a culmination of several individual and system failures within the Correctional Service of Canada. These failures are symptoms of serious problems previously identified within Canada's federal correctional system and are not applicable only to Ms. Smith; and
- immediate action must be taken by the Federal Government in order to address these failures and prevent other deaths from occurring in Canada's penitentiaries.

I would like for example to highlight some paragraphs in the report, as follows:

Paragraph 17. While in federal custody over 11.5 months, Ms. Smith was involved in approximately 150 security incidents, many of which revolved around her self-harming behaviours. These incidents consisted of self-strangulation using ligatures and some incidents of head-banging and superficial cutting of her arms. Whenever attempts to negotiate the removal of a ligature failed, staff would (on most occasions) enter Ms. Smith's cell and use force, as required, to remove it. This often involved the use of physical handling, inflammatory spray, or restraints. Ms. Smith was generally non-compliant with staff during these interventions.

Paragraph 20. Ms. Smith would often not cooperate or consent to assessment, and she continued engaging in maladaptive, disruptive and self-injurious behaviours. She was certified four times under the Mental Health Services Act of Saskatchewan and four times under the Mental Health Act of Ontario. The fact that it was necessary to have Ms. Smith certified eight times in less than one year of incarceration should have highlighted to the Correctional Service the urgent need to have a comprehensive mental health assessment completed for this young woman.

Paragraph 24. In addition, despite having Ms. Smith in its custody for over 11 months, and despite having access to previous mental health records, the Correctional Service never made any advancements in its treatment of Ms. Smith. A concrete, comprehensive treatment plan was never put into place for this young woman, despite almost daily contact with institutional psychologists. The attempts that were made to obtain a full psychological assessment were thwarted in part by the Correctional Service's decisions to constantly transfer Ms. Smith from one institution to another.
[...]

Paragraph 26. What mental health care Ms. Smith did receive differed from one institution to another; there was no consistency. [...]

Paragraph 29. On eight occasions, Ms. Smith was certified under provincial mental health legislation and was admitted to psychiatric facilities; however, she was usually released after a very short period of time without having been fully assessed or meaningfully treated. This left the Correctional Service with a dilemma because its own *Mental Health Strategy for Women,* and its *Intensive Intervention Strategy for Women* were not appropriately designed or resourced to provide assistance to women who required specialized mental health care and intervention.

12. **Final report on Ms. Smith's psychiatric assessment and stay at the Institut Philippe-Pinel in Montreal from April 13 to May 8, 2007, prepared by**

indicates that she assessed Ms. Smith twice during her stay at the Institut Philippe-Pinel, specifically on April 14 and 18, 2007. She starts her report by summarizing the report sent by the Prairie Regional Psychiatric Centre, where Ms. Smith had been admitted to the *Intensive Healing Program* from December 20, 2006, to April 12, 2007. notes that the diagnosis issued by at the time Ms. Smith left the Prairie Regional Centre was the following:

Axis I: None
Axis II: Antisocial personality disorder with borderline traits
Axis III: Under examination for Wilson's disease
Axis V: GAF: over 50

Given Ms. Smith's prior history, a pre-admission plan, to which she had consented in writing, had been prepared. However, as soon as she was admitted, Ms. Smith became agitated and had to be placed in restraints. She was not compliant with the treatment plan, refused to change to put on her security gown, tried to harm herself by cutting her forearms or by throwing herself against her room door, tried to hit, grab, pinch and spit on the staff, and damaged her bed to remove pieces of wood. Restraints were used on a daily basis. From April 27 to May 8, 2007, Ms. Smith attempted to strangle herself three times with elastic bands or cloth ties, and spit on and bit the staff members who were trying to take away her ligatures. The staff suspected that Ms. Smith was hiding objects in her body cavities.

Ms. Smith received various medications every day while she was checked in; the following medications were prescribed as required (PRN) and not on a regular basis:

- Diphenhydramine (Benadryl) 50 mg, PO or IM q1h, PRN, max: 3 doses per 24 hours
- Lorazepam 2 mg, PO or IM, q1h, PRN, max. 3 doses per 24 hours
- Loxapine 50 mg, PO or IM, q1h, PRN, max. 3 doses per 24 hours
- Quetiapine 50 mg, PO, q1h, PRN, max. 3 doses per 24 hours

At the end of her report, concludes that her clinical observations of Ms. Smith support those of Ms. Smith began to present with conduct

disorder at the age of 13 and continued experiencing adjustment difficulties since then. She was repeatedly diagnosed with antisocial personality disorder. An investigation for Wilson's disease must be completed since such a condition could have an impact on her behaviour.

concludes her report by indicating that the Institut Philippe-Pinel would be prepared to re-admit Ms. Smith to their unit if she developed treatment goals. However, at the time of her discharge, Ms. Smith had no personal insights on her condition and she had not even reached the stage where she could start considering a change model. Therefore, it was not possible to influence her in any way.

13. Commissioner's Directives – Correctional Service of Canada: Management of Security Incidents (567), Use of Force (567-1), Use of Restraint Equipment for Health Purposes (844) and Recording and Reporting of Security Incidents (568-1)

These documents are very clear and I will not summarize them. However, I would like to highlight certain specific points that are pertinent to the situation considered here.

Various paragraphs in the document entitled "Commissioner's Directive 567 - Management of Security Incidents" warrant special attention, as follows:

- Assessment of the situation, paragraph 23: "The inmate's current behaviour, situational factors (e.g. location, presence of weapons, other inmates, social history, etc.), tactical considerations (past behaviour, size of inmate, skills of the officer, availability of backup, etc.) and the risk relating to the incident must be assessed on an ongoing basis." According to CSC's bulletin 2009-11, "past behaviour includes an offender's history of self-harm and the potential for future or cumulative self-harm when determining whether immediate intervention is required."

- Inmate behaviour, paragraphs 26 to 31: these paragraphs provide clear definitions of inmate behaviour during incidents involving security and safety. I find the differences between paragraph 28 (physically uncooperative) and paragraph 29 (assaultive) particularly relevant.

It would also be useful to highlight a number of paragraphs from "Commissioner's Directive 844 – Use of Restraint Equipment for Health Purposes," as follows:

– Roles and responsibilities, paragraph 11:

"In accordance with professional standards, relevant legislation and CSC policy:

a. licensed physicians, psychiatrists, psychologists and nurses may authorize the use of soft restraints when it is determined that not doing so will result in serious bodily injury; and

b. the on-call physician or psychiatrist shall be contacted immediately when a health care professional other than a physician or psychiatrist (i.e. nurse or psychologist) authorizes the application of soft restraint equipment as they are the treating physician directing the inmate's care."

– Chemical constraints, paragraph 20: "Chemical restraint shall never occur."

– Chemical constraints, paragraph 21: "Medication shall only be prescribed and administered when indicated for the treatment of an underlying medical diagnosis established by a physician/psychiatrist and according to CD 803."

– Assessment and monitoring, paragraph 30: "A psychiatrist, psychologist or physician must assess the inmate's mental health status within two hours of the application of restraints."

– Assessment and monitoring, paragraph 36: "Food and fluids shall be offered at least every four hours during the day and evening shifts and as required on the midnight shift."

– Assessment and monitoring, paragraph 37: "The inmate shall be offered the opportunity to meet his/her elimination needs at least hourly while awake [...]"

14. Documents produced concerning the treatment received at Joliette Institution, Quebec, from June 27 to July 26, 2007

14.1. Report produced by Canada's correctional system concerning the use of force on Ashley Smith

This is the Board of Investigation report on the allegation of inappropriate injections administered to Ms. Smith at Joliette Institution (Quebec) from June 27 to July 26, 2007, revised version, dated September 30, 2008. The

convening order and terms of reference of this Board were signed by Mr. Keith Coulter, Commissioner, Correctional Service of Canada.

The Board particularly focused on the incidents of July 16, 22 and 23, 2007, during which Ms. Smith had presented self-harm behaviours, and on the incident of July 26, 2007, involving Ms. Smith's inter-regional transfer to the Nova Institution for Women.

In regard to the incidents of July 16, 22 and 23, 2007, the Board of Investigation found that Ms. Smith had displayed self-harm behaviours that presented a threat to her life and that the immediate security and medical action and the use of four-point restraints were necessary to preserve Ms. Smith's life and integrity.

During the incident of July 22, 2007, prescribed medications were administered to Ms. Smith against her will. The Board found that administering this medication was warranted by the situation, which was an emergency as defined in article 13 of the *Civil Code of Québec*. Under this article, consent to medical care is not required in case of emergency if the life of the person is in danger or his/her integrity is threatened and the person's consent cannot be obtained in due time.

According to the Board, the medications prescribed by the psychiatrist on July 16, 22 and 23, 2007, were necessary as a result of a medical diagnosis for which such treatment was indicated and agreed to. Ms. Smith willingly accepted an injection of medication on July 26, 2007, without force being used.

The Board also noted that during these four interventions, the members of the Institutional Emergency Response Team (IERT) demonstrated considerable self control, respect and compassion for Ms. Smith, even though she often displayed aggressive behaviour such as spitting on staff members and trying to strike and grab them.

The investigation report contains a section describing a detailed chronology of certain events that took place from June 27 to July 26, 2007, more specifically those of July 16, 22, 23 and 26, 2007.

In page 40 of the document, the Board reports that Ms. Smith was diagnosed at the Regional Psychiatric Centre (Prairie) and at the Institut Philippe Pinel de Montréal (IPPM) as suffering from:

- Axis I: None
- Axis II: Borderline personality
- Axis III: Under examination for Wilson's disease (CPR)
- Axis V: Global Assessment of Functioning (GAG): over 50

In page 41 there is a table outlining the medication prescribed by the institution's physician on Ms. Smith's arrival to facilitate her transition to the institution and also by the psychiatrist, who was under contract to the institution, one week later, and throughout her stay at the institution. On July 6, 2007, the prescription issued by the psychiatrist was as follows: Benzotropine 2 mg three times a day, PRN; Benadryl 50 mg, intramuscular, three doses per 24 hours, PRN; Loxapac 10 mg twice a day, PRN; Seroquel 300 mg HS (at bedtime); and Risperdal 2 mg once a day + PRN.

In page 44 of the report there is a table describing the various medications that Ms. Smith was given during the day on July 22, 2007, as well as the use of physical constraints. This table indicates that Ms. Smith received four injections of medication between the psychiatrist's first prescription at 10:45 a.m. and the last injection at 3:15 p.m. The first injection prescribed by the psychiatrist at 10:45 a.m. was for Clopixol Acuphase 50 mg, intramuscular. At 1:30 p.m. Ms. Smith was administered Haldol 5 mg, Ativan 4 mg, and Benadryl 25 mg, intramuscular, and Cogentin 2 mg per os liquid. At 1:55 p.m. she received Haldol 5 mg, Ativan 2 mg, and Benadryl 25 mg, intramuscular.

In page 45, the Board reports that during their investigation, the workers and Acting Chief of Health Services who were on the day shift on July 22, 2007, stated that the inmate's consent was not necessary at that point because they believed she was unable to give informed consent and that there was a risk to Ms. Smith's health, as demonstrated by her significant level of agitation. Ms. Smith was unable to stop moving, she constantly pulled and tried to release her restraints, she rocked the stretcher, was unable to maintain eye contact with the nurse during the medical examinations, had trouble acting appropriately with the nurse and members of the emergency team and, lastly, would not calm down. Staff hoped that Ms. Smith would stop her behaviour for her own protection and that of others because they thought she was in possession of objects in her body cavities that could injure her or others. Their decision to treat her against her will was based on the *Civil Code of Québec*, as set out under article 13. The Board of Investigation found that during the incident of July 22, 2007, Ms. Smith's conduct posed a danger to her life and threatened her personal integrity, and medical and security interventions were necessary, even without her consent, to preserve her integrity.

In regard to the incident of July 23, 2007, the Board reports that Ms. Smith had refused the injections but said she was prepared to take orally the medications she had refused that morning. Ms. Smith agreed to receive the injections after a nurse explained to her that the three injections were necessary and why the three medications could not be given in one single injection. The Board found that Ms. Smith had consented to care after she was informed by the nurse of the prescribed treatment.

Concerning the incident of July 26, 2007, the Board reports that on July 24, 2007, in preparation for Ms. Smith's transfer to Nova Institution for Women, the psychiatrist prescribed a medication to be given as required (PRN) before departure and during the trip in case she became too agitated or lost control. The following medications were prescribed: Loxapac 50 mg + Ativan 2 mg + Benadryl 50 mg, with the first dose being administered thirty minutes before departure and the second two hours afterwards. Ms. Smith agreed to the injections after the nurse explained the reasons for administering them and that she had to remain clam during the flight because the pilot would not accept the kind of behaviour she had displayed on the previous occasion she had travelled by air. The Board of Investigation found that that the treatment proposed by the psychiatrist was a prescription in case Ms. Smith became highly agitated or lost control; in fact, the prescription was interpreted as having to be administered right away, before departure.

In page 50 of the report, the Board of Investigation states that there was a lack of detail concerning the information given to the psychiatrist on the inmate's behaviour when she prescribed the injections. The psychiatrist based her assessment of the patient on the information received by telephone. She subsequently determined the procedure for the effective treatment of the patient. Those details are essential and must be noted in the clinical documentation.

In page 93, the Board of Investigation reports that in all the investigations, including this one, that injections were prescribed by telephone and that the physicians/psychiatrists were not on site. They relied on the explanations of the health professionals on site to make their diagnosis and prescribe what they considered to be appropriate treatment. The Board of Investigation reports that a memo dated November 1, 2007, requested that the institutional on-call physician be on site to assess whether the inmate met the criteria for treatment against her will, but not CD 844. The Board of Investigation found that if the Service wants this Directive to be a national policy implemented by all institutions, this requirement should be clearly established in CD 844.

14.2. Correctional Investigator's preliminary report on the incidents of June 27 to July 26, 2007

The Office of the Correctional Investigator produced this report after reading the report issued by the Correctional Service of Canada on the use of force on Ashley Smith during her stay at the Joliette detention centre from June 27 to July 26, 2007, and after viewing the videos focusing on these incidents and reading the incident reports prepared by the various administrative authorities (institutional, regional, national, Women Offender Sector).

In its findings, the Office of the Correctional Investigator claims to be concerned about certain observations contained in the report of the Canadian correctional system because they are inconsistent with their own observations to the effect that

1. immediate security and medical intervention was necessary to preserve Ms. Smith's life;

2. in the incidents of July 22 and 23, 2007, prescribed medications were administered to Ms. Smith against her will. The rationale used in administering those medications was that staff members were dealing with an emergency as defined in article 13 of the *Civil Code of Québec;*

3. the medications were prescribed by the psychiatrist on July 16, 22 and 23, 2007, that they were necessary, based on a medical diagnosis for which such treatment was indicated and agreed to;

4. there is no CSC policy or guideline to inform the operational units of the various regions on the relevant provincial legislation to ensure a balance between the offender's rights and CSC's obligations. Every institution and region is left to its own devices and must scrutinize the acts and their applicability;

5. Ms. Smith accepted the injection of medications on July 26, 2007, of her own free will and without force being used;

6. in those four interventions, the members of the IERT acted in accordance with the Situation Management Model. They also demonstrated considerable self-control, respect and compassion for Ms. Smith, **even though she often displayed aggressive behaviour such as spitting on staff and trying to strike and grab them**;

7. medical treatment does not constitute a use of force and should not be subject to review as specified in CD 567 1, "Use of Force." This kind of medical intervention should be reviewed by a committee of persons with expertise in the health field, such as the medical review committees of the Health Institutions in the Province of Quebec.

14.3. Reports on the incidents of July 22, 23 and 26, 2007, produced by Joliette Institution, the regional level (Institutional Operations, Quebec Region) and Health Services, Mental Health Sector

These various reports contain certain points related to medical issues that warrant special attention, as follows:

- Incident of July 22, 2007

At 9:45 a.m. Ms. Smith first tried but failed to obstruct the camera and then injured herself by pulling out the electrical plate. She then struck her cell window with the object and played with the cable leads and electric wires.

The nurse in charge received a call at 10:1 5 a.m. informing her of Ms. Smith's behaviour, and indicating that she had apparently injured herself and inserted an object in a body cavity. During the very cursory assessment

the nurse reported observing about ten drops of blood on the floor. She was not able to determine the source of the blood or the extent of the injuries. Ms. Smith did not present any clinical signs of hemorrhaging and her life did not seem to at risk for the time being.

The nurse informed the psychiatrist of the situation at 10:30 a.m. The nurse prescribed physical restraints to the limbs, chemical restraints and a possible transfer to the emergency department at the CHRDL (Lanaudière Regional Hospital) so the inmate (who might have been concealing an object inside a body cavity) could be examined.

At about 11 a.m. an officer tried to negotiate with Ms. Smith. After first refusing, she agreed to let him look at her injuries and to give him the heavily bloodied piece of metal. However, she refused to take off her security gown so she could be searched for other hidden objects. In the face of her refusal, Ms. Smith was advised that the Institutional Emergency Response Team (IERT) would have to intervene. After viewing a videotape of this incident, the management at Joliette Institution indicated that Ms. Smith refused to cooperate and engaged in non-violent negative behaviour.

The IERT became involved after the SMEAC was presented at 12:30.

After taking the decontamination shower, Ms. Smith was willingly led away to be placed in restraints. She cooperated all through this movement. The subject was then taken to health services so she could be given the injections prescribed by the psychiatrist.

Following decontamination, an officer reported that [TRANSLATION] "Ms. Smith was willingly led away to be placed in restraints. She was compliant throughout this movement. The subject was then taken to health services so she could be given the injections prescribed by the psychiatrist." Another officer reported that [TRANSLATION] "the inmate offered slight resistance but everything went well."

When she arrived at health services, Ms. Smith was reported to have been agitated. She tried to grab equipment and bite or spit at the staff, attempted to remove her wrist restraints on two occasions, tried to rock the stretcher several times, tried to bang her head against the wall and on the stretcher rails and attempted to bite the mattress, revelling in her mischief.

The health services report points out that Ms. Smith was not informed of the type of medications administered to her or why they were being used, other than being told it was to calm her down. Ms. Smith clearly refused to take the

medication, while the nurse told her that she had no choice but to take it, since this was a medical action. The nurse used a threatening tone to ask Ms. Smith whether she wanted another injection, knowing full well that the inmate did not want it, and to tell her, [TRANSLATION] "if you don't calm down you will get another injection" (when Ms. Smith was calm, at that moment) or, on another occasion, "if you don't calm down, you will get a third injection, a bigger one." At 2:29 a.m. Ms. Smith was given an injection when she appeared to be calm. At 5:21 a.m. the nurse informed her that the psychiatrist had ordered that the restraint measures be extended for another four hours, while she was relatively calm, which raises the question of what kind of information the health care staff was providing the psychiatrist. In addition, the film recordings of the situation indicate that the time intervals between the injections seemed to be too short and not necessarily warranted.

- Incident of July 23, 2007

  At approximately 4:50 p.m. Ms. Smith is reported to have broken an object and tried to injure her wrists. An order was issued to take the inmate, conduct a strip search and monitor her while work was done to repair her cell. She would have to be placed in restraints if she became agitated.

  The IERT intervened at 6:15 p.m. to extract the inmate from her cell. Since Ms. Smith was not cooperating, a chemical agent was used and she had to be subsequently decontaminated. During the decontamination, she struck the radiator in the shower room several times and refused to stop despite the staff's orders to do so. She was informed that the nurse had found she was upset and that she should be placed in restraints. She decided to be compliant and the application of restraints went smoothly. Once she arrived at health services Ms. Smith was given three injections prescribed by the psychiatrist despite having refused them. Ms. Smith had however verbally agreed to take medication orally. It is noted that "despite a few snags when she arrived at health services, the inmate was quite cooperative."

- Incident of July 26 2007

  This was a planned intervention to carry out Ms. Smith's transfer. The inmate was compliant during the incident. She was somewhat recalcitrant, but agreed to receive the medications through an injection administered by the nurse. The nurse threatened that she would be given more injections if she became agitated. The psychiatrist had been consulted the day before the transfer.

The regional report (Institutional Operations, Quebec Region) found that staff used the force necessary to carry out Ms. Smith's transfer.

14.4. Videos of use of force during injections administered to Ashley Smith on July 22, 23 and 26, 2007

On October 30, 2009, I saw the videos related to the use of force on July 22, 23 and 26, 2007, at the Office of the Correctional Investigator in Ottawa. Without going into the full detail of the events, which are clearly described in the Correctional Service of Canada's investigation report from pages 20 to 37, I will provide a few observations that I feel will be useful from a medical standpoint.

- Incident of July 22, 2007

At the beginning of the video that starts at 11:41 a.m. we learn that Ms. Smith was in her cell, was disorganized, had pulled a metal plate off the wall and began to injure herself at 9:45 a.m.

The IERT arrived at the door of Ms. Smith's cell at 12:28 p.m. Ms. Smith refused to cooperate and obey the order to drop down on her knees, face to the wall, hands on her back. They then used a chemical agent.

Ms. Smith was calm when she left her cell at 12:33 p.m., handcuffed with her hands behind her back. She remained calm during her decontamination shower.

After taking her shower, she expressed her refusal to see the nurse; also, she at first refused to place her hands behind her back to be handcuffed, but ended up agreeing to do so. An IERT member told her that "everything was going fine."

Ms. Smith was relatively calm while she was being restrained on the stretcher (12:52 p.m.). She moved her arms and legs a bit and complained they hurt because there was too much pressure on them, but she was not agitated, did not utter threats and did not shout insults at the staff.

At 1:02 p.m. the nurse can be heard saying: "She is so angry." There was a concern that if she became too agitated, the stretcher could fall on the ground. (However, Ms. Smith was not particularly agitated at that time and there were at least five workers around her). The nurse said she was going to give her an injection and Ms. Smith replied, "No."

At 1:09 p.m. Ms. Smith was given the first antipsychotic injection (Clopixol Acuphase 50 mg intramuscular) even though she said, "No, no injection." She became somewhat more agitated in the stretcher by moving her limbs.

At 1:10 p.m. the nurse said, "I'm calling the psychiatrist, that will not be enough, she is super-agitated." It was noted that she had cut herself on her right middle finger when she had pulled off the metal plate.

At 1:19 p.m. Ms. Smith refused the intramuscular injection. She received another injection containing an antipsychotic and an anxiolytic drug prescribed by the psychiatrist (Haldol 5 mg and Ativan 4 mg intramuscular) but agrees to take an oral medication (Cogentin 2 mg).

At 1:24 p.m. the nurse asked her, "Do you feel good now?"

At 1:32 p.m. when Ms. Smith moved a bit in her stretcher, the nurse told her, "Do you want to pass out from the injections? Stop moving!"

From 1:39 p.m. to 2:08 p.m. the IERT members tried to leave to see if Ms. Smith would calm down. They had to come back when she tried to free her wrist or leg from the restraints. She made spitting gestures several times when she was held down.

At 2:08 p.m. the nurse told her that she would be given another injection if she did not calm down.

At 2:25 p.m. she tried to free a limb from her restraints and rocked the stretcher as if to tip it over.

At 2:29 p.m. a third intramuscular injection was administered (Haldol 5 mg, Ativan 2 mg, and Benadryl 25 mg).

At 3:19 p.m. the nurse told her, "I don't know what to do with you anymore. We will let you rest, you stay calm or we will give you another injection."

At 3:21 p.m. the nurse told her, "Relax, or I'm coming in with another injection. If you do anything at all, we will come back to give you an injection. Do you want another injection? (Ms. Smith answered, "No"). You are not being very cooperative. Lie down, close your eyes, this is your last chance!"

Ms. Smith tried to sit up, said she needed to change her sanitary tampon, played with the edge of the bed and smiled.

At 3:29 p.m. she was given a fourth injection (Haldol 5 mg, Ativan 2 mg, Benadryl 25 mg).

From 3:30 p.m. to 7:57 p.m. Ms. Smith was restless in her stretcher. She tried a few times to remove her wrist from the restraint and to bite the mattress.

A transfer to the CHRDL emergency department to do a body cavity examination was refused because Ms. Smith was not psychotic.

At 7:57 p.m. the nurse told her that the psychiatrist had prescribed another injection because she was still agitated. Ms. Smith replied, "I don't want it!" The injection was administered (an anxiolytic, according to the Correctional Service of Canada's investigation report).

A transfer to Pinel was requested but was not possible.

From 8:00 p.m. to 10:30 p.m. Ms. Smith continued to struggle now and then on her stretcher. She tried to climb down, sat up, tried to remove one limb or another from her restraints, bit the mattress, and lightly banged her head on the edges of the stretcher.

She calmed down at 11:00 p.m. She was smiling and told a joke to the staff.

Throughout these events of July 22, 2007, Ms. Smith understood the instructions she was given and never appeared to be hallucinating or delirious, or speaking incoherently, presenting signs of an underlying psychotic or organic disorder that could have affected her capacity to make decisions or her behaviour, or her ability to give free and informed consent.

- Incident of July 23, 2007

At 4:50 p.m. Ms. Smith was reported to have removed a metal plate. Blood was seen on her gown. She tried to obstruct her camera. She had a new injury in her wrists.

The IERT intervention started at 6:18 p.m. The nurse commented that Ms. Smith was disorganized and was not listening.

During decontamination, Ms. Smith learned that she could not return to her cell right away because of the repairs that had to be done. She headed towards the radiator in the shower room and tried to break it. Health services

notified the psychiatrist, who prescribed the application of restraints and an injection of Loxapac 50 mg, Ativan 2 mg, and Benadryl 50 mg.

Ms. Smith offered slight resistance to being placed in restraints but she was not agitated, and did not make threats or offensive comments.

She became somewhat more agitated when the nurse tried to examine her and acted as if she was going to spit on her. She refused the intramuscular injection, but said that she would agree to take an oral medication. The intramuscular injection was administered at 7:10 p.m. as prescribed.

At 9:00 p.m. Ms. Smith was calm and removal of the restraints was authorized.

- Incident of July 26, 2007

The video starts at 4:43 a.m. The IERT leader presented the SMEAC to the Acting Warden, with a psychologist and a nurse in attendance. The objective was to control Ms. Smith's behaviour very closely during her transfer because it was suspected that she could have hidden objects in her body cavities and that she could became unstable and act out by injuring herself or assaulting a staff member.

Although she agreed to the transfer, she was likely to change her mind, as she often did. Negotiations worked when she was not in a "dysregulated" behaviour state. However, after the first few days, she was in a "dysregulated" behaviour state and only very slowly returned to a calmer level. The medication was mandatory and not debatable. Thirty minutes before her departure she would receive an injection against her will and the use of force was an option if necessary.

The Acting Warden asked why the psychiatrist had prescribed an involuntary injection. The nurse replied that Ms. Smith had to remain clam during the air transfer. She had not been calm during her previous air transfer, and that could endanger the lives of everyone on board.

In fact, on July 24, 2007, the psychiatrist had prescribed injections of Loxapac 50 mg, Ativan 2mg, and Benadryl 50 mg, to be administered as required, in preparation for her transfer, in case Ms. Smith became too agitated or lost control. One injection was to be administered half an hour before departure, the next two injections two hours apart, and then another injection four hours after the third, for a maximum of four doses.

Ms. Smith woke up at 5:32 a.m. and went to the bathroom. A strip search was conducted. Her cooperation was good. She refused the injection at first, saying that the medication made her sleep. She agreed to the injection after the nurse explained that she had no choice but to take it and that the air trip would be easier for everyone.

15. Review of relevant scientific literature

The following are the diagnoses made by ' and who examined Ms. Smith many times:

Axis I: None
Axis II: Antisocial Personality Disorder with Borderline traits
Axis III: Under examination for Wilson's disease
Axis V: GAF: Over 50

The multiaxial system of DSM-IV-TR[4] classifies all mental disorders under Axis I with the exception of personality disorders and mental retardation. Axis I includes, among others, organic disorders, substance use disorders, schizophrenia and other psychotic disorders, and mood (affective) disorders. Axis II is reserved for personality disorders and mental retardation. Disorders classified as Axis II are not considered to be medical conditions.

The DSM-IV-TR defines personality disorders as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible" and affects cognition, affectivity, impulse control and need gratification. This pattern has an onset in adolescence or early adulthood, is stable over time, and causes distress and impairment in functioning. Individuals afflicted by personality disorders are typically not aware that their personality traits are problematic.

Antisocial Personality Disorder is characterized by a pattern of disregard for, and violation of, the rights of others, while Borderline Personality Disorder is characterized by very poor impulse control and instability in interpersonal relationships, self-image, and emotions. These two types of personality disorder, or at least traits related to each personality type, can co-occur within the same individual.

There is little evidence to suggest antisocial personality disorder can be successfully treated by psychiatric interventions. To date, no psychiatric treatment

has proved effective. Individuals do not learn much from the painful consequences of their behaviour. Those who are successful in forming a therapeutic alliance with a psychotherapist can show positive changes, as can those who manifest certain depressive traits or capacity for introspection when confronted by their peers in a prison or military setting.[5] Hospitalization has few beneficial effects.

Although there are no studies showing that antisocial personality disorder can be altered through pharmacological treatment, certain symptoms and behaviours may respond positively to medication if compliance to treatment can be enhanced through institutional or community supervision. Psychotic symptoms in certain individuals who have been diagnosed with schizophrenia and antisocial personality disorder respond well to antipsychotic medication, just as certain symptoms of depression and anxiety may respond to antidepressant or anxiolytic medication.[6]

Various psychotherapeutic approaches for antisocial personality disorder have been investigated, including family therapy, residential therapy, cognitive-behavioural therapy and the psychodynamic approach. Cognitive-behavioural therapy is the most frequently used method and can help certain individuals presenting with less severe psychopathology. Psychoanalytical therapy is not usually effective but a psychodynamic approach can provide a better understanding of the psychodynamics of these individuals. Certain clinical features have been identified as contraindications to psychiatric treatment, specifically a history or sadistic and violent behaviour; total absence of remorse; intelligence two standard deviations from the mean; no history of attachments; and fear of predation on the part of experienced clinicians without any overtly threatening behaviour by the patient.[6]

Kernberg also indicates that antisocial personalities have a very poor prognosis for the entire range of psychological treatments. He raises, among others, the problem of self-destructive tendencies in certain individuals with borderline personality organization; these tendencies lead them to self-destroy or destroy any help offered by those around them, with the ultimate goal of triumphing over them, even if they themselves succumb in the process.[7]

The primary psychiatric treatment for borderline personality disorder is psychotherapy, complemented by symptom-targeted pharmacotherapy. There is no empirical evidence establishing that any one approach is more effective than another. Long-term or extended psychotherapy helps attain and maintain improvement in patient personality, interpersonal problems and overall functioning. Pharmacotherapy helps reduce symptoms such as affective instability, impulsivity, psychotic-like symptoms and self-destructive behaviour.[8]

Clinical experience indicates that a combination of both psychotherapy and pharmacotherapy is the most beneficial approach for patients with borderline personality disorder. Two psychotherapy approaches have been shown in randomized controlled trials to be effective, namely psychoanalytic/psychodynamic therapy and dialectical behaviour therapy (DBT).

There is no specific pharmacological treatment currently approved but pharmacotherapy can diminish the severity of symptoms and optimize functioning. However, medications do not cure character. Commonly used medications include antidepressants, mood stabilizers, and low-dose neuroleptics. Since this treatment is long-term, patient participation must be voluntary.

The treatment of chronic self-destructive behaviour and the association of antisocial traits and violent behaviour present particular challenges, depending on the severity of these features. In milder cases, individual cognitive therapy may encourage individuals to weigh the risks against the benefits of their behaviour as well as its long-term consequences. In more severe cases, residential treatment may be indicated, including group therapy and medication to control episodic outbursts of anger. When the threat of violence is imminent, psychotherapy becomes ineffective and voluntary or involuntary hospitalization is necessary. It should be kept in mind that certain patients with borderline personality disorder with co-occurring antisocial traits may not be good candidates for therapy, in particular those presenting with narcissistic traits such as grandiosity, conning, lack of remorse, lying and manipulativeness.

Violence is the most troublesome symptom associated with antisocial personality disorder. Some researchers have developed a pharmacological approach to the treatment of violence and aggression based on an understanding of the neurobiological systems involved in the manifestation of these symptoms. Making a distinction between affective aggression (featuring high levels of emotion and in response to an imminent threat) and predatory aggression (emotionless and planned), they suggest various pharmacological interventions acting on the gamma-aminobutyric acid (GABA) system (benzodiazepines), noradrenergic system (lithium, propranolol), serotonergic system (lithium, fluoxetine), and electrical "kindling" (phenytoin, carbamazepine). These are symptom-targeted treatments that elicit widely varied responses from one individual to another. In all cases, these treatments require the patient's agreement and cooperation because they are long term and the medication has to be taken on a daily basis.[6]

In acute violence settings the use of intramuscularly administered medication is indicated to reduce risks for the patient and the staff. Benzodiazepines are quick-acting and efficacious. They are the first-line drugs for moderate to severe agitation and for cases where there is a potential for escalating behavioural dyscontrol.

Antipsychotics are also effective in reducing agitation and violence in both psychotic and non-psychotic patients. High-potency neuroleptics such as Haloperidol, and more recently atypical antipsychotics including olanzapine, ziprasidone and risperidone, are being increasingly used in combination because of the synergy of the drugs' efficacy and rapid onset of action.[9]

The use of seclusion and restraint in correctional psychiatry is complicated by the fact that correctional services have procedures regarding the use of these measures for non-medical purposes. The use of these control measures for clinical purposes must occur in response to patients exhibiting behaviour that is dangerous to self or others as a result of mental illness. Certain definitions can help make this distinction clearer, as follows:

> "Clinically ordered restraint is a therapeutic intervention initiated by medical or mental health staff to use devices designed to safely limit a patient's mobility. Custody restraint is not the same as clinically ordered restraint. When custody staff orders the use of restraints, medical staff monitor the health status of inmates while in custody restraint, and mental health staff respond to security or medical staff requests for consultation regarding the use of, or response to, custody ordered restraint.
>
> Clinically ordered seclusion or "time-out" is a therapeutic intervention initiated by medical or mental health staff to use rooms designed to safely limit a patient's mobility. It is not the same as segregation or isolation as generally applied in corrections (i.e., [...] used primarily for punitive purposes)."[10]

Isolation is a less restrictive procedure than restraint. It is used with individuals who retain a certain degree of control. They may be placed in a security room without concern that their degree of agitation will pose a risk of injury. Restraint becomes appropriate in cases where there is no minimal control and patients are extremely agitated, posing a risk of injuring themselves or others or a risk of damaging objects.[11] In both cases, medication to reduce agitation should be offered. When a patient in restraints remains agitated and refuses the medication, it should be administered involuntarily until the patient has calmed down.[12]

Discussion

The Ombudsman and Child and Youth Advocate provides a clear overview of Ashley's journey in page 8 of his investigation report, as follows:

"Ashley Smith became involved in the youth criminal justice system at the age of thirteen when she was charged with assault and disturbance in a public place, offences under the *Criminal Code of Canada*. From that point on, the events involving a young teenager, unconsciously relying on the services provided by a number of provincial governmental stakeholders, went spiralling into an increasingly frustrating and disturbing experience for all parties involved. From conventional education to alternative programs, open custody to secure custody, youth detention centre to adult correctional facility, Ashley Smith appears to have remained the one constant in an ever changing series of initiatives taken by various interveners to have her fit a mould of stability that only resulted in mind-boggling unstable results."

From a psychiatric perspective, Ms. Smith suffered from antisocial personality disorder with borderline traits. She presented with long-term traits that were stable over time and characterized by violation of the rights of others, contempt, impulsivity, instability in interpersonal relationships and emotions, and lack of self-examination regarding her behaviour, which was often disruptive, oppositional and self-destructive. The co-occurrence of these two types of personality made her management difficult from both psychiatric and correctional perspectives. Attempts to offer her psychiatric treatment in various health care units failed because she did not cooperate and acted out several times. Prospects for a positive response to psychotherapeutic and/or pharmacological treatments were therefore very limited in her case, particularly in view of her inability to commit to and follow a treatment plan. Ms. Smith was almost always kept in segregation and often placed in physical restraints in care units and correctional facilities because of her self-destructive and hetero-aggressive behaviours.

Ms. Smith was incarcerated at the Joliette Detention Centre from June 27 to July 26, 2007. On July 22 and 23, 2007, she was placed in restraints and received injections of antipsychotic and anxiolytic medication after being extracted from her cell because she had pulled a metal plate off the wall and had hurt herself or deliberately injured herself with screws, and did not follow the staff's instructions. The nursing staff who assessed her found she was agitated and posed a danger to herself and others. The psychiatrist on duty was contacted and prescribed the use of physical restraints and injections of antipsychotic and anxiolytic medication, on the basis of the information provided to him. The institutional emergency response team became involved to extract Ms. Smith from her cell, place her in restraints and observe her until she calmed down.

In these two incidents, the use of restraints and involuntary administration of the injection were warranted under article 13 of the *Civil Code of Québec*, which sets out that "consent to medical care is not required in case of emergency if the life of

the person is in danger or his integrity is threatened and his consent cannot be obtained in due time," and under article 118.1 of the Quebec *Act respecting health services and social services,* which is states that "Force, isolation, mechanical means or chemicals may not be used to place a person under control in an installation maintained by an institution except to prevent the person from inflicting harm upon himself or others. The use of such means must be minimal and resorted to only exceptionally, and must be appropriate having regard to the person's physical and mental state." This Act has be complemented by certain departmental orientations that guide institutions in developing their protocols for the application of control measures, including the following: "Chemical substances, restraints and isolation are used as control measures purely for ensuring safety in situations where risk is imminent."

A review of the video recordings of the incidents of July 22 and 23, 2007, helped determine that there was no medical condition affecting Ms. Smith's capacity to give free and informed consent and that there was no serious or imminent risk placing her life in danger of threatening her integrity or the integrity of others. First, during the incident of July 22, 2007, there was a delay of slightly over two and a half hours between the time when Ms. Smith was seen with the metal plate in her hands and blood on her gown and the IERT's intervention to extract her from her cell (9:45 a.m. and 12:28 a.m.). In addition, Joliette Institution managers who viewed the video recording of this period found that Ms. Smith "refused to cooperate and engaged in non-violent negative behaviour." It is difficult to conclude, on the basis of these observations, that this was a situation involving serious and imminent risk.

Ms. Smith was calm when she exited her cell at 12:33 a.m., her hands handcuffed behind her back. Also, she remained calm while taking her decontamination shower.

After taking her shower, Ms. Smith voiced her refusal to see the nurse and initially refused to put her hands behind her back to be handcuffed, although she eventually agreed to do so. An IERT member told her that "everything was going fine."

Ms. Smith was relatively calm while being placed in restraints on the stretcher (12:52 p.m.). She moved her limbs a bit and complained that she was being hurt and there was too much pressure on her limbs, but she was not agitated, did not utter threats and did not shout insults at the staff.

Throughout these events of July 22, 2007, Ms. Smith understood the instructions she was given and never appeared to be hallucinating or delirious, or speaking

incoherently, presenting signs of an underlying psychotic or organic disorder that could have affected her capacity to make decisions or her behaviour.

At 1:02 p.m. her nurse is heard saying, "She is so angry." There was a concern that if she became too agitated, the stretcher could fall on the ground. (However, Ms. Smith was not particularly agitated at that time and there were at least five workers around her). The nurse said she was going to give her an injection and Ms. Smith replied, "No."

The description of Ms. Smith's status at that time, specifically "She is so angry," does not agree with what is seen in the video. This is also the case a few minutes later at 1:10 p.m. when the nurse is heard saying, "I'm calling the psychiatrist, that will not be enough, she is super-agitated."

Afterward, Ms. Smith's behaviour, while she was in four-point restraints, can be characterized as negative, uncooperative and non-violent (as mentioned previously) rather than agitated and disorganized. In my opinion, her behaviour matched the description provided in paragraph 28 of CD 567, *Management of Security Incidents*, specifically that of a physically uncooperative inmate ("The inmate refuses to comply with staff directions or orders or refuses to move from an area or leave a cell. The inmate may offer active physical, but not assaultive, resistance by pulling or running away or resisting staff attempts to move him or her to a standing position"), and not that of an assaultive inmate, as outlined under paragraph 29 of the same document ("The inmate threatens verbally, or implies through physical behaviours, actions or gestures, the intent to apply force to harm or injure another person. The inmate, directly or indirectly, applies force against another person in a manner that causes or has the potential to cause harm or injury").

It is therefore pertinent to question the information about Ms. Smith's status given to the psychiatrist by telephone, since this information was the basis for placing Ms. Smith in physical restraints and giving her several medications through injections, which were administered against her will, rather quickly at the beginning, and in large doses, even though this was not clinically warranted by Ms. Smith's status. Over a seven-hour interval, Ms. Smith received the following medications:

1:09 p.m.:	Clopixol 50 mg IM
1:23 p.m.:	Haldol 5 mg IM, Ativan 2 mg IM, Cogentin 25 mg PO
2:29 p.m.:	Haldol 5 mg IM, Ativan 2 mg IM, Benadryl 50 mg IM

3:30 p.m.: Haldol 5 mg IM, Ativan 2 mg IM, Benadryl 50 mg IM

7:59 p.m.: injection of anxiolytic medication, whose nature I could not determine from the information available.

The injection of four doses of antipsychotic medication over a period of two and a half hours is also disturbing. Usually injections of tranquilizers are prescribed to be given once on the hour except in cases of very severe agitation, which was certainly not the case here.

The protocols for the application of restraints and segregation defined by the two institutions mentioned (Pierre-Janet and MUHC) do not specify how often a patient in restraints must be assessed by medical staff. All that is mentioned is that the interprofessional team must conduct and record an assessment on every shift. Otherwise, article 30 of Commissioner's Directive 844 ("Use of Restraint Equipment for Health Purposes") states that a "psychiatrist, psychologist or physician must assess the inmate's mental health status within two hours of the application of restraints." This directive is dated May 27, 2008, and I am not able to determine whether it was in effect when the incidents of July 22, 2007, occurred. During these incidents the on-call psychiatrist did not go on site to assess Ms. Smith's mental status, although she was kept in physical restraints for just under 12 hours and received large doses of medication. I can only agree with the directive of May 27, 2008, and urge its implementation.

Ms. Smith was kept in physical restraints for a period of just under 12 hours. The protocol seeing to the fluids, food, elimination and personal hygiene needs of a patient placed in restraints was not consistently observed during this period.

On several occasions Ms. Smith tried to rock her stretcher as if to tip it over. This behaviour was assessed as agitation. It could be surmised that she would have been more comfortable and would not have acted that way had she been placed on a suitable, sufficiently large bed.

During the incident of July 22, 2007, Ms. Smith was placed in restraints and received antipsychotic and anxiolytic medications involuntarily, although she did not pose a serious or imminent danger to her health.

During the incident of July 23, 2007, there was a delay of one and a half hours from the moment when it was observed that Ms. Smith had again pulled apart a metal plate and there was blood on her gown, and the IERT's intervention to extract her from her cell. Once again, had there been imminent danger, a major incident would have occurred during this period; however, nothing happened. Ms.

Smith became somewhat more agitated during the decontamination and struck the radiator when she learned she could not immediately return to her cell because of the repair work. The nurse called the psychiatrist, who prescribed she be placed in physical restraints and be given an injection of medication. Ms. Smith offered some non-violent resistance to being placed in restraints and made a spitting gesture when the nurse examined her. She refused to receive an injection but said she would agree to take medication orally. The injection was administered anyway.

Throughout this entire incident, and similarly during the incident of July 22, 2007, Ms. Smith understood the instructions she was given and never appeared to be hallucinating or delirious, or speaking incoherently, presenting signs of an underlying psychotic or organic disorder that could have affected her capacity to make decisions or her behaviour.

The degree of agitation observed in the video recording during this incident certainly does not meet the criteria of serious and imminent risk and did not warrant the use of physical restraints or the intramuscular administration of medication against her will. Ms. Smith agreed to take the medication orally. The prescription should have been flexible enough to allow for this option.

The incident of July 26 involves the fact that Ms. Smith was told that she did not have the choice to refuse the medication because it had been prescribed by the psychiatrist as being mandatory, while in fact it seems that the psychiatrist had prescribed it on a PRN (as-required) basis, to be given only if she was agitated before her departure and later during the transfer. Ms. Smith then agreed to take a medication that was not medically indicated because she was calm both when she woke up and at the time of departure. The situation would have been clinically different and more ethically defensible had Ms. Smith agreed to take a regularly prescribed medication to better control her aggressiveness and impulsivity.

On this last point, I was not able to determine from the information on file whether Ms. Smith was taking the antipsychotic medication that had been regularly prescribed during her incarceration at Joliette Institution. The Correctional Service of Canada's Board of Investigation report contains a table on page 40 indicating that on July 6 a psychiatrist prescribed Risperdal 2 mg DIE + PRN, and Seroquel 300 mg HS. The reports indicate at various times that Ms. Smith did not cooperate with the assessments. There is no mention of whether she was taking this medication on a regular basis as prescribed or of its effects, if she was indeed taking it.

In the three incidents of July 22, 23 and 26, 2007, two other factors were raised to justify the interventions carried out, namely the fear that Ms. Smith had hidden objects in her body cavities that she could use to harm herself or injure the staff,

and the fact that she had a history of serious self-destructive and hetero-aggressive behaviour. In my view, the strip search could have been conducted without placing her in physical restraints, as had been done before her transfer on July 26. Furthermore, I feel that the act of using control measures such as physical and chemical restraints "because of her history," when the clinical situation did not warrant such an action does not seem to be medically indicated and leads us rather to the use of control measures for correctional purposes. It seems to me that the threatening tone used at times by the nursing staff during the incidents of July 22 reflect this attitude.

Control measures could have been used preventively as part of a planned intervention within a care plan with Ms. Smith's consent as described in the terms of reference on the exceptional use of control measures: restraint and isolation, prepared by the Association des hôpitaux du Québec. In the absence of Ms. Smith's consent, the intervention fell under the classification of unplanned intervention and therefore should have met the criterion of imminent danger to the safety and security of the person or of others.

Conclusion

Ms. Smith suffered from very complex problems characterized by a combination of antisocial personality disorder and borderline personality traits. Her journey through the correctional system and the various care units was marked by her disruptive, oppositional, maladaptive, aggressive and self-injurious behaviours. Given that personality disorders are not considered to be medical conditions for which there are specific and effective treatments, the attitudes of staff working within the correctional system towards these disruptive behaviours can easily vary according to their understanding, training and capacity for tolerance. The self-destructive acts and repeated assaults can severely test even the most experienced of workers and the line separating interventions intended as therapeutic from correctional interventions can become rather blurred.

In my view, there were several ethical, clinical and equipment-related shortcomings in the way the events of July 22, 23 and 26, 2007, involving Ms. Smith, were managed at Joliette Institution.

From my observations, gathered from watching the video recordings of these three days, nothing indicates that Ms. Smith was incapable of giving her free and informed consent; also, her behaviour did not pose an imminent danger to her life, or a threat to her integrity or the integrity of others, as set out in article 13 of the *Civil Code of Québec* to obviate the necessity for consent to care. Ms. Smith was therefore placed in

restraints and received antipsychotic and anxiolytic medications that were not medically indicated during these events.

Several comments made by the nursing staff on Ms. Smith's state of health during the incidents of July 22 and 23, 2007, do not match the state she presented and raises doubts about the information that was given over the telephone to the psychiatrist on call and on the basis of which this psychiatrist prescribed that Ms. Smith be placed in restraints and given injections of medication. Sometimes these comments were made in a threatening tone of voice, which could have further provoked Ms. Smith, whose behaviour was oppositional by nature. The medication injections were administered to Ms. Smith without any explanation of what they were, since it had been determined that she was not capable of giving consent. I recommend that the knowledge and information on the understanding, assessment and approaches used for states of agitation be regularly reviewed with staff members, especially where related to severe personality disorders where the boundary between medical and correctional concerns is not always clear.

The protocols for the use of physical and chemical restraints do not specify how often a patient in restraints must be assessed by medical staff. On July 22 and 23, 2007, the on-call psychiatrist received information from the nursing staff by telephone, but never reported on site to assess Ms. Smith in person. Paragraph 30 of Commissioner's Directive 844 (Use of Restraint Equipment for Health Purposes) states that a psychiatrist, psychologist or physician must assess the inmate's mental health status within two hours of the application of restraints. Because this directive is dated May 27, 2008, I am unable to determine whether it was in effect when the July 22, 2007, incidents occurred. I recommend, however, that the implementation of this directive be ensured because the nursing staff or any other personnel working in the correctional system cannot be expected to have the same level of knowledge and expertise as hospital staff. Therefore it is particularly advisable to have health care staff conduct assessments on site during emergency situations.

On July 22, 2007, while Ms. Smith was kept in physical restraints for just under 12 hours, the protocol indicating how to meet the fluids, food, elimination and personal hygiene needs of a patient was not consistently observed. In addition, Ms. Smith's was kept in restraints on a stretcher that was prone to overturning if she moved too much. Restraints applied for such a long time should have been applied on an adequate bed. Someone must ensure that the protocols on the care to be provided are observed and the equipment and space required are available in detention centers to facilitate the use of physical and chemical constraints and the monitoring of patients.

In my view, during the incidents of July 22 and 23, 2007, the IERT members could have extracted Ms. Smith from her cell to examine her injuries, conduct a strip search and then place her in segregation as it was often done under such circumstances.

In my opinion, during the incident of July 26, 2007, Ms. Smith was forced to take the medication, although she took it involuntarily, because she was told that she had no choice but to take it, although this medication had been prescribed only on an as-required basis, in case she became agitated. The nursing staff and the psychologist had decided to modify the psychiatrist's prescription in the expectation that Ms. Smith would exhibit disruptive behaviours at the time of her transfer, given her history of such behaviours in similar situations. It cannot be determined from the video whether this modification had been discussed with and approved by the psychiatrist.

These comments concern only the three incidents of July 22, 23 and 26, 2007, and obviously do not address the problems posed by Ms. Smith's multiple disruptive, self-injurious and hetero-aggressive behaviours throughout her incarceration in the correctional system and her stays in health care facilities.

A review of the literature indicates that antisocial personality disorder does not respond favourably to psychiatric intervention. The combination of borderline personality with significant narcissistic traits such as grandiosity, conning, lack of remorse, lying and manipulativeness makes the prognosis even more guarded. Cases where psychotherapy and pharmacotherapy had a beneficial effect featured certain basic elements such as a multidisciplinary approach integrated in a long-term and consistent intervention plan fostering the development of a therapeutic alliance based on trust and cooperation. The use of physical and chemical restraint measures may even be considered in these circumstances with the patient's consent. In Ms. Smith's case, it is very likely that the fact that she was continually kept in isolation without an adequate care plan and transferred seventeen times over an eleven-month period from one detention facility to another in the federal correctional system hindered the formation of such an alliance.

(*original signed*)

Paul Beaudry, MD, FRCPC
Psychiatrist

PB/jd

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