

Lived and Living Experience of Mental Health, Substance Use, and Incarceration in Nova Scotia

Final Report and Recommendations

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Executive Summary

The objective of this study was to better understand lived and living experiences of mental health, substance use, and incarceration in Nova Scotia, with the aim of improving resources, supports, and services for substance users with mental health issues in provincial custody, in community, and as they transition between. Data was gathered to inform policy, protocols, and praxis of both government agencies and community-based organizations and service providers.

This report has generated 32 recommendations for change, based on the study findings. A summary of recommendations can be found at the end of the report (pages 43-47).

This study was undertaken in partnership with the Mobile Outreach Street Health (MOSH) and funded in part by a Research Project Development Grant from the *Canadian Research Institute for Substance Matters – Atlantic Node*. Ethics approval was granted via the Carleton University Research Ethics Board (A, clearance #123014). Twenty-one individuals participated in one-on-one semi-structured interviews with the lead researcher (Dr. Laura Beach).

The research findings support broader patterns identified by prior studies in Nova Scotia and across other jurisdictions, including the prevalence of mental health issues, addictions, and adverse childhood experiences among incarcerated people, the insufficient assessment, treatment, and supports for mental health and addictions in custody, the exacerbation of substance use and mental health via conditions of confinement, questionable prescription practices in custody, lack of release planning and supports for community reentry, and a lack of continuity of care between jail and the community – factors that contribute to recidivism and perpetuate the cycle of incarceration (Browne et al., 2022; Giacomantonio & Jervis, 2023; Hu et al., 2020; Jennings et al., 2021; Link et al., 2019; MacKenzie & Amirault, 2021; Morrison, 2022).

The findings of this study are structured here according to four overarching themes: 1) the deep entanglement of mental health, substance use, and incarceration; 2) the lack of assessment, treatment, and supports for mental health and addictions in jail; 3) the *debilitating*, rather than *rehabilitating*, effects of incarceration; and 4) barriers to community reintegration, which perpetuate the cycle of incarceration. Targeted recommendations accompany each theme and are summarized at the end of the report. These recommendations also align with prior studies, including the recent evaluation of the MOSH Justice Initiative, which further underscored the importance of collaboration between correctional institutions and community organizations, particularly with regards to facilitating continuity of care (Giacomantonio & Jervis, 2023).

Notably, many of the recommendations stemming from this research study also reiterate or reaffirm prior calls to action from local health and prison justice organizations in recent years, including the March 2024 *Month of Action* (<https://www.pathlegal.ca/month-of-action>) and the recent *Intersectoral Action Plan for Decarceration in Nova Scotia* (2024). Findings and recommendations regarding the lack of assessment, treatment, and support for mental health and addictions in Nova Scotian jails align with recently released Deaths In Custody Review

Committee recommendations (2026) and recall prior commitments made by the Government of Nova Scotia following the 2010 inquiry into the tragic death of Howard Hyde – commitments that have yet to be fully implemented more than a decade later (Nova Scotia, 2011). In particular, this report calls on the Government of Nova Scotia to uphold its promise to:

- Develop and implement an improved screening / assessment tool to better identify mental health issues among justice-involved individuals (Nova Scotia, 2011, p. 43);
- Provide better care in custody for individuals with mental health issues via intersectoral collaboration between the Departments of Justice, Health, and Community Services as well as community-based service organizations (Nova Scotia, 2011, pp. 20–24);
- Develop a “culture of respect and empathy” via targeted training of health and criminal justice system employees (Nova Scotia, 2011, p. 27); and,
- Support individuals as they transition from custody back into the community, including via the provision of safe and affordable housing (Nova Scotia, 2011, pp. 44–45).

As Nova Scotia Premier Tim Houston observed in the Nova Scotia Action for Health Strategic Plan 2022-2026 (which, disconcertingly, doesn’t address the provision of health care in custody), transforming health in Nova Scotia “will not be easy. It will be expensive. And it will not happen overnight” (Government of Nova Scotia, 2022, p. 4). This report calls on Premier Houston and his government to fulfil their promise to “do the work and make the investments needed to give Nova Scotians the health system they deserve”, and, following the 2003 World Health Organization *Declaration on Prison Health as part of Public Health*, to include Nova Scotians in provincial custody in this important work (Government of Nova Scotia, 2022, p. 4).

Research Project Overview

Background

Individuals with mental health issues and addictions are over-represented across the Canadian criminal justice system and often cycle in and out of prison. The criminalization of substance use in the community, within prisons, and via parole/probation conditions perpetuates this cycle of incarceration. Beyond limited access to Opioid Agonist Therapy, there remain significant barriers to harm reduction initiatives in Nova Scotian prisons, despite the known risks associated with illicit substance use – including increased risk of infection and overdose.¹ Furthermore, there are substantial gaps in the continuity of care as individuals transition back and forth from facility to community. Together, these factors intensify the vulnerability of substance users and hinder successful rehabilitation and reintegration.

¹ There is comparably better access to harm reduction in federal institutions, including clean needle exchange initiatives. Prisoners may, however, be reticent to access needles due to fears of “outing” themselves as users.

The province of Nova Scotia spends close to \$100 million per year on correctional services, and over \$300 per person per day in adult custody (Nova Scotia Department of Justice, 2025). The average daily count of all four adult correctional facilities in total in 2024-2025 was 525, a 12% increase since 2017-2018 (NSDOJ 2025). For the same period, there were ~4000 new arrivals (individuals entering provincial custody), with a median length of stay of 26 days. Unsentenced prisoners (i.e., individuals remanded to pre-trial custody), now comprise over $\frac{3}{4}$, or 76%, of Nova Scotia's provincial prison population, up from 71% in 2022-2023 and 61% in 2017-2018 (NSDOJ 2019). Notably, individuals with addictions and mental health issues are statistically over-represented among remanded populations, as they are less likely to be granted bail due to systemic discrimination (Deshman & Myers, 2014, pp. 72–73). Remanded prisoners may also face additional barriers to accessing supports and resources while incarcerated, including programming and medical treatment, as their length of stay within the facility is unknown and dependent upon external factors, including criminal justice system processes and timelines.

A snapshot of adults in provincial custody in Nova Scotia in 2005 found that “Nova Scotia Correctional Services offers little by way of [addictions] programming or treatment for adult offenders incarcerated under its authority, despite research showing a positive correlation between substance abuse and crime” (Kitchin, 2005, p. 501). *The findings of this study suggest that little has changed in over twenty years.*

Research Objective

The objective of this research project was to better understand lived and living experiences of mental health, substance use, and incarceration within Nova Scotia, toward the improvement of services and supports in provincial correctional facilities, in community, and during the transition between. The project was designed to collect data to inform changes to policy, protocol, and practices of government agencies (Nova Scotia Correctional Services [NSCS] and Nova Scotia Health – Correctional Health Services [NSH-CHS]), community organizations (e.g., John Howard Society), and service providers (e.g., North End Community Health Center) related to assessment, treatment, and support for mental health and substance use, as well as intake, release, and continuity of care between community and facilities.

Research Methods

Design

The research project was designed in partnership with Mobile Outreach Street Health (MOSH), a program of the North End Community Health Center (NECHC), based in Halifax, Nova Scotia.

As the community partner, MOSH:

- Identified a need for research grounded in experiences of criminalized substance users, toward the improvement of both institutional and community services and supports;
- Assisted in project development, including research objectives, methods, and timeline;
- Participated in a stakeholder consultation, to help guide the development of data collection instruments (i.e., interview and focus group guides);
- Facilitated participant recruitment via: a) printing and displaying posters for interviews, b) circulating posters to other service providers and community organizations, and c) informing clients that there was a research project underway;
- Provided feedback on preliminary findings.

The guiding question for this research project was: *What are the most significant challenges faced by criminalized substance users with mental health issues, as they cycle in and out of correctional facilities in Nova Scotia?*

The lead researcher (Beach) and community partner (MOSH) anticipated that these challenges would include access to substance use treatment and harm reduction services within provincial jails as well as continuity of care upon intake and/or release (including discontinuation of prescribed medications). However, to ensure the research findings reflected the experiences of the research population, an inductive approach was taken, with the understanding that the most significant challenges would be identified via thematic coding and analysis. The primary method of data collection (semi-structured interviews) reflected this approach, allowing participants to articulate challenges otherwise unanticipated by the research team.

The research unfolded over seven phases:

PHASE 1 – literature review + stakeholder consultation

PHASE 2 – ethics application

PHASE 3 – participant recruitment + data collection

PHASE 4 – transcription, coding, & preliminary analysis

PHASE 5 – feedback from stakeholders

PHASE 6 – thematic analysis

PHASE 7 – final report + recommendations

Literature Review

Literature reviewed was comprised of relevant scholarship, policy documents, and reports from government agencies and community organizations and was guided by the following questions:

- What are the established and/or hypothesized correlations between substance use, mental health issues, and criminal activity / criminalization?
- Have any similar studies been conducted, and if so, what are the results?
- Are there any accessible policy documents or government reports regarding substance use treatment and harm reduction within Nova Scotia prisons? Are there any accessible policy documents or government reports regarding continuity of care upon intake/release from Nova Scotia prisons? If so, what do these policy documents prescribe?
- Are there any relevant reports from community organizations within Nova Scotia? If so, what are their findings and recommendations?

In place of a standalone literature review section, sources are integrated throughout this report.

Recruitment & Data Collection

Recruitment posters were displayed at various community service agencies / organizations in the Halifax Regional Municipality, including the North End Community Health Centre, the Salvation Army, the Brunswick Street Mission, and the Elizabeth Fry Society of Mainland Nova Scotia, as well as shelters and transitional/supportive housing facilities. MOSH also circulated the poster to community organizations / service providers and informed clients about the research project. After the interviews began, recruitment also took place via organic snowball sampling, with participants telling friends/acquaintances about the opportunity to participate.

Twenty-one individuals participated in the research project between May and August 2025. Participation involved a one-on-one semi-structured interview with the researcher ranging from 20 to 90 minutes, as well as a demographic questionnaire which collected data toward an intersectional analysis (Abrams et al., 2020), including age, race/ethnicity, gender, and sexual identity, as well as employment, housing, and histories of incarceration. Semi-structured interviews focused on experiences of accessing supports / services for substance use and mental health both in jail and in the community, and experiences of transitioning between the community and the prison. The final question – *Is there anything else that you would like to share, or anything that you feel it is important for me to know?* – allowed participants to raise anything they felt was relevant or important or reiterate what they felt was most crucial from what they had shared. Most offered suggestions toward improving conditions of confinement, breaking the cycle of incarceration and/or addictions, and facilitating community re-entry and reintegration. These suggestions were incorporated into the final report and recommendations.

Participants were given the choice of a one-on-one interview or a focus group. All participants chose to be interviewed; hence, no focus groups were conducted.

Data Analysis

Interviews were analyzed using an inductive, thematic analysis approach (Clarke & Braun, 2017; Nowell et al., 2017), following a process designed by the lead researcher (Beach) in consultation with Dr. Leah Genge (NECHC, Principal Applicant of the CRISM grant). Otter AI was used for verbatim transcription, which was then edited by Beach, to preserve participants' language, phrasing, and delivery. Beach read through all transcripts to become familiarized with the data, then manually coded two interviews using an *in vivo* method, which entails sticking as closely as possible to the participant's language, meaning, and intent, with minimal researcher interpretation. NVivo software was used for the first round of descriptive coding (Chandra & Shang, 2019), generating 273 codes (e.g., addictions – withdrawal; institutional lockdown; feeling judged and mistreated by correctional staff). Code saturation was reached after transcription of 14 interviews (i.e., new codes ceased to be generated). These codes were used to build a codebook, using a hierarchical classification scheme that reflected emergent themes and followed the principles of non-duplication and independent codes to support flexibility in analysis (e.g., “interpersonal violence”, “experiences of incarceration”, and “shelter experiences” versus “interpersonal violence in prison” and “interpersonal violence in shelters”).

The original codebook consisted of eleven parent (or “top level”) codes, and 222 child and grandchild codes (e.g., cycle of incarceration [parent] → revolving door [child] → can't remember how many times incarcerated [grandchild]), with definitions assigned to each code to support consistency. All twenty-one interviews were coded using this codebook, which was further refined throughout the process, reflecting the iterative nature of inductive coding. The final codebook consisted of twelve parent codes and 262 nested codes. To ensure *intracoder* reliability (single coder), three interviews were re-coded six weeks later (Cofie et al., 2022). There was no significant difference between coding sessions.

NVivo was used to identify prevalent codes and terms. Cross-tabulation and matrix coding were employed to develop thematic analysis and identify key quotes. For example, cross-tabulation of the codes “community re-entry” and “challenging factors” supported the preliminary finding that lack of housing was the most significant challenging factor vis-à-vis community re-entry.

Emergent themes and preliminary findings were shared with MOSH via a PowerPoint presentation and with the broader community via a public event held at the North End Memorial Public Library in Halifax in November 2025 (see appendices). Feedback and recommendations were provided by MOSH and were discussed alongside preliminary findings and emergent themes in consultation with Dr. Leah Genge. The final phase of analysis consisted of connecting the most significant categories under overarching themes and sub-themes, which were used to structure the findings presented below. The completed draft report was circulated to MOSH and additional community stakeholders for input before being released to the public. Several health and justice organizations have endorsed the 32 report recommendations, including Dalhousie

Health Justice Institute, East Coast Prison Justice Society, the Elizabeth Fry Society of Mainland Nova Scotia, People’s Advocacy and Transitional Hub, and Wellness Within.

Ethics & Funding

This project was reviewed and cleared by the Carleton University Research Ethics Board (A), clearance #123014. Funding was provided by a Research Development Grant from the Canadian Research Institute on Substance Matters (CRISM) – Atlantic Node.

Limitations

The study was designed as a pilot project with a small budget, which is reflected in both the relatively small sample size and the focus on a single region. All participants were recruited in the Halifax Regional Municipality, which hinders comparisons of correctional facilities across the province. For example, few participants had been incarcerated at the jail in Cape Breton.

Of the 21 participants, a disproportionate number identified as women (13/21, 62%), compared to the proportion of women in Nova Scotia correctional facilities (7.4%; Nova Scotia Department of Justice 2025). This is in part due to more women independently reaching out to the researcher upon seeing the recruitment poster in various community settings and shelters, and in part due to widespread interest at one transitional housing facility.

Participant Profile

Participant Demographics

Semi-structured interviews were conducted with 21 people who had been incarcerated in a provincial correctional facility in Nova Scotia at least once within the past five years.

- 13 (62%) participants identified as women, 7 (33%) participants identified as men, and one participant (5%) identified as non-binary.
- The majority (15, 71%) of participants identified as heterosexual, 3 participants (14%) identified as pansexual, two participants (10%) identified as bisexual, and one participant (5%) identified their sexuality as “other”. All participants who identified as men also identified as heterosexual. Over one third of participants who identified as women (5/13, 38%) identified as pansexual, bisexual, or other.
- Approximately half of participants (10/21) were between the ages of 36 and 45, 4 participants (19%) were between 26 and 35 years old, 4 (19%) were between 46 and 55 years old, and 3 participants (14%) were between the ages of 56 and 65.

- 12 participants (57%) identified as white, 3 (14%) as Black (including Afro-Indigenous and African Nova Scotian), and 6 (29%) as Indigenous (Mi'kmaw, Ojibwe, Mohawk).
- Most participants (19/21, 90%) were unemployed. Two (10%) were working part time.
- 10 participants (48%) were living in transitional or supported housing (e.g., Caitlan's Place, Holly House, The Overlook), 5 participants (24%) were living in a shelter, one participant (5%) was living in their own house, two participants (10%) were living with friends or family, and two participants (10%) were unhoused (i.e., living on the street).
- 4 participants (19%) had some college education, two participants (10%) had attended university, 6 participants (29%) had a high school diploma or equivalent, 8 participants (38%) had a grade 8 education, and one participant – an Indigenous woman whose mother hid her and her siblings in the bush in Northern Ontario to stop them from being taken to Residential School – dropped out of school in grade 7.

Histories of Incarceration

In addition to being provincially incarcerated in Nova Scotia,

- 5 participants (24%) had also served time in a federal prison in Nova Scotia, and 8 participants (38%) had served time in a provincial prison in another province.
- 3 participants (14%) were incarcerated in youth facilities within Nova Scotia, and one participant (5%) was incarcerated in a youth facility outside of Nova Scotia.
- 4 participants (19%) were also incarcerated in a psychiatric facility in Nova Scotia and two participants (10%) were incarcerated in a psychiatric facility outside of NS.

Two participants (10%) had also spent time in foster homes as children. One participant noted that the shelter where she was currently housed felt like being incarcerated.

- 7 participants (33%) had only been incarcerated in a provincial prison in NS. Most participants (14/21, 67%) had been incarcerated in two or more types of facilities. 6 participants (29%) had been incarcerated in three or more types of facilities.

One third of participants (7/21, 33%) had been incarcerated more than seven times. Most participants (14/21, 67%) couldn't remember how many times they had been incarcerated.

- 3 participants (14%) had only been incarcerated once, and one participant (5%) had been incarcerated twice.
- 3 participants (14%) recalled being incarcerated three times.
- One participant estimated they were incarcerated four times, while 5 participants (24%) estimated it was five times, and one participant estimated it was six times.
- One participant estimated they were incarcerated over seven times.
- 3 participants (14%) estimated they were incarcerated over a dozen (12) times.
- One participant estimated they were incarcerated over 20 times.

- One participant estimated they were incarcerated “dozens” (24+) of times.
- One participant estimated they were incarcerated between 25 and 30 times.

More than half of participants had been incarcerated in the past year (11/21) while five participants (24%) had last been incarcerated more than four years before the interview.

Participants sometimes discussed reasons for incarceration during interviews, including:

- drug charges (possession, trafficking)
- theft (including stealing to support addiction, and stealing food to eat)
- sex work (including one incident of entrapment)
- assault (including psychosis-related violence and self-defense within the context of intimate partner violence)
- fraud
- dropped charges (wrongfully accused)
- administration of justice offences (e.g., breach of parole/probation conditions)
- truancy (skipping school)

Notably, the majority of offences reported by participants are nonviolent, many of which are best understood as crimes of survival, and many which might have been prevented via adequate supports for mental health and addictions in custody and in community.

Cycle of Incarceration

Most participants were first incarcerated before the age of twenty (between age 12 and 19), had been incarcerated more than five times in two or more correctional facilities, and could not remember how many times they were incarcerated. Chris, a white man in his late forties, was first incarcerated at the youth correctional facility in Shelbourne, NS at age 12 for skipping school. While there, he and other youth were forced to steal by facility staff during trips into town. Chris was in and out of youth corrections before “graduating” to provincial jail, and then serving time in federal prison, inside and outside Nova Scotia. At the time of the interview, Chris was unemployed, in recovery, in a precarious housing situation, and awaiting sentencing for theft. Chris estimated he had been incarcerated between 25 and 30 times. He explained,

“I was in a *lot* of different places. It started out with Shelbourne Youth Center. And then I ‘graduated’ to the Sackville Correctional Center. From there, I went to Spring Hill... and I've done some time all over Ontario, different provincial jails. And I went to Burnside. I was in Cape Breton. I got a lot of time in, probably half my life.”

Like Chris, many participants had been caught in a cycle of incarceration they struggled to break. Several factors were attributed to perpetuating this cycle: inadequate treatment and support for mental health and addictions (alongside a lack of meaningful activity) in jail,

insufficient support and planning around release from jail, and, relatedly, difficulty securing safe and affordable housing, which was identified as the biggest barrier to community reintegration.

Findings

The key findings of this study are organized under four overarching and interrelated themes: 1) the interrelatedness of mental health, substance use, and incarceration; 2) the lack of assessment, treatment, and supports for mental health and addictions in jail; 3) the debilitating (rather than rehabilitating) effects of incarceration; and 4) barriers to community reintegration, which perpetuate the cycle of incarceration. **Targeted recommendations accompany each theme and are summarized at the end of the report.**

These findings support broader patterns identified by studies in Nova Scotia and across other jurisdictions, including the prevalence of mental health issues, addictions, and adverse childhood experiences among incarcerated people, the insufficient assessment, treatment, and supports for mental health and addictions in custody, the exacerbation of substance use and mental health due to conditions of confinement, questionable prescription practices in custody, lack of release planning and supports toward community re-entry, and lack of continuity of care between jail and the community – factors which contribute to recidivism and perpetuate the cycle of incarceration (Browne et al., 2022; Giacomantonio & Jervis, 2023; Hu et al., 2020; Jennings et al., 2021; Link et al., 2019; MacKenzie & Amirault, 2021; Morrison, 2022).

As with the study findings, the recommendations presented here align with prior studies, including the recent evaluation of the MOSH Justice Initiative, which further underscored the importance of collaboration between correctional institutions and community organizations, particularly with regards to facilitating continuity of care (Giacomantonio & Jervis, 2023). Notably, many of the recommendations stemming from this research study also reiterate or reaffirm prior calls to action from local health and prison justice organizations in recent years, including the March 2024 *Month of Action* (<https://www.pathlegal.ca/month-of-action>) and the recent *Intersectoral Action Plan for Decarceration in Nova Scotia* (2024).

The literature review revealed that the failure to adequately treat and support individuals with mental health issues and addictions in Nova Scotia jails has been well-known for decades, and concrete solutions have been clearly articulated – as has the Nova Scotia Government's commitment to implement these solutions. The recommendations in this report recall prior commitments made by the Government of Nova Scotia following the 2010 inquiry into the tragic death of Howard Hyde – commitments that have yet to be fully implemented well over a decade later (Nova Scotia, 2011). They also align with recommendations from the provincial Deaths in Custody Review Committee (2026). This report provides further evidence of the debilitating

conditions of confinement in Nova Scotian jails, which have been linked to unprecedented rates of deaths in custody in recent years, stressing the importance of timely action.²

Theme I: Mental Health, Substance Use, and Incarceration

The lived and living experiences of research participants reveals that rather than a straightforward causal relationship (e.g., substance use leads to incarceration), mental health, substance use, and incarceration are all deeply entangled – or interdependent – forming a web of mutual influence. Notable contributing factors to this nexus include housing insecurity / homelessness and adverse childhood experiences, including physical and sexual abuse.

Substance Use and Incarceration

Many participants cited substance use as reason for incarceration, including being intoxicated while engaging in behaviour leading to criminal charges (e.g., assault), being charged for drug-related offences (possession, trafficking), and committing offences to “support their habit” (e.g., theft, fraud). Participants also highlighted the role of incarceration toward substance use. Chris, for example, started using substances while incarcerated as a young teenager.

“I was introduced to drugs in Shelbourne. And then once I got out, I started hanging around with older people and stuff... and alcohol became a big part of it. So, I mean, just a vicious cycle, just around and around and around.”

Chris also discussed how the experience of incarceration – specifically, the lack of meaningful activity – can increase the desire to use substances. In Central Nova Scotia Correctional Facility (CNSCF, aka Burnside), for example, Chris noted, “There's *nothing*. There's absolutely *nothing* to do. So... why not try to pass the time by... however.” The experience of having nothing to do while incarcerated in provincial jail was echoed by many participants. Some contrasted this with time spent incarcerated in federal prison, where they were enrolled in programs for anger management and substance use, pursued their education, and participated in prison labour. Brett, an Indigenous man in his 50s who had been incarcerated half a dozen times in provincial and federal correctional facilities across Canada, noted that Burnside was the “worst prison [he] had ever seen”. Like Chris, he depicted substance use as a coping mechanism – a way to escape conditions of confinement, including staff comportment and environmental conditions.

“People get addicted to drugs because you want to escape from, you know, your reality, which is being incarcerated, and you know, you're getting harassed by the staff and... Burnside, you don't get barely any air, and the water's nasty...”

² There have been ten deaths in custody since the start of 2023, three of which occurred in April 2026. All deaths in provincial custody should be listed on the “Justice Reportable Incident Updates” government webpage (<https://novascotia.ca/just/updates.asp>). At least two publicly confirmed deaths are not listed here – Sarah Rose Denny, a 36-year-old woman from Eskasoni First Nation who died in hospital after being transferred from CNSCF, and an unnamed individual who died inside CNSCF on October 9, 2023 (Beach et al., 2024, pp. 4–5).

At this point in the interview, Brett rolled up his sleeve and showed the interviewer a distinct rash on his forearm, which he attributed to the water in the shower at Burnside.

Mental Health and Incarceration

The impact of conditions of confinement on mental health and wellbeing was a prevalent theme across interviews. Participants described overpopulated facilities, overcrowded units, and an overreliance on institutional lockdown – a widespread and well-documented phenomenon in Nova Scotia’s jails (Beach et al., 2024; East Coast Prison Justice, 2023; Evans & Mussell, 2024). These conditions contribute to rising tensions between and among prisoners and correctional officers, who were depicted in interviews as generally indifferent and neglectful, with some actively antagonistic, and a few “good” staff who seemed to care about the wellbeing of prisoners. Travis, a white man in his early thirties who had been incarcerated approximately five times in several Nova Scotian jails, remembers spending approximately 15 out of 22 months incarcerated in Burnside in lockdown. “It was nuts”, he noted,

“I was in units where people were throwing shit at each other, stuff like that. They weren’t clean. The guards didn’t really care about a whole lot. It was pretty rough.”

Clara, a white woman in her early 40s who was incarcerated once on charges that were eventually dropped, shared a cell with a woman with severe mental health issues in Burnside’s East Unit. During recurrent institutional lockdowns, sometimes lasting nearly a week, Clara was locked in a small room with her cellmate for upwards of 20 hours per day, often going without a shower for days.³ She noted that her cellmate sometimes seemed fine, but other times was “off”, which Clara attributed to inconsistent medication – possibly an effect of lockdowns. When “off”, Clara’s roommate would become aggressive and verbally abusive, and spread her excrement on the walls of the cell. The worst part of being incarcerated, for Clara, was “just being in that space alone with that person”. She emphasized that even though her roommate could easily have hurt her, the COs didn’t check in on them, “they just threw the meals”.

Clara reported that when she tried to talk to the COs about the excrement on the cell walls, they told her they were busy. She suggested her cellmate be put in a cell on her own, to which a CO responded, “That’s not your job. Don’t tell us how to do our job.” She tried to talk to a CO about the possibility that her cellmate wasn’t taking her medication properly and was told, “that’s not your concern”. According to Clara, the COs were not only dismissive of her cellmate’s behaviour – which Clara interpreted as a clear sign of severe and complex mental health issues that weren’t receiving adequate care and attention – they were indifferent to the biohazardous conditions of the cell. Clara recalls banging on the door of her cell for two days before someone

³According to the East Coast Prison Justice Society, prisoners have reported being locked in their cells for up to 96 hours continuously, apparently due to staffing shortages (Beach et al., 2024, p. 25).

came to clean the excrement off the walls. The next time it happened, she gave up and hid under her blanket. “My mental health definitely declined being in there”, she concluded.

Impact of Close Confinement

Clara’s experience of declining mental health during lockdowns aligns with the observation made by Justice Brothers in a 2023 court decision that,

“Even a person with robust mental health would find it challenging to be regularly confined to a cell, often for more than 20 hours per day, with little notice and no ability to earn more time out. This practice is dehumanizing, and it is setting these individuals up to fail. They deserve better.”

– Downey v. Nova Scotia (Attorney General), 2023 NSSC 204 at para 94.

The findings of this study further support observations regarding the impact of lockdowns by the East Coast Prison Justice Society, a civil society organization that operates a toll-free phone line for incarcerated people in Nova Scotia toward individual and systemic advocacy around conditions of confinement. In their 2022-2023 annual report, ECPJS denounced the increasing overreliance on institutional lockdown, which has impeded bail and release planning, thus increasing time in jail, as well as contributing to the exacerbation and onset of serious health issues further decreased access to timely healthcare services (Beach et al., 2024, p. 3). According to ECPJS, prisoners reported that repeated and indeterminate lockdowns are “profoundly destructive” to their physical and mental health. As noted above, there has been an unprecedented number of deaths in provincial custody in recent years, many which can be linked to deleterious conditions of confinement: of the ten deaths in custody since the start of 2023, at least two were apparent suicides (Peter Paul of Eskasoni First Nation and Christopher Young) and at least one was linked to unaddressed mental health issues (Richard Murray).⁴

Travis recalled several suicide attempts during the 22 months he was incarcerated in Burnside,

“Being on lockdown was pretty sad... I don't know how many times somebody tried to kill themselves just because of lockdown, 24 hours, they can't handle it.”

Travis’ observation reminds us that for every completed suicide in a Nova Scotian jail, there are many more attempts. The number of attempted suicides related to inhumane and unbearable conditions of confinement, including institutional lockdowns, is not publicly available and may not be fully documented by NSCS. Travis fortunately didn’t struggle with suicidality, but he did feel he had been permanently altered by the experience of lengthy, indeterminate, and recurrent lockdowns. “[It] definitely screwed me up,” he observed. “It changes you... Like, I don't know, it's hard for me to be in a group, a big group of people. Even though that was so long ago.”

⁴ See Tutton (2024, 2024) and Sweet (2023) for more detail.

Recommendation 1

This report calls on the **Government of Nova Scotia and NSCS** to develop stronger and clearer legislation and policy around the limits of close confinement, including the prohibition of close confinement for periods longer than 20 hours per day, and to further identify a baseline of daily time out of cell, which if unmet must be justified and communicated to prisoners.⁵

Recommendation 2

To further increase transparency and accountability around the practice of close confinement, this report calls on the **Nova Scotia Office of the Ombuds** to publish the results of their quarterly audits of close confinement in provincial jails.⁶

Like Clara, Travis described COs' apparent disregard for prisoners' mental health and wellbeing. He recalled being on a range where individuals were being badly "picked on" by other prisoners, or obviously depressed or in distress, and the COs didn't seem to notice. He explained,

"A guard will walk through the range, and they don't really see an issue that's going on, or they can't tell when there's a problem. And I feel like they *should* be able to see something, you know? And I know there's stuff they are trained for, but when it comes to mental health, they should be able to see like... you know?"

Travis concluded that COs should have similar training to social workers, so they would be better equipped to recognize the signs of deteriorating mental health and to intervene appropriately. COs have the most contact with prisoners on a day-to-day basis, a reality that is reflected in the *Correctional Officer Core Competencies* outlined by the Nova Scotia Department of Justice. These Competencies emphasize professional integrity, observation (including "recogniz[ing] signs and symptoms of offender behaviour" as well as changes in behaviour) and "managing and monitoring the offenders by being present, building rapport, and ensuring standards are consistently met" (Nova Scotia Department of Justice, 2021b). The *Nova Scotia Correctional Officer Training Standards* likewise emphasize the importance of "recogniz[ing] the signs of a mentally ill offender", and "apply[ing] appropriate responses to specific behaviours of the mentally ill offender" (Nova Scotia Department of Justice, 2021c).

The role of COs toward ensuring the physical and mental wellbeing of the people in their custody is particularly important within the context of recurrent and indeterminate institutional lockdowns, which disrupt the timely provision of healthcare services and significantly impede incarcerated people's contact with other jail staff, legal representation, and outside supports, including family and friends. It is concerning that rather than feeling supported and encouraged,

⁵ See recommendation 8 in the ECPJS Visiting Committee (VC) Annual Report 2022-2023 (Beach et al., 2024, p. 42).

⁶ Reiterating recommendation #12 in the ECPJS VC Annual Report 2022-2023 (Beach et al., 2024, p. 43).

the participants in this study overwhelmingly reported feeling judged, mistreated, and neglected by COs they perceived as largely indifferent to their needs and concerns.

Recommendation 3

This report calls on the **Nova Scotia Department of Justice** to uphold the commitment made by the **Government of Nova Scotia** in the wake of Howard Hyde’s death to ensure all correctional staff receive adequate mental health and addictions training, including de-escalation and crisis intervention, “so they are better prepared to respond appropriately – with respect and empathy and in a way that puts care needs first” (Nova Scotia, 2011, p. 28).⁷

Substance Use, Mental Health, and Adverse Childhood Experiences

The disproportionate incarceration of substance users with mental health issues, including but not limited to diagnosed disorders, has been documented across Canada and beyond (Andersen, 2004; Fazel et al., 2016; Lamb & Weinberger, 2001). There is also a correlation between mental health issues and substance use and “adverse early childhood experiences” (ACE), which include emotional, physical, and sexual abuse, emotional and physical neglect, and an unstable home environment. Studies suggest that adverse childhood experiences are a determining factor for substance use (Dube et al., 2003; Lutgen-Nieves & Petty, 2024) and mental health issues – including self-harm and suicidality (Ford et al., 2020; McLachlan et al., 2024; Pessoa & Almeida, 2024), as well as police contact, housing precarity, criminal justice involvement, and victimization (Craig et al., 2017; Crick et al., 2024; Edalati et al., 2017; McLachlan et al., 2024; Pessoa & Almeida, 2024; Testa et al., 2025; Umpunjun et al., 2025). There is also evidence of a correlation between ACE and recidivism among women (Schick et al., 2020). A recent systematic review and meta-analysis of over thirty studies conducted over a thirty year period found that approximately half of all persons incarcerated in Canada have experienced childhood abuse (Bodkin et al., 2019). Adverse childhood experiences are more prevalent among women, Indigenous persons, and sexual and gender minorities – all groups who are disproportionately incarcerated (Baglivio & Epps, 2016; Muir & Viljoen, 2022).

This research study supports the findings above. The interviewer never asked about histories of abuse, assault, neglect, or home environments, but experiences were brought up organically by nearly half of all participants (9/21, 43%). Six women and three men introduced the topic of adverse childhood experiences and/or experiences of assault or abuse in later life. Four out of six women identified as Indigenous, one as Black and Indigenous, and one as white. Three

⁷ The training provided via the Canadian Police Knowledge Network on “recognition of emotionally disturbed people” has evidently been inadequate. This report calls for the development of training specifically geared toward correctional officers, grounded in best practice, and in partnership with community-based experts.

identified as heterosexual, two as pansexual, and one as bisexual. Of the three men, two identified as white, one as Indigenous, and all identified as heterosexual.

All three queer women and two straight women experienced physical abuse in childhood. Four women disclosed intimate partner violence as adults; one had been incarcerated for physically assaulting her abuser. One woman, who identified as Black and Indigenous, witnessed frequent intimate partner violence as a child and was sexually abused by her father, her brother, and several other males throughout her childhood. Two women (one white, one Indigenous, both queer) also disclosed childhood sexual abuse and sexual assault as teens and adults.

Chantal, a white, bisexual woman in her early 40s who had been incarcerated three times over the past year and a half, talked about being retraumatized via interactions with both police and correctional officers. She disclosed repeated childhood sexual abuse, starting from the age of 10, sexual assault and rape throughout her teen years after being abandoned by her primary caregiver, and rape two years prior and two months prior to the interview. Chantal recalled having to “squat and cough” while naked in front of two male officers at a Halifax Regional Police station after being arrested, as well as being strip-searched upon intake at a provincial jail. “I’m a sexual assault victim,” Chantal emphasized, “and you have to get naked in front of a guard when you first go in. That is so demeaning and humiliating...” Chantal also disclosed that she had been branded with a hot metal object on her body by an abuser, which added to the humiliation. “I don’t want people seeing that, you know?”, she explained.

Will, a white man in his early 30s, likewise drew attention to the re-traumatizing practice of daily strip-searching of prisoners accessing methadone at Burnside. Will hadn’t been sexually abused but noted that many of his fellow methadone users had been, including abuse by staff at NS youth correctional facilities (Jerrett, 2025; Kimber, 2023; Petracek, 2023). Will described thinking that this was “the norm”, before he was transferred to another facility where prisoners weren’t forced to subject themselves to such intense and harmful scrutiny to access harm reduction medication. According to Will, the strip-searches were also carried out “lazily and unethically”, with the entire group of prisoners herded into the admission and discharge cells and ordered to strip. Will explained, “one person would walk down, look at everybody. You could see the people across from you... it was so normalized.” The practice eventually ceased, but not before causing incalculable harm to countless, vulnerable individuals with complex trauma.

Another man, Indigenous and in his late 40s, disclosed having been “molested” as a child and noted that he had a difficult time being incarcerated alongside men charged with child sexual offences. The prevalence of adverse childhood experiences alongside other histories of violence (including intimate partner violence) among incarcerated persons and the high potential for retraumatization via interactions with police and correctional officers underscores the importance of trauma-informed training, as well as screening for ACE and trauma-informed supports in jails (Baglivio & Epps, 2016, p. 1).

Recommendation 4

This report calls on the **Nova Scotia Department of Justice** to ensure that all peace officers – particularly police and correctional officers – receive trauma-informed training alongside training on addictions and mental health.

Recommendation 5

This report further calls on the **Nova Scotia Departments of Health and Justice** to incorporate adverse childhood experiences into the development of a trauma-informed screening tool for mental health and addictions upon intake into all provincial custodial settings, including residential school impacts, intergenerational trauma, child welfare involvement, family separation, and experiences of racism and discrimination.

Participants also emphasized the importance of access to peer support, in addition to mental health professionals. Maya, an Afro-Indigenous woman in her mid-40s, had only recently begun to process decades of sexual abuse and assault, beginning in childhood.

“Usually, people think of grief as losing a loved one, but to me, if I would have had help grieving the fact that I never really had a childhood... I think peer support, you know, just someone to listen to me about everything that I survived... a shoulder to cry on or person to just vent to... I’ve carried a lot on my own shoulders.”

Brandi, an Indigenous woman in her early 30s, had been in and out of jail over half a dozen times since she was a teenager. Brandi also had a history of childhood sexual abuse, and likewise spoke to the need for not only trained professionals, but, in her words, “people that have been through it, who needed the help back then, but recognize, ‘hey, I want to offer help now’.” The Government of Nova Scotia has likewise acknowledged the benefits of peer support, noting that such programs “can help remove or reduce stigma and discrimination as well as offer better support and outcomes for people living with mental illness” – alongside the commitment to expand existing peer support programs across the province (Nova Scotia, 2011, p. 13).

Recommendation 6

This report calls on the **Nova Scotia Departments of Health and Justice** and **Nova Scotia Correctional Services** to collaborate with existing peer support services and community-based organizations to provide in-custody peer support programs for mental health and addictions.

Theme II: Lack of Assessment, Treatment, Programming, Supports

Despite the prevalence of mental health issues and substance use among incarcerated people, and the interrelatedness of mental health, substance use, and involvement with the criminal

justice system, there is a glaring paucity of assessment, treatment, programming, and supports in Nova Scotian jails. Every participant was asked whether they had access to supports for mental health and addictions while in provincial custody. The most common response was simply: *no*. Kyle, a white man in his early 40s who had recently been released from Burnside, struggled with both substance use and mental health while incarcerated. When asked how he coped, given his attestation that he had no access to treatment, programming, or supports, Kyle stated, “I just slept.” Clara’s conclusion that, “They didn't care about my mental health, they didn't care about my addictions,” unfortunately summarizes most participant experiences.

These findings align with prior studies documenting inadequate treatment and support for incarcerated individuals with mental health issues and addictions, including a shortage of mental health professionals, inadequate screening and assessment processes, and insufficient programming and staff training (Lamb & Weinberger, 2001; Pessoa & Almeida, 2024; Weil, 2015). Some have further observed a “lack of awareness and understanding of the prevalence and severity of mental health conditions among inmates, further contributing to the insufficient attention and care they receive” which, combined with inadequate screening and assessment, leads to undiagnosed and/or untreated mental health issues (Pessoa & Almeida, 2024, p. 4).

Healthcare in Nova Scotia’s jails is provided by Nova Scotia Health – Correctional Health Services (NSH-CHS). According to their patient and family guide, the Correctional Health Services healthcare team includes registered nurses, licensed practical nurses, a family physician, a dentist, psychiatrists, paramedics, social workers, and registered nurses “specializing in mental health” (Correctional Health Services, 2023, p. 2). Notably, the health care team does not include any addictions experts, and has no mention of substance use assessment, treatment, or support aside from opioid agonist therapy and treatment for communicable diseases associated with substance use (Hepatitis C and HIV), which are listed as “special programs”. The guide also lists the mental health services which are purportedly available, including assessment, diagnosis, medication management, and individual therapy.

Lack of Screening & Assessment

Despite the prevalence of mental health issues among incarcerated people, and the stated availability of screening, assessment, and treatment in Nova Scotia adult correctional facilities, *not one participant recalled having a mental health assessment while in provincial custody.*

Several participants described their experiences of the intake process, which included a body cavity search, a basic physical assessment, and a medication review. According to Barb,

“Within the first 24 hours, you come through and you gotta go through your whole squat and cough, shower, go lock up. You tell them about medications, this, that, whatever, and if you're lucky, a nurse will come down that day.”

Will’s experience aligns with Barb’s. “They do a very quick medical assessment,” he noted, “but I wouldn’t really even call it that – you’re lucky if you get seen by an actual nurse. I think even the

guards do a lot of *those*.”⁸ In 2024, NSH-CHS reported that as of that spring, there were new hires to increase access to mental health resources in jails, including a clinical pharmacist and several healthcare social workers. According to NSH-CHS, this means that prisoners might be referred to a social worker or nurse from the “mental health team” instead of the psychiatrist. The efficacy of the new process and expanded team is unclear: even participants who had been in jail after spring 2024 didn’t recall having an assessment or access to mental health resources. Crucially, the expanded team does not appear to include anyone with addictions expertise.

When asked what would be most helpful for incarcerated substance users, Cat, a white, non-binary person in their late 20s, suggested integrating screening and assessment for substance use into the intake process. “Instead of being locked down for two days... within the first one or two days of you being in prison, there should be a survey, like that –”, Cat pointed to the demographic questionnaire used in this research study. “– that helps you, that asks you, ‘do you have addiction problems – this, that, and the other thing’?”

Recommendation 7

This report calls on the **Nova Scotia Departments of Health and Justice** (particularly, **Nova Scotia Health – Correctional Health Services, Mental Health and Addictions Services** (MHA), and **Nova Scotia Correctional Services**) to collaborate toward integrating the provincial mental health and addictions intake into the intake process for all individuals entering provincial custody –to be completed by a healthcare provider with mental health and addictions expertise.

Recommendation 8

This report calls on **Nova Scotia Health – Correctional Health Services** to add a minimum of one full-time position for a healthcare provider with addictions expertise to the mental health team, to assess and inform protocols and practices across all institutions on an ongoing basis.

The study findings suggest that a standardized mental health and addictions screening process with integrated MHA intakes could be life-changing for individuals, decreasing recidivism and associated costs. As the Nova Scotia Deaths in Custody Review Committee has recently observed, “the admissions and intake processes are critically important” (2026, 1). Several participants described cycling in and out of correctional facilities for years without a proper diagnosis or treatment for a severe mental health condition (e.g., schizophrenia, bipolar

⁸ The involvement of COs in health services has also been documented by ECPJS. COs at certain facilities were performing mouth checks on prisoners after they were administered medication to determine if they were attempting to divert, effectively granting them power over prisoners’ access to medication, given NSH-CHS’s punitive policy of tapering down / cutting people off medications due to suspected diversion (Beach et al., 2024). In 2024, NSH-CHS reported to ECPJS that this practice had ceased.

disorder). Barb, a white woman in her early 50s, observed that prisoners' mental and physical health issues were often dismissed by correctional and healthcare staff who assumed they were side effects of substance withdrawal. Barb struggled for years with symptoms of what was eventually diagnosed as a serious psychiatric disorder. In the meantime, she remembers correctional officers and medical staff telling her there was nothing wrong with her, that she was just coming down off drugs, that it was "all in [her] mind". "They don't notice it," she concluded. "They know it all, right? Or so they think. But if there's somebody sitting there telling you, 'This is what's happening with me, this is how I'm feeling', take it seriously."

Barb was first incarcerated in the early 1990s and then cycled in and out of prison for decades. She was finally assessed and diagnosed with bipolar disorder when she was federally incarcerated in the late 2000s. Years later, Barb was re-diagnosed with schizophrenia by a doctor in the community following a referral from the psychiatrist at Burnside. It took nearly twenty years of cycling in and out of correctional facilities before Barb received a proper diagnosis and was prescribed medication that helped her to manage her symptoms. At the time of the interview, Barb expressed feeling like she was finally getting her life "back on track".

Carrie, a white woman in her early 60s, likewise spent thirty years in and out of provincial custody, starting at age thirteen, with no mental health assessment or supports. She was finally diagnosed with bipolar disorder in federal custody. "I was like this all my life!", she emphasized. Now on stabilizing medication, Carrie has quit drinking, reunited with her son, and is building a relationship with her grandson. "I wouldn't stop [taking the medication] for the world", she was adamant, "I think I'd die if I tried to stop it. I wouldn't know what was happening to me."

Other participants emphasized the role of substance use treatment – including safe supply and opioid agonist therapy – toward community reintegration. Krystal, a white woman in her late 30s, was on safe supply and living in a supportive, transitional home at the time of the interview. Krystal had been in and out of Burnside about half a dozen times over a five-year period, each time because she of theft charges. "I was stealing to support my habit," she noted. "But now I'm on safe supply, so..." When asked if she thought being started on safe supply earlier might have prevented her from being incarcerated so many times, she responded, "probably".

Lack of Access to Timely Healthcare

When asked if she was able to put in a health care request to access mental health support, Barb laughed. "That's a joke, right?" she asked. "That's gotta be a fucking joke." She went on,

"The bulk of what I did was trying to get health care. You gotta fill out your request forms for everything. It's always a paper trail, right? Fine. I get it. To see a doctor, it could take weeks, sometimes months. Don't get me wrong, you could see the nurse... but to get into the actual doctor or the psychiatrist... you're looking at 3 to 6 months."

Access to timely and responsive healthcare is an issue for many if not most Nova Scotians, in part due to outdated infrastructure and a shortage of healthcare professionals across the province in recent years (Government of Nova Scotia, 2022). It is especially crucial to ensure adequate access to healthcare in Nova Scotia's jails within this context. As the World Health Organization emphasizes in the *Declaration on Prison Health as part of Public Health* (2003), incarcerated populations are disproportionately comprised of the poorest, and most marginalized and vulnerable members of society – including people who use drugs and have mental health issues. These individuals tend to have chronic, untreated, and often undiagnosed health conditions, including tuberculosis, sexually transmitted infections, HIV/AIDS, and mental disorders. Conditions of confinement – overcrowding, violence, inadequate nutrition, lack of light, fresh air and clean water – are also precursors of disease, leading to onset and/or exacerbation of physical and mental health issues. Finally, most incarcerated people return to the community, some cycling back and forth over the course of a lifetime, many already infected with or at high risk of disease *without effective treatment and follow-up*. This presents a risk of spreading communicable diseases both within and beyond correctional facilities. Simply put, the health of the broader community is in part dependent upon the health of prisoners.

Moreover, conditions that go untreated while incarcerated – and the exacerbation of issues otherwise easily resolved – manifest in increased “downstream” demands on the public health system (and associated costs to taxpayers). The link between poor health outcomes and recidivism represents another hidden cost of inadequate healthcare in custody: evidence suggests physical and mental health are significant determining factors for successful reintegration or re-incarceration (Link et al., 2019). Above all, we have a moral duty to ensure adequate care for persons in custody. As the College of Family Physicians of Canada has noted,

“Incarceration provides a public health opportunity and the ethical and legal imperatives to offer exemplary and accessible primary and preventive health care services. Additionally, it provides a forum to address the public health needs of an at-risk population” (2022, p. 1).

Nevertheless, the College has observed that the quality of healthcare in many prisons across Canada is “consistently below the standard that is available in the community, including for prevalent disorders such as substance use”, and that discharge planning is often poor or non-existent (2022, p. 1). This is certainly the case in Nova Scotia, with serious implications for the short- and long-term physical and mental wellbeing of individuals in custody (Beach et al., 2024). Cat, for example, recalled waiting several months to see a dentist, with a tooth that was “clearly rotting”. Cat also emphasized the impact of lengthy wait times on substance users. “If you *are* addicted to drugs,” they observed, “and you're not getting assessed properly, and they're not giving you to a doctor fast enough for you to be on a medication?”

This was a common experience for participants. Kyle suffered through opioid withdrawal while waiting to see a doctor on several occasions. While incarcerated during the COVID-19

pandemic, Kyle recalled being locked in his cell for three months solid, with only 20 minutes out per day. Like Barb, Kyle submitted many healthcare requests for addictions and mental health treatment, to no avail. Sometimes, he was put on a waitlist, but each time, he was released before being seen. “Takes too long to see a doctor”, he noted. When asked what he would do to improve incarceration, Kyle – like many participants – reiterated the importance of timely healthcare: “If you could see doctors a lot quicker in jail, it would help. Big time.”

Timely access to healthcare was also highlighted as a significant issue by ECPJS. According to the organization, prisoners commonly reported putting in numerous requests to see a doctor but never getting an appointment or receiving a response. ECPJS noted that, “as a result, individuals with significant and worsening conditions have been forced to wait lengthy periods of time without any update on when they will be granted access to a physician or psychiatrist. While awaiting medical attention, especially in lockdown circumstances, callers reported increasing feelings of hopelessness, depression and anxiety” (Beach et al., 2024).

Recommendation 9

This report calls on the **Nova Scotia Department of Health** and **Nova Scotia Health – Correctional Health Services** to significantly decrease the wait times for physicians including psychiatrists in custody. Relatedly, this report calls on **Nova Scotia Health – Correctional Health Services** to clarify the new triage process under the expanded mental health team, which includes the addition of healthcare social workers and Licenced Practical Nurses, and to articulate how the new process will operate to decrease wait times for persons in custody.

Recommendation 10

This report calls on **Nova Scotia Health – Correctional Health Services** to provide both receipts and responses to prisoners placing healthcare requests, and to implement unique tracking numbers for request and complaint forms to facilitate the documentation and timely resolution of needs and concerns.⁹

Questionable Prescription Practices

Integration of mental health and addiction intakes and acute care models would help ensure that people who use substances and have mental health issues receive proper assessment, treatment, and supports while incarcerated. Proper diagnoses and prescription medication – including psychopharmaceuticals and harm reduction medications, like Suboxone – are key to effective treatment. Participants’ experiences of arrest and incarceration while actively using,

⁹ Reiterating recommendation #17 in the ECPJS VC Annual Report 2022-2023 (Beach et al., 2024, p. 46).

and of ensuing withdrawal and deterioration of physical and mental wellbeing, underscores the importance of timely health interventions, including appropriate prescription medication, in jail. Conversely, many participants described being cut off medications they had been on for years, being prescribed multiple psychopharmaceuticals with negative side effects, and/or having harm reduction medication suddenly and drastically reduced.

Participants who saw the psychiatrist recalled perfunctory appointments, with no discussion or diagnosis of underlying mental health issues. According to Travis, the psychiatrist “sort of did things quick. He didn’t really listen a whole lot. He more or less just said, ‘This is what you’re on in the outside, I’m going to do this.’... They didn’t really look into things, you know?”

Psychopharmaceutical Medication

Long before receiving a proper diagnosis, Barb recalled being prescribed multiple psychopharmaceuticals. “There were six or seven different ones”, she noted.

“It took them that many years to figure it out in the system. And I just felt, and I still feel today, that they use inmates as guinea pigs. ‘Let’s try this one. Let’s try this one. Let’s try-’ – that’s not right. Instead of treating me like a guinea pig and giving me all these meds for bipolar when there’s not an ounce of bipolar in me, you’re misdiagnosing me and you’re fucking me up more. So that’s what happened there.”

Like Barb and Kyle, Brandi placed countless requests to see a doctor or psychiatrist. Brandi had complex mental health issues and had been heavily medicated since she was a child. While in Burnside, her prescription medications were switched without consultation. “They put me on medication that weren’t the ones that I was on, and they made me real suicidal, and I didn’t want to take them, but they made me take them”, she recalled. According to Brandi, a nurse informed her that she would be put on a list, and that someone would come and follow up with her. When no one did, Brandi asked the nurse who was administering medications. “They said there’s nothing that they can even do about it,” she sighed. “They deal with a lot of people in the run of a day... Not all so memorable, especially when all of us are suffering with the same thing, and it’s such a goddamn endless cycle.” Marie, an Indigenous woman in her early 40s with complex mental health issues, had been incarcerated over a dozen times in provincial and federal facilities both inside and outside of Nova Scotia, including a psychiatric hospital. Like Brandi, she was cut off her mental health medication while incarcerated in Burnside. “I tried to tell them I gotta take my medication,” she recalled, “but they wouldn’t give it to me.”

Several participants observed that it was common for people to be cut off their medication upon entering provincial custody. According to Chris, “it didn’t really matter what you were on... they didn’t really accommodate you. They’d usually just cut you off – especially if it’s like, a benzo.” Travis likewise explained, “they try to switch up people’s medication a lot, because... because some could be abused.” The potential for misuse/abuse of particular medications is a common

rationale underlying prescription practices in carceral settings. Importantly, however, some of the most prescribed drugs in Nova Scotian jails – notably Seroquel and Vyvanse – also have the potential for diversion and abuse (Rabiner, 2013; Tcheremissine, 2008; Vento et al., 2020), as well as negative long-term health impacts, including potential cardiovascular complications (Cortese et al., 2026; Pugliese et al., 2020; Westover & Halm, 2012; Zhang et al., 2024).

When asked about mental health supports in custody, Cat responded, “They gave me meds. If I asked for meds, they gave me meds.” Cat was prescribed Valium (diazepam), medication for Attention Deficit Hyperactive Disorder (likely lisdexamfetamine [Vyvanse], methylphenidate, or methamphetamine), and Seroquel (quetiapine fumarate, a second-generation antipsychotic). Valium and Seroquel are both central nervous system depressants; taken together, they can result in dizziness, drowsiness, and impaired cognitive function (Himmerich & Hamilton, 2020). Will was prescribed both Seroquel and Vyvanse – drugs commonly prescribed to participants. “It’s very weird”, Will observed, “a lot of people are on the same medications in Burnside”. He also noted that he was never diagnosed with a “severe mental illness”. Instead, Will – like many others – was prescribed Seroquel off-label (for non-indicated purposes) to help him sleep. “It knocks me right out”, he noted, “but how does that interact with your methadone and all kinds of other things?” Upon release, Will’s community physician took him off Seroquel due to the potential negative interaction with methadone (another a central nervous system depressant).

Nearly 40% of participants (8/21) recalled being prescribed Seroquel while incarcerated. Half, like Will, were given it to treat insomnia, while three did not remember being told why it was prescribed to them. Brandi was the only participant who recalled being prescribed Seroquel as a mood stabilizer to treat a major psychiatric disorder – as a replacement for her regular medication. Rather than helping with her symptoms, Brandi described several negative side effects, including weight gain, “profuse sweating”, and suicidality. “I was 260 pounds,” she recalled, “and suicidal as fuck... and I just felt sticky and clammy all the time.”

Other participants experienced similar side effects, as well as bloating, constipation, and extreme sedation. Barb remembers being on 1200 milligrams of Seroquel, well over the maximum recommended dose (750mg). “I was just like... a *zombie*”, she emphasized. Chris was prescribed Seroquel for sleep, but stopped taking it shortly after, due to a similar experience. “It turned me into a zombie”, he observed, “It was *disgusting*... It just dried your mouth out, it made you hungry, made you thirsty, made you restless – there were so many side effects. It was just horrible.” Chris further noted that “when you go to see the doctor, it doesn’t matter what you ask for, that’s what he gives you. Seroquel.” Although he wasn’t prescribed Seroquel himself, Brett similarly observed that “they don’t know how to treat mental health. At Burnside, there were a lot of people getting prescribed Seroquel, which is just comatosing people.”

Participants’ experiences and observations align with long-standing concerns regarding the overuse of psychotropic medication – particularly Seroquel – in Canadian jails (Beach, 2025; Convict, 2017; Kilty, 2012; The Correctional Investigator Canada, 2014). They also support a

trend observed by community health service providers consulted as stakeholders for this study: individuals released from jail with prescriptions for the same medications – including high doses of Seroquel – without accompanying psychiatric diagnoses, and with potential negative interactions. The overuse of Seroquel for non-indicated purposes (e.g., to treat insomnia, not schizophrenia) is especially alarming given the litany of adverse side effects.¹⁰ The extreme sedation experienced by prisoners on Seroquel is effectively psychotropic pacification, which resonates with stakeholders’ concerns that such drugs are being prescribed as a form of “chemical management”, and with broader critiques of medication as a pharmaceutical solution to problems of over-crowding, understaffing, and lack of meaningful activity and mental health support in various institutional settings, including prisons (Beach, 2025; Hatch, 2019), disability institutions (de Menil & Cohen, 2009), and foster homes (Gibson, 2023).

Stakeholders also emphasized that community healthcare providers have no way to access information regarding decisions made by in-custody prescribers, including why a medication was stopped or started, which significantly constrains their ability to advocate on behalf of their patients. There is also a lack of transparency regarding who decides which drugs are on the in-custody formulary, the method of administration, or guidelines for titration.¹¹ The *Nova Scotia Drugs and Therapeutics Committee* is mandated with making such decisions for prescribed medications in the community. Once the decisions have been approved by the Health Authority Medical Advisory Committee, they are published via biannual newsletters. None of the newsletters (dating back to 2016) reference prescribing practices in correctional facilities.¹²

Recommendation 11

This report calls on the **Nova Scotia Department of Health** and **Nova Scotia Health – Correctional Health Services**, in concert with the **Nova Scotia Drugs and Therapeutics Committee** to implement a policy to ensure in-custody prescribers abide by the World Health Organization guidelines for rational use of medicines (2002), including minimizing “poly-pharmacy”, limiting the off-label use of psychotropic medication, minimizing interruption of care via medication changes and/or prescription of drugs likely to be disrupted upon release (e.g., those not covered under Nova Scotia Pharmacare), and fully informing patients which drugs they are being prescribed and why.

Recommendation 12

This report calls on **Nova Scotia Health – Correctional Health Services** to provide a written justification for all in-custody prescriptions that do not follow established practice guidelines, to be documented in the patient’s Nova Scotia Health Record.

¹⁰ Side effects of Seroquel (quetiapine fumarate) are numerous and well documented, prompting concerns regarding the off-label use of quetiapine – specifically for the treatment of insomnia (Reeves, 2012). These concerns are not limited to use within prisons, but include psychiatric institutions (Pierre et al., 2004), nursing homes (Zarowitz, 2011), and the general public (Gugger & Cassagnol, 2008).

¹¹ ECPJS has previously raised concerns regarding administration of medications (Beach et al., 2024, p. 46).

¹² <https://physicians.nshealth.ca/resources/drugs-and-therapeutics-newsletters-archive>

Recommendation 13

This report further calls on **Nova Scotia Health – Correctional Health Services** in concert with the **Nova Scotia Drugs and Therapeutics Committee** to develop a Sub-Committee specifically oriented toward ensuring best practice vis-à-vis prescription medications in provincial custodial facilities (including but not limited to correctional facilities, forensic hospitals, and long-term care homes), and to ensure that the Committee is comprised of both pharmacists and healthcare providers/prescribers with expertise in mental health and addictions.

Harm Reduction Medication

Most participants (14/21, 67%) described undergoing “cold-turkey” withdrawal while incarcerated – essentially coming off of drugs with no support, treatment, or medication aside from over-the-counter painkillers. For many, this process was agonizing. Marie recalled withdrawing from alcohol while incarcerated at Burnside. “I was shaking”, she remembered, “Couldn’t eat for three days. I was sick. I couldn’t even touch my plate – just the juice.” Clara had been using opiates when she was arrested and incarcerated. Instead of a hot cloth, she would take one of her socks and dip it in the toilet water. She explained,

“It was terrible. I didn't want to go through withdrawal, right? If I were to quit, I would have done it differently. I wouldn't have made myself suffer, right? And I wouldn't have locked myself in a room for 20 hours, and pooped and peed in front of other people... And especially when you have a little bit of mental health issues... I was getting depressed.”

Clara didn’t initially disclose that had been actively using opiates, but eventually told the COs when the effects of withdrawal progressed to vomiting and sweating. According to Clara, the CO told her there was nothing they could do because she didn’t have an active prescription for opioid agonist therapy (e.g., Methadone, Suboxone), and simply said “sucks to be you”. Three other participants likewise described trying to get a prescription for Suboxone, to no avail. Barb was never on OAT herself, but witnessed others who had been on methadone in the community but hadn’t picked up their prescription for several days prior to being in provincial custody and so were not considered to have an “active” script. “So, their methadone gets cut,” she noted, “and now they’re suffering, and they’re literally in there shitting themselves, because they can’t control their bodily functions. It’s horrible the way inmates get treated over there.”

Access to harm reduction within Nova Scotia prisons is inadequate, despite some positive developments in the wake of Howard Hyde’s tragic death in 2010 (Bodkin et al., 2020; Nova Scotia, 2011; Wildeman et al., 2023). The current policy for Opioid Agonist Therapy (OAT) mandates that individuals without an active prescription for OAT in the community when they enter the prison cannot be started on OAT within the prison. Due to this policy, substance users who are incarcerated without an active prescription have an increased risk of overdose, sepsis, and/or contracting communicable diseases such as hepatitis and HIV. For these reasons, the

College of Family Physicians of Canada recommends initiation and maintenance of OAT for all incarcerated persons who meet the criteria – “without delay” (2019, p. 2).

In contrast to established guidelines for best practice, even participants who had been on Suboxone or Methadone in the community described going through withdrawal, either due to having their doses drastically reduced, or waiting to have their prescription filled. According to Will, prisoners sometimes have to wait several days to get their first dose, due to how long it takes to see a healthcare practitioner. “That’s a loooooong time,” he emphasized, “especially if you’re on the street using other things, oh my god, it’s *horrible*.” Sebastien, a white man in his early 40s, described undergoing opioid withdrawal in Burnside while waiting to see a medical practitioner. He noted that he had been a daily intravenous substance user when he was arrested and incarcerated. Sebastien believed that the police had waited to arrest him until Friday, knowing that he would be in withdrawal over the weekend. Chris had been on 140mg of Methadone one of the many times he was arrested and incarcerated at Burnside. Instead of picking it up from the pharmacy every day, Chris had been picking it up every other day. When he got to Burnside, he was told that because he hadn’t been taking the medication as prescribed, he was going to be cut off. “I was on 140,” he remembered, “and they cut me down to 50, and the next day was 40, then 30, then 20, 10, *zip*. And that’s *very, very dangerous*.”

In 2024, after years of advocacy efforts by civil society organizations around the policy to not initiate OAT in custody, NSH-CHS reported that the standard operating procedure would be updated “in the near future”, allowing initiation and increasing access for incarcerated substance users (Beach et al., 2024, p. 47).¹³ The findings of this research study, alongside ongoing consultation with community stakeholders, suggests that this has yet to be implemented across NSCS facilities. Stakeholders have also expressed concern regarding the increased use of extended-release buprenorphine (Sublocade), mirroring the shift in federal prisons toward Sublocade as the first-line OAT option and the removal of buprenorphine/naloxone (Suboxone) from the open-formulary. As noted by the HIV Legal Network (2025), this change is not supported by available clinical evidence, nor substantiated by scientific evidence. Conversely, incarcerated persons have reported “painful injections, inadequate preparation or monitoring, large injection-site masses, severe allergic reactions, and trauma or fear related to injection”, alongside experiences of withdrawal / return of cravings after transitioning from Suboxone to Sublocade (HIV Legal Network, 2025). These reports align with Chris’ experience of being put on Sublocade in place of Suboxone: over a year later, his lower stomach still had a large mass from a poorly administered dose.

¹³ ECPJS advocacy efforts included individual advocacy letters, annual reports, meetings with NSH-CHS representatives, and an EPJCS-assisted human rights complaint filed in 2023.

Recommendation 14

This report calls on **Nova Scotia Health – Correctional Health Services** to immediately abolish the policy restricting the prescription of Opioid Agonist Therapy (OAT) to prisoners with substance use disorders, enabling prisoners to be started on OAT while incarcerated.¹⁴ This report further calls on **Nova Scotia Health – Correctional Health Services** to streamline access to OAT – including both Suboxone and Sublocade – via the integration of the NS Mental Health and Addictions intake into the intake process for all persons entering provincial custody.

Recommendation 15

This report also calls on **Nova Scotia Health – Correctional Health Services** to further introduce related trauma-informed harm reduction policies that are responsive to the needs of incarcerated substance users.¹⁵

Programming

The findings of this research study suggest that access to substance use programming in Nova Scotian jails is extremely limited as well as gendered. Of the twenty-one people who were interviewed, only two participants, both women, recalled being offered programming. Krystal, who had been recently incarcerated, took a program called “Substance Abuse Management” during one of the half dozen times she was incarcerated at Burnside. More vividly, however, she recalled undergoing opiate withdrawal on several occasions, in so much agony she thought she was going to die, until she was able to buy drugs from another prisoner. Barb also remembered taking a course, facilitated by correctional officers, but didn’t find it helpful. She explained,

“Once or twice a week, you’d go into the program room and she's *out of a book* and she's trying to tell ya... that don't work for me. Bring a professional in! You’re sending these officers out on these courses for a week or two, and then you’ve got them coming back, and they’re going step by step [through the book], ‘da da da, da da da’... it just didn’t make sense to me.”

Barb also noted that Narcotics Anonymous (NA) held a meeting about once a month – but it was often canceled. Tiffany, a Black woman in her late 50s who had been incarcerated about a dozen times in provincial facilities both inside and outside of Nova Scotia, also remembered attending NA meetings while at Burnside, but didn’t find them very helpful, stating, “I do my own 12 steps.” The two things that Tiffany found helpful were the social worker, who provided some mental health support, and the few times she attended an Indigenous Sweat Lodge Ceremony.

Male participants had even less access to programming and supports in provincial custody. Will noted that out of all the times he was incarcerated at Burnside, he was offered one program –

¹⁴ Reiterating recommendation #13 in the ECPJS VC Annual Report 2022-2023 (Beach et al., 2024, p. 44).

¹⁵ Reiterating recommendation #13 in the ECPJS VC Annual Report 2022-2023 (Beach et al., 2024, p. 44).

but he it was canceled for some reason. He also noted that if there had been a program, it would have been facilitated by correctional officers. “You’d think you’d have professional counselors or therapists doing those courses, that aren’t connected to the jail at all”, he observed, “that *can’t* write you up or give you a level [a disciplinary charge]. That have no access to your file, and don’t know why you’re in there. It’s crazy to me that that’s how it’s handled.” When asked if he had access to any other forms of substance use support, Will’s response was immediate: “*never*”. Travis likewise responded, “No, no, other than talking to another inmate, definitely not. Definitely not.” When asked if there had ever been an Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meeting he could go to, Travis simply laughed and shook his head.

Concerns regarding COs delivering programming were articulated in a 2006 review of substance use programming in Nova Scotian jails. The study found that the provision of programming across facilities was sparse and inconsistent, and that having COs deliver programming “can have a negative impact on inmate trust, motivation, and interest” (Kitchin, 2006).

Recommendation 16

This report calls on the **Nova Scotia Department of Justice** and **Nova Scotia Correctional Services** to waive the fee for criminal record checks for AA and NA volunteers to better facilitate access to meetings in prison.

Recommendation 17

This report calls on the **Nova Scotia Department of Justice** and **Nova Scotia Correctional Services** to provide alternatives to abstinence-based addictions support in provincial jails via formal partnerships with community-based harm reduction organizations, agencies, and initiatives, including the North End Community Health Center, and Direction 180.

Recommendation 18

This report further calls on the **Nova Scotia Department of Justice** and **Nova Scotia Correctional Services** to ensure that all programming designed to address mental health and addictions is offered by trained mental health and addictions experts, not Correctional Officers.

Recommendation 19

This report also calls on the **Nova Scotia Health – Correctional Health Services**, in partnership with **Nova Scotia Correctional Services**, to dedicate resources to facilitating access to sacred medicines, providing culturally relevant mental health supports, and funding an Indigenous Community Health Liaison, embedded in an Indigenous-led health governance body, to assist with needs assessments upon entry and release.¹⁶

This report further calls on **NSCS** to establish minimum service standards guaranteeing timely access to Elders, Knowledge Keepers, Cultural Advisors, and Ceremony.

¹⁶ Reiterating ECPJS VC Annual Report recommendations #33 and #35 (Beach et al., 2024, p. 57).

Community Supports

Participants described various harm reduction services they accessed in community, including ReFix (Atlantic Canada’s first overdose prevention site), Direction 180 (a non-profit, community-based opioid treatment program run by the Mi’kmaw Native Friendship Center), and the NECHC’s Safer Supply program. Several participants described these services as “lifesaving”. Some described accessing supports via the Navigator Street Outreach Programs (initiated by business associations/commissions in Halifax’s downtown core, North End, and Dartmouth and funded by Halifax Regional Municipality), which help facilitate access to food, shelter, medication, identification, and mental health and addictions services for houseless individuals. Participants also noted accessing support via shelter staff, including the Salvation Army. According to Chris, “There’s *lots* of outreach programs. There’s a *ton* of them everywhere.”

Overall, participants had significantly better access to harm reduction and mental health services in community, but these services were almost always disrupted upon incarceration. It is also important to note that depending on how long an individual is incarcerated, they may need to begin the intake process all over again upon release. The findings of this research study further evidence that continuity of care is a major issue for individuals who are in conflict with the criminal justice system (Haas et al., 2022; Hu et al., 2020; MacKenzie & Amirault, 2021; Priebe et al., 2008). This issue is further explored under theme IV (community re-integration).

This study found two exceptions to the overall pattern of disruption / severing of supportive connections with community organizations and service providers: Elizabeth Fry Society of Mainland Nova Scotia (EFry) and Caitlan’s Place, a supportive housing facility for women and gender-diverse people recently released from a correctional facility or otherwise involved with the criminal justice system run by the Coverdale Justice Society. Both Caitlan’s Place and EFry have established agreements with NSCS to provide in-reach support to clients. *Notably, both organizations only serve women or gender diverse people, which means their services are unavailable to over 90% of provincially incarcerated people.*

The John Howard Society of Nova Scotia supports justice-involved men in community, providing bail verification and supervision, facilitating employment, and delivering programming, although none of the participants of this study recalled accessing any of these services. There are two in-reach programs listed on the JHSNS website: *Nova Ramp Up!*, an initiative funded by the Government of Nova Scotia that aimed at improving accessibility of small businesses through the provision of wooden ramps. The program employed three incarcerated men during fall 2022.¹⁷ The other in-reach program is listed as supporting “restorative approaches” at the “NOVA Center for Women” (Nova Institution is a federal correctional facility).

¹⁷ Low engagement with incarcerated individuals is not listed as one of the limitations in the program’s final report.

Recommendation 20

This report calls on the **Nova Scotia Correctional Services** to establish formal partnerships with community organizations and service providers (e.g., MOSH, Direction 180, Mi'kmaw Native Friendship Center, Mi'kmaw Legal Support Network, African Nova Scotian Justice Institute, 902 Man Up, John Howard Society of Nova Scotia) to facilitate in-reach, *particularly geared toward supporting incarcerated men*.

This report further calls on the **Government of Nova Scotia** to allocate financial resources toward in-reach programming and supports, to bolster the capacity of community-based organizations and service providers to meet the needs of incarcerated Nova Scotians.

Recommendation 21

This report calls on the **John Howard Society of Nova Scotia** to prioritize in-reach programming and supports in provincial jails and to ensure that in-reach is accessible to all incarcerated men.

Theme III: Incarceration as Debilitation not Rehabilitation

Despite Nova Scotia Department of Justice's (DOJ) stated commitment to rehabilitating offenders, the findings of this study suggest that incarceration is, by and large, *debilitating*. Likewise, studies on the prevalence of disabilities in prisons have not only documented the disproportionate representation of disabled people in carceral institutions, they have also found that carceral environments are themselves disabling. Bixby et al., for example, concluded that,

“In addition to the high risks of incarceration experienced by disabled people, being incarcerated can increase disablement and exacerbate existing disability. The physical and social environments of prisons and jails, characterized by high levels of stress and violence, are disabling” (2022, p. 1467).

In addition to physical disabilities, Canada's *Human Rights Act* recognizes substance dependence and mental disorders (including anxiety, depression, and schizophrenia) as disabilities. Given the prevalence of substance dependence and mental health issues among incarcerated Nova Scotians, it is safe to assume that Nova Scotians in provincial custody are also disproportionately disabled.¹⁸ Furthermore, the exacerbation/onset of mental health issues and substance use, alongside the exacerbation/onset of physical health issues due to conditions of confinement can be understood as a form of disablement, and the failure to provide adequate assessment, treatment, and supports for mental health and addictions can

¹⁸ A 2005 study on substance use among provincially incarcerated adults in NS found that 77% were “challenged by substance use”, 85.5% reported that substance use was related to their criminal activity, and 92% expressed a desire for substance use education, programming, and/or treatment while incarcerated (Kitchin, 2005, 2006).

be understood as failure to accommodate a disability.¹⁹ In addition to disabling conditions of confinement, participants cited numerous negative impacts of incarceration on their lives and life trajectories – from employment and employability to relationships with their children.

Recommendation 22

This report calls on the **Nova Scotia Human Rights Commission** to investigate the failure to accommodate disabled Nova Scotians in provincial custody, particularly the failure to provide adequate treatment and support for people with mental disorders and substance dependence.

The overall lack of meaningful activity and overreliance on institutional lockdown detailed above illuminates a disconcerting gap between the purported mandate of Nova Scotia’s correctional facilities and the reality of incarceration. According to the DOJ, the “core business” of Nova Scotian jails is to, “provide safe and secure custody, direction and control of individuals in custody, and, to provide programs that address dynamic criminogenic factors to assist with the successful, reintegration of individuals into the community” (2021a). Conversely, many participants did not feel safe or secure while in custody, many noted that their interactions with correctional staff were limited, sporadic, and largely negative, and most did not recall having any access to programming whatsoever. As will be explored in the final theme, rather than feeling prepared to reintegrate into the community, participants described feeling like they were being “set up to fail” or “thrown to the wolves” upon being released from jail. Participants also, on the whole, did not receive any support from correctional staff toward planning for community re-entry, which meant that most were released without safe and secure housing.

Lack of meaningful activity

The commitment to provide programming geared toward supporting reintegration through addressing “criminogenic factors” is affirmed under provincial correctional policy (31.00.00). The policy lists ten factors, including substance use, mental health, education/ employment, and life skills. As noted above, only two out of twenty-one participants recalled taking a substance use program, and none recalled being offered programming related to mental health. Similarly, only two participants – both women – recalled being offered any other programming. Meghan, an Indigenous woman in her early 40s who was incarcerated once, in Burnside’s East Unit, vaguely remembered a program offered by the Elizabeth Fry Society but couldn’t recall any details. Barb remembered a program that involved training dogs that was available to a few women in one wing of the East Unit in Burnside, possibly over a decade ago. “We’d get up every morning and we’d go down to where they kept the dogs”, she remembered, “and we’d take the dogs out, and we’d clean out the cages, and then we’d take them outside and stuff. And a lot of

¹⁹ The failure to provide programming, treatment, and supports for substance use in particular was well-documented and made aware to correctional authorities over 20 years ago (Kitchin, 2005, 2006).

times we'd bring all the dogs down to the unit with us, keep them down there with us for the day and stuff. It was pretty good. It was kind of awesome.” Unfortunately, Barb noted that nowadays, “There’s not enough going on there. I don’t feel Burnside has nothing to offer anybody.”

Many participants emphasized not only a lack of programming, but a lack of meaningful activity whatsoever. Brandi provided a particularly vivid description of her life in jail:

“Getting people into a routine would be nice, and I know they say ‘Oh, you're incarcerated. You're in a routine.’ *No, you're not.* You're in your head, or staring at a wall, or reading a book you've read four times, or drunk as fucking shit, or silently overdosing in your goddamn cell on fentanyl because they give you carfentanyl instead, and nobody's there to help you, because you're afraid to get help.”

Carrie similarly observed that,

“They put you in Burnside and you don’t do anything. There’s no programs. You fight... And you eat canteen, and you get fat. That's it.”

Most participants felt that incarceration wasn’t rehabilitative. Many drew a correlation between the lack of meaningful activity and recidivism, noting that conditions of confinement perpetuate rather than disrupt the cycle of incarceration. Chantal, for example, was adamant that, “if you’re going to incarcerate people, have a fucking program so when they get out – especially the men... do something to integrate them into society so that they don’t reoffend, you know?”

All participants who had been in federal custody noted that their experiences in provincial jail were comparatively far worse, particularly with regards to meaningful activity and programming. Some believed that if they’d had access to the types of programs that were available in federal prison – including substance abuse programming as well as anger management and programming geared toward life skills and employment – when they were first incarcerated provincially, they could have avoided cycling in and out of jail. Carrie, who was first incarcerated as a young teen and spent most of her life in and out of provincial custody, reflected,

“Do you know what, truthfully? If I would’ve went to Nova way back in the day, I wouldn't have been in and out of jail because they had good programs there. Even if they had good programs in *Burnside*, I wouldn't have gone back to jail.”

When later asked what would be helpful for people in Burnside, Carrie responded immediately.

“Programs. And to do things in the day, like go to the gym, like they used to. Go to the gym... Work in the laundry room, work in the kitchen. But *get paid*. Things like that, things to do. Programming needs to be put in there. *Programming.*”

Recommendation 23

This report calls on **Nova Scotia Correctional Services** to adhere to their own policy (31.00.00) and stated purpose to “provide programs to assist with the successful, reintegration of these individuals into the community” (Nova Scotia Department of Justice, 2021a). This report further calls on **NSCS** to publish the statistics they collect on programming (including number of programs offered, requests and enrolment rates) as per policy 31.00.00.

Recommendation 24

This report calls on the **Nova Scotia Office of the Ombuds** to investigate the lack of programming available to incarcerated Nova Scotians – *particularly in male-designated units* – as a contravention of Correctional Services Policy 31.00.00, and a failure to adhere to the overarching mandate of Nova Scotia Correctional Services.

There is growing evidence of the beneficial role of Occupational Therapists in custodial settings toward the physical and mental wellbeing of individuals in custody, supporting the development of life skills, and preparing incarcerated persons for successful community re-entry and reintegration (Colibaba et al., 2023; Craswell et al., 2021; Dieleman, 2014; Jaegers et al., 2020).

Recommendation 25

This report calls on **Nova Scotia Correctional Services** to integrate occupational therapy into rehabilitative programming by employing one full-time occupational therapist per institution.

Institutionalization

Participants also described the debilitating effects of becoming accustomed to conditions of confinement (particularly under lockdown), a phenomenon commonly referred to as “institutionalization”, which Crane and Pascoe define as a “chronic and often disabling state resulting from prolonged incarceration” (Crane & Pascoe, 2021, p. 307; see also Crane, 2019). This study found a correlation between institutionalization and difficulty with community reintegration. Travis, for example, was under lockdown right before being released. When his sister picked him up from the facility, she wanted to take him to the mall to buy him new clothes. Travis left the mall almost immediately to go wait in the car. “I just couldn’t do it.”, he recalled, “Too many people, you know? And you’ve got that... jail mindset still, you know?” Even six months after he was last incarcerated, Travis continued to struggle with social anxiety. “I sort of stick to myself now, for sure.” He observed, “And I’m not sure if it’s that I stick to myself because I was on lockdown so long that my mind’s just like, ‘*stay alone*.’”

Clara likewise recalled “adapting” to life in custody, being told what to do and when, including the limited amount of time she was allowed to be out of her cell. She noted that other people were even more impacted than she was,

“Some people, like my friend – she was there for two years. When she got out of jail five years ago, she stayed with me, and she slept on the floor because she was so used to sleeping on the floor in jail. It took her about seven, eight months to adjust to a bed. So, that's it. You're adjusting to life on the outside.”

Impact on life & livelihood

Rather than facilitating “successful reintegration of individuals into the community”, participants depicted incarceration as a profound disruption of their lives and livelihoods, straining social networks and personal relationships, and contributing to housing precarity and health issues. Reflecting on three and a half decades cycling in and out of correctional facilities, and the impact on his overall wellbeing, Chris concluded, “It's definitely negative. It's just, I can't even... I really can't even explain, it just- it's all negative. Like, *nothing* good has come of it.”

Several participants described the impact of incarceration on personal relationships, notably children. Barb recalled really struggling the first time she was incarcerated. She had recently given birth and had a toddler. “First and foremost,” she stressed, “it was traumatic for me being away from my kids.” Clara also felt the strain on her relationship with her children. She recalled receiving a letter from her 9-year-old son, one month after it had been sent. The institution held it onto it until a few days before Clara was released, claiming that it had traces of drugs on it.

Will described the impact his father’s own incarceration had on him as a child,

“He sold dope his whole life. Didn’t sell coke [cocaine] or anything like that, but sold weed, so back then, he was a criminal, and I wasn’t allowed to go see him [in jail], and it just *messed me up*. I never had that relationship with him, and I still don’t. So that just really... I *know* that’s a root of why I use [substances].”

Krystal noted that the thing she struggled with the most while incarcerated was the loss of social connection. “Everybody forgets on the outside,” she lamented. “They forget about you, while you’re in there. Most people do. You find out who your true friends are when you go to jail.”

Sebastien had spent his whole life in a small fishing community, until he was incarcerated in a federal penitentiary. He had a job, a house, and a family waiting for him back home, but his parole officer insisted he remain in the Halifax Regional Municipality after being released from the halfway house. “There's no fishing here in the middle of the city,” he stressed. “I've been fisherman all my life!” Far from home, unaccustomed to living in a city, with no social network, Sebastien struggled with the intensity of his surrounding environment. “I couldn't even walk 100

feet from the house the first two weeks,” he recalled, “there's just too much people, too much noise, too much... building, building, building.” Without viable housing or employment, Sebastien ended up in the shelter system, where he relapsed and started using substances. “I would’ve been home with my family and still a functioning member society,” he observed. “I don't feel like being a functioning member of anything right now because of this.” Sebastien ended up in provincial jail after breaching his parole conditions by failing to appear at court.

Many participants described the negative impacts of incarceration on housing, employment, and employability, which they linked to increased substance use. Clara was a healthcare professional for over a decade before being incarcerated for a crime she claimed she didn’t commit. When Clara was arrested, her car was towed and impounded. By the time she was released, she owed thousands of dollars to the impound lot, which she was unable to afford. The charges against her were dropped (which supports Clara’s claim to innocence), but the damage had already been done: Clara had lost her job, and her reputation had been tarnished via media coverage of the crime. She was released suddenly, with no housing, employment, or transportation, and few material possessions. A social worker found her a bed at a shelter, but the first night there, somebody was stabbed, so Clara left and started living in an encampment behind a fast-food restaurant. She began using intravenous drugs to escape from the reality of living in an encampment, and everything incarceration had cost her. Clara explained,

“You know, you lose everything, for somebody else's crime, and then you do a little bit of time, and your whole life is fucked... Over ten years of working in healthcare went to... as if I had been a criminal for twenty years. It completely destroyed my career. I came out, and I’m living on a cot. With nothing. I lost *everything*.”

Cat similarly recalled the experience of losing everything due to incarceration, which, in their case, occurred on multiple occasions. “I had to start over so many times,” they remembered,

“I didn't even have my own bed. When I first moved into my own place, I had my own bed, dressers and stuff, and I had to leave it all behind...”

Theme IV: Community Reintegration – Supported or Set Up to Fail?

The negative impacts on participants’ lives and livelihoods – including estrangement, institutionalization, and loss of employment, transportation, home, ID, and material possessions – all pose significant barriers to community reintegration. On the whole, participants felt ill-prepared to re-enter the community, as if successful reintegration was foreclosed before they were even released – in other words, as if they had been “set up to fail”. In addition to the lack of access to safe, secure, and affordable housing – which was consistently identified as the biggest barrier to reintegration – participants also reported a disconcerting lack

of support and resources toward planning for their release, which significantly hindered their ability to successfully reintegrate, thus contributing toward recidivism and re-incarceration.

Importance of Safe, Secure, and Affordable Housing

Like Cat, Travis reflected on how stressful it was to be released to the community from jail with nothing. He observed this was a common experience, especially for substance users.

“A lot of people that get out, they have nobody, they have nothing... they were in a shelter or at a friend's place before they went to jail, so all their stuff's gone. They don't have a phone, they don't have ID or nothing... And I still see it – I know people who are constantly in and out, same thing, they're on drugs, have nothing when they go in and they get out clean but have nothing, so they're stuck going back to the same shelter, so they just get caught in the same cycle.”

Carrie made a similar observation. When asked what would be most helpful for people being released from jail, she responded immediately,

“A place to live. There's a lot of people that come out of jail, and they got no place to go. So, they're gonna go tour around, and they're gonna do crime to get money, for drugs, because they can't sleep on the street. Right back in the same routine.”

The use of substances to cope with precarious, unstable, and unsafe housing underscores the importance of safe, secure, affordable housing. Likewise, as the Government of Nova Scotia observed, following the inquiry into the death of Howard Hyde, “people living with mental illness can only successfully transition back into the community if they have a safe place to stay” (Nova Scotia, 2011, p. 6). Unfortunately, the province of Nova Scotia is currently experiencing an unprecedented housing shortage, with a notable lack of affordable options. The median price of a home in Nova Scotia increased by 63% from 2019 to 2022 while median rental prices increased by 24% over the same period – nearly double the increase over the previous three years and the average rent for a unit under new tenancy between 2021 and 2022 increased by 28% (Nova Scotia's Provincial Housing Needs Assessment Report, 2023, p. 2). Data from the 2024 Canadian Social Survey from Statistics Canada revealed that more than 65% of Nova Scotians reported facing one or more housing challenges in the past year (Seguin, 2025).

The study findings reflect this reality: housing insecurity was consistently identified by participants as the most significant barrier to community reintegration, followed by loss of material possessions and identification, financial issues, being released far from home, and employment/employability. These barriers highlight the integral role of proactive release planning and supports toward successful community reintegration. It is deeply disconcerting, then, that few participants recalled any assistance toward release planning while incarcerated.

Recommendation 26

This report calls on **Premier Tim Houston** and the **Government of Nova Scotia** to improve housing affordability across the province through instituting rent control measures, including the immediate closure of the fixed-term lease loophole.

Several study participants noted that rather than sudden release from the facility, they would have benefited from transitional housing, akin to the federal Community-Based Residential Facilities (aka halfway houses), which provide wrap-around support and life skills programming.

Recommendation 27

This report calls on the **Government of Nova Scotia** and the **NS Department of Justice** to launch a pilot project providing transitional housing for individuals being released from provincial custody, in partnership with community-based organizations and service providers.

Lack of release planning & support

In addition to the commitment to provide programming geared toward assisting successful reintegration, the NS DOJ *Correctional Officer Training Standards* emphasize the importance of case management. According to the *Standards*, a CO should be able to: “define case management and the role the Correctional Officer has in case management”, “identify key components of an effective rehabilitation program”, and “describe the process of administering an offender from admission to release” (Nova Scotia Department of Justice, 2021c). Within Nova Scotian jails, release planning falls under the purview of “Case Management Workers” (CMWs), though social workers are also listed in the *Offender Handbook* as a conduit for connection to community resources (Nova Scotia Department of Justice, 2024, pp. 14–15). Notably, CMWs are also Correctional Officers, who may not have a background in social work. According to the *Handbook*, prisoners can submit a request to meet with a CMW or a social worker. The study findings, however, suggest that this is not a well-known or well-accessed resource: *none of the 21 participants recalled being assisted by a CMW in planning their release, and many did not even know that they existed*. More commonly, participants described being released with no plan in place, no safe and secure housing, and often no transportation.

When asked if she had a CMW, or someone who helped her with a release plan, or to secure shelter before she was released, Marie responded, “No. I just got out and... that was it. I can’t even remember how I did it... I just got out and I think somebody picked me up?” Unlike Marie, many participants didn’t have anyone to pick them up, or anywhere to go. Cat recalled living on the street for the first time in their life after being released from jail. “After I was locked up, I said, ‘I have nowhere to go’”, they remembered, “but they didn’t release me with anywhere to go.” The next time they were charged, Cat advocated for herself during sentencing and was able to

secure a bed in a supportive housing facility, which made it “a lot easier” for them to navigate re-entering the community. “I complained last time, pretty bad,” Cat emphasized, “You can’t just let someone out – it’s hard enough for you to get out of prison and have nothing. Imagine getting out of prison, not having a paycheck, not just being able to pick up where you left off.”

Will made a similar observation about the difficulties of community reintegration in the absence of a release plan and accompanying resources and supports,

“That’s SO overwhelming. You literally just go do something to go back inside, because it’s overwhelming, to be honest with you. You gotta pay bills. You gotta go look for a place. Those things are *very* tough for people. They’re tough for *normal* people- not to say that people inside aren’t normal- but they’re tough for people that *don’t* have criminal records, let alone people who use drugs and have mental health issues and criminal records. Like those things are just... *overwhelming*.”

Like Cat, and Clara, and several other participants, Kyle ended up living on the street after being released from provincial custody. When asked if a Case Management Worker, or some form of support for release planning would have been helpful, Kyle replied,

“That would have been very helpful. You know, you get released and you don’t know where you’re going, you don’t have somewhere to go, you don’t have a place, you don’t have *nothing* - just wandering around. A guy I was in with I’ve seen him get out twice and each time, he’s sitting in the city, waiting for a bus, not knowing where he’s going, where he’s going to live... It’s stupid. ‘Goodbye! Good luck!’ Some [facilities] will buy you a ticket to get back home... But there’s nothing in the city.”

Will also noted a difference in resources for release across different institutions:

“In Pictou [Northwest Nova Scotia Correctional Facility], they gave you a cab to the bus, bus tickets. They gave me meds for the week. It was unreal! It was crazy. Burnside, you’re lucky to get a bus ticket.”

Many participants expressed frustration at what they felt was a missed opportunity for the facility to help toward successful reintegration. Echoing a common refrain, Chris observed that,

“Provincial jails are basically just... sit back and do your time. There’s *nothing* going on. And it really sucks because there’s a lot of things that they could do to help some individuals get on the right track or help them with their release, make a pre-release plan, whatever. It’s just, yeah... it’s hard.”

Recommendation 28

This report calls on **Nova Scotia Correctional Services** to adopt the case management process for youth in custody (as outlined in Correctional Policy 34.02.00) in all adult facilities, thereby

ensuring that all adults in custody who are remanded or sentenced to 30 days or more are assigned a Case Management Worker within two business days of admission, to assist with the development and facilitation of a plan for reintegration and release. This report further calls on **NSCS** to ensure that all Case Management Workers have a degree in social work / occupational therapy or equivalent experience and familiarity with regional supports and resources.

Coordination of Health Care & Supports

The lack of transparency around prescription practices described in the second theme not only constrains the efforts of community healthcare providers to advocate on behalf of incarcerated patients, it is also a barrier to continuity of care. In addition to individuals released from jail without prescriptions – or diagnoses – for the drugs they were prescribed inside, stakeholders noted that many drugs prescribed in jails aren't covered under Pharmacare (the provincial formulary). Some medications, like Vyvanse – reported by participants as one of the most prescribed medications in jail – requires special authorization to be covered under Pharmacare. Thus, many individuals are “left in the lurch” without coverage for medications they are now accustomed to taking. Stakeholders emphasized that it is irresponsible to start someone on medication they can't feasibly continue in community, demonstrating a lack of “prescribing stewardship” by healthcare providers starting individuals on these drugs. Stakeholders further noted that these are potentially life-saving or stabilizing medications, which means they could play a crucial role in breaking the cycle of incarceration (as was the case with Barb and Carrie).

Without any information regarding the diagnosis/justification for prescriptions, community healthcare providers struggle to determine an appropriate substitute. Stakeholders noted that it is hard to tell what the underlying issue is based solely on the doses prescribed. For example, they have observed many individuals released on very high doses of Seroquel (e.g., 300mg) without any underlying psychotic illness or bipolarity. These challenges are exacerbated by the lack of discharge planning or handover from in-custody to in-community healthcare providers and the inability of community providers to access patients' in-custody healthcare records.

Recommendation 29

This report calls on **Nova Scotia Health – Correctional Health Services** in concert with the **Nova Scotia Drugs and Therapeutics Committee** to develop best practice guidelines for prescription medication not covered under Pharmacare to facilitate continuity upon release, such as ensuring medications are either on the provincial Pharmacare formulary or have an “exception status”, or mandating the prescriber to immediately apply for special authorization.

Recommendation 30

This report further calls on **Nova Scotia Health – Correctional Health Services** to implement a process for discharge / release planning that takes into account continuation of prescription medication, healthcare provision, and coverage. This includes ensuring that individuals are released with up-to-date paperwork with healthcare information as well as information on local community support agencies, paralleling the hospital discharge process. This would entail maintaining a living document of medical issues and treatment (including prescription decisions) for each in-custody patient, as well as adopting a process whereby healthcare files are reviewed by an in-custody physician prior to release to flag any actions that need to be taken, including but not limited to renewing or reviewing prescription medications.

Recommendation 31

This report also recommends that **Nova Scotia Health – Correctional Health Services** establish a process for ongoing communication with incarcerated persons' healthcare providers in community. As above, this report further recommends that **Nova Scotia Health – Correctional Health Services** establish a formal partnership with community-based service organizations such as **MOSH**, in order to facilitate continuity of care.

The thirty-one recommendations outlined above should not be interpreted as a call for increased provincial budget allocation to Nova Scotia Correctional Services or to the Department of Justice. Rather, following calls to action from local health and justice organizations, including East Coast Prison Justice Society, PATH Legal, and the Elizabeth Fry Society of Mainland Nova Scotia, this report calls for decarceration and budget reallocation.

Recommendation 32

This report calls on the **Government of Nova Scotia** to curb rising rates of pre-trial incarceration and revolving-door provincial sentences, through intersectoral action on decarceration, including sustained investment in community-based legal, social and health supports for justice-involved people and full resourcing of Indigenous and African Nova Scotian-led transformative justice initiatives.²⁰

²⁰ Reiterating one of the calls to action during the March 2024 *Month of Action* spearheaded by ECPJS and PATH Legal and supported by a coalition of health and prison justice organizations (<https://www.pathlegal.ca/month-of-action>; Beach et al., 2024, p. 6).

Summary of Recommendations

Recommendation 1

This report calls on the **Government of Nova Scotia and NSCS** to develop stronger and clearer legislation and policy around the limits of close confinement, including the prohibition of close confinement for periods longer than 20 hours per day, and to further identify a baseline of daily time out of cell, which if unmet must be justified and communicated to prisoners.

Recommendation 2

To further increase transparency and accountability around the practice of close confinement, this report calls on the **Nova Scotia Office of the Ombuds** to publish the results of their quarterly audits of close confinement in provincial jails.

Recommendation 3

This report calls on the **Nova Scotia Department of Justice** to uphold the commitment made by the **Government of Nova Scotia** in the wake of Howard Hyde's death to ensure all correctional staff receive adequate mental health and addictions training, including de-escalation and crisis intervention, "so they are better prepared to respond appropriately – with respect and empathy and in a way that puts care needs first" (Nova Scotia, 2011, p. 28).

Recommendation 4

This report further calls on the **Nova Scotia Department of Justice** to ensure that all peace officers – particularly police and correctional officers – receive trauma-informed training alongside training on addictions and mental health.

Recommendation 5

This report calls on the **Nova Scotia Departments of Health and Justice** to incorporate adverse childhood experiences into the development of a trauma-informed screening tool for mental health and addictions upon intake into all provincial custodial settings, including residential school impacts, intergenerational trauma, child welfare involvement, family separation, and experiences of racism and discrimination.

Recommendation 6

This report calls on the **Nova Scotia Departments of Health and Justice** and **Nova Scotia Correctional Services** to collaborate with existing peer support services and community-based organizations to provide in-custody peer support programs for mental health and addictions.

Recommendation 7

This report calls on the **Nova Scotia Departments of Health and Justice** (particularly, **Nova Scotia Health – Correctional Health Services, Mental Health and Addictions Services** (MHA), and **Nova Scotia Correctional Services**) to collaborate toward integrating the provincial mental health and addictions intake into the intake process for all individuals entering provincial custody –to be completed by a healthcare provider with mental health and addictions expertise.

Recommendation 8

This report calls on **Nova Scotia Health – Correctional Health Services** to add a minimum of one full-time position for a healthcare provider with addictions expertise to the mental health team, to assess and inform protocols and practices across all institutions on an ongoing basis.

Recommendation 9

This report calls on the **Nova Scotia Department of Health** and **Nova Scotia Health – Correctional Health Services** to significantly decrease the wait times for physicians including psychiatrists in custody. Relatedly, this report calls on **Nova Scotia Health – Correctional Health Services** to clarify the new triage process under the expanded mental health team, which includes the addition of healthcare social workers and Licenced Practical Nurses, and to articulate how the new process will operate to decrease wait times for persons in custody.

Recommendation 10

This report calls on **Nova Scotia Health – Correctional Health Services** to provide both receipts and responses to prisoners placing healthcare requests, and to implement unique tracking numbers for request and complaint forms to facilitate the documentation and timely resolution of needs and concerns.

Recommendation 11

This report calls on the **Nova Scotia Department of Health** and **Nova Scotia Health – Correctional Health Services**, in concert with the **Nova Scotia Drugs and Therapeutics Committee** to implement a policy to ensure in-custody prescribers abide by the World Health Organization guidelines for rational use of medicines (2002), including minimizing “poly-pharmacy”, limiting the off-label use of psychotropic medication, minimizing interruption of care via medication changes and/or prescription of drugs likely to be disrupted upon release (e.g., those not covered under Nova Scotia Pharmacare), and fully informing patients which drugs they are being prescribed and why.

Recommendation 12

This report calls on **Nova Scotia Health – Correctional Health Services** to provide a written justification for all in-custody prescriptions that do not follow established practice guidelines, to be documented in the patient’s Nova Scotia Health Record.

Recommendation 13

This report further calls on **Nova Scotia Health – Correctional Health Services** in concert with the **Nova Scotia Drugs and Therapeutics Committee** to develop a Sub-Committee specifically oriented toward ensuring best practice vis-à-vis prescription medications in provincial custodial facilities (including but not limited to correctional facilities, forensic hospitals, and long-term care homes), and to ensure that the Committee is comprised of both pharmacists and healthcare providers/prescribers with expertise in mental health and addictions.

Recommendation 14

This report calls on **Nova Scotia Health – Correctional Health Services** to immediately abolish the policy restricting the prescription of Opioid Agonist Therapy (OAT) to prisoners with substance use disorders, enabling prisoners to be started on OAT while incarcerated. This

report further calls on **Nova Scotia Health – Correctional Health Services** to streamline access to OAT – including both Suboxone and Sublocade – via the integration of the NS Mental Health and Addictions intake into the intake process for all persons entering provincial custody.

Recommendation 15

This report also calls on **Nova Scotia Health – Correctional Health Services** to further introduce related trauma-informed harm reduction policies that are responsive to the needs of incarcerated substance users.

Recommendation 16

This report calls on the **Nova Scotia Department of Justice** and **Nova Scotia Correctional Services** to waive the fee for criminal record checks for AA and NA volunteers to better facilitate access to meetings in prison.

Recommendation 17

This report calls on the **Nova Scotia Department of Justice** and **Nova Scotia Correctional Services** to provide alternatives to abstinence-based addictions support in provincial jails via formal partnerships with community-based harm reduction organizations, agencies, and initiatives, including the North End Community Health Center, and Direction 180.

Recommendation 18

This report further calls on the **Nova Scotia Department of Justice** and **Nova Scotia Correctional Services** to ensure that all programming designed to address mental health and addictions is offered by trained mental health and addictions experts, not Correctional Officers.

Recommendation 19

This report also calls on the **Nova Scotia Health – Correctional Health Services**, in partnership with **Nova Scotia Correctional Services**, to dedicate resources to facilitating access to sacred medicines, providing culturally relevant mental health supports, and funding an Indigenous Community Health Liaison, embedded in an Indigenous-led health governance body, to assist with needs assessments upon entry and release.

This report further calls on **NSCS** to establish minimum service standards guaranteeing timely access to Elders, Knowledge Keepers, Cultural Advisors, and Ceremony.

Recommendation 20

This report calls on the **Nova Scotia Correctional Services** to establish formal partnerships with community organizations and service providers (e.g., MOSH, Direction 180, Mi'kmaw Native Friendship Center, Mi'kmaw Legal Support Network, African Nova Scotian Justice Institute, 902 Man Up, John Howard Society of Nova Scotia) to facilitate in-reach, *particularly geared toward supporting incarcerated men*.

This report further calls on the **Government of Nova Scotia** to allocate financial resources toward in-reach programming and supports, to bolster the capacity of community-based organizations and service providers to meet the needs of incarcerated Nova Scotians.

Recommendation 21

This report calls on the **John Howard Society of Nova Scotia** to prioritize in-reach programming and supports in provincial jails and to ensure that in-reach is accessible to all incarcerated men.

Recommendation 22

This report calls on the **Nova Scotia Human Rights Commission** to investigate the failure to accommodate disabled Nova Scotians in provincial custody, particularly the failure to provide adequate treatment and support for people with mental disorders and substance dependence.

Recommendation 23

This report calls on **Nova Scotia Correctional Services** to adhere to their own policy (31.00.00) and stated purpose to “provide programs to assist with the successful, reintegration of these individuals into the community” (Nova Scotia Department of Justice, 2021a). This report further calls on **NSCS** to publish the statistics they collect on programming (including number of programs offered, requests and enrolment rates) as per policy 31.00.00.

Recommendation 24

This report calls on the **Nova Scotia Office of the Ombuds** to investigate the lack of programming available to incarcerated Nova Scotians – *particularly in male-designated units* – as a contravention of Correctional Services Policy 31.00.00, and a failure to adhere to the overarching mandate of Nova Scotia Correctional Services.

Recommendation 25

This report calls on **Nova Scotia Correctional Services** to integrate occupational therapy into rehabilitative programming by employing one full-time occupational therapist per institution.

Recommendation 26

This report calls on **Premier Tim Houston** and the **Government of Nova Scotia** to improve housing affordability across the province through instituting rent control measures, including the immediate closure of the fixed-term lease loophole.

Recommendation 27

This report calls on the **Government of Nova Scotia** and the **NS Department of Justice** to launch a pilot project providing transitional housing for individuals being released from provincial custody, in partnership with community-based organizations and service providers.

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This report calls on **Nova Scotia Correctional Services** to adopt the case management process for youth in custody (as outlined in Correctional Policy 34.02.00) in all adult facilities, thereby ensuring that all adults in custody who are remanded or sentenced to 30 days or more are assigned a Case Management Worker within two business days of admission, to assist with the development and facilitation of a plan for reintegration and release. This report further calls on **NSCS** to ensure that all Case Management Workers have a degree in social work / occupational therapy or equivalent experience and familiarity with regional supports and resources.

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