

# Commentary: The Top Ten Reasons to Limit Prescription of Controlled Substances in Prisons

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Implementation of a treatment protocol for prescribing stimulant medications in adult prisons where such a protocol and oversight did not previously exist is prudent management, clinically relevant, and appropriate. There are multiple challenges to using controlled substances in correctional settings, many of them a consequence of the very high prevalence of substance use disorders among inmates. This article describes 10 of the reasons to limit the prescription of controlled substances in prison, among them the implications for nursing and correctional security staff and the overwhelming of the already limited psychiatric resources available in most prisons.

**J Am Acad Psychiatry Law 37:50–2, 2009**

In the preceding article, Kenneth Appelbaum<sup>1</sup> describes both the process of developing a treatment protocol for adult attention deficit hyperactivity disorder (ADHD) and the treatment protocol itself. The protocol calls for better, more explicit documentation related to diagnostic criteria including evidence of childhood onset, assessment of current functioning, and psychological testing. Inmates must agree to ongoing participation in adjunctive, nonpharmacologic therapies to qualify for pharmacological interventions. Initial pharmacological management consists of nonstimulant medications, but stimulants may be prescribed after a failure of one or more nonstimulant agents or when such trials are contraindicated. The development of the protocol Appelbaum describes was undertaken in the context of a prison system in which the prescription of stimulants was previously uncontrolled and unmonitored. Subsequently, the most vocal opponents to the protocol, other than prisoners of course, were prescribers who, not unsurprisingly, viewed the protocol as an attack on their medical autonomy and prescriptive authority since the bottom line was to require some degree of diagnostic rigor, monitoring of re-

sponse to treatment, and evidence of attempts to follow a treatment algorithm. Other challengers to the protocol development were rather less vocal, except those who suggested using the opportunity of protocol development to remove stimulants from the correctional formulary altogether. Nursing and correctional staff were supportive in general, seeing the protocol implementation as either neutral, because it created no additional burdens on them, or positive, in that it could lead to fewer inmate prescriptions of stimulant agents, given the diagnostic burden of proof and potential for improvement on nonstimulant pharmacological agents.

It is one thing to impose restrictions on an existing unmonitored formulary drug, as in the case of the Massachusetts protocol, and quite another to add a controlled substance onto a prison formulary where it did not previously exist. Almost all of the correctional facilities of which I am aware do not include stimulants on adult formularies. Implementing a protocol to add stimulants would be met with quite different responses from prescribers, nursing staff, correctional staff, and inmates. Toward this end, I have attempted to articulate a top 10 list of reasons to limit the prescription of stimulants in adult correctional facilities, although I am certain that the list is neither exhaustive nor are the items mutually exclusive, in that many of them are intimately interrelated.

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## The Top 10 Reasons to Limit Stimulant Availability in Adult Prisons

### **Reason 10: High Prevalence of Substance Use Disorders in Prison Populations**

Prevalence rates for substance use disorders among correctional populations are estimated to be in the range of 70 to 90 percent.<sup>2</sup> Controlled substances such as amphetamines have a very high abuse potential, and their use in a population with an already high prevalence of substance use disorders is of concern. Psychiatrists should be reluctant to become unwitting suppliers for people with addictions. On the other hand, recent studies have also demonstrated that the prevalence of ADHD is higher in persons who are substance dependent than among those who are not, and so reason number 10 is not an absolute ban on stimulants but must be considered.<sup>3</sup>

### **Reason 9: Potential for Misuse**

This reason is related to the prevalence of substance use disorders mentioned previously. There is the possibility in prison, as elsewhere, that the medication would be used to achieve an intoxicated state rather than as a medication to treat target symptoms of a clinically significant syndrome. Although it would be naïve to suggest that substance abuse does not occur in correctional facilities, at least some of the illicit substance use is limited by the inconsistent supply route. Inmates, therefore, have creatively used other medications that are generally not abused in the community, where illicit substances are more easily and consistently accessed. They ferment their own alcoholic beverages; they crush and snort bupropion; and they seek quetiapine prescriptions for its sedating properties. A steady supply of quality-controlled amphetamine delivered directly to the cell door is almost too good to be true for those inmates seeking a high in prison.

### **Reason 8: Barter, Sell, Trade**

Amphetamines are an extraordinarily valuable commodity in prisons. Even inmates with legitimate need could be tempted to divert their prescribed medications for other items such as cash, commissary items, illicit drugs, or alcohol. In addition, protection or an assault, sexual favors, tattoos, or other activities contrary to the orderly operation of the institution can be purchased with contraband, controlled substances, and other medications. Prohibit-

ing amphetamines would not make these problems disappear, but permitting them would contribute an exceptionally valuable asset in the covert trade among inmates.

### **Reason 7: Intimidation and Victimization**

There is no doubt that some prisoners will intimidate weaker inmates with ADHD into surrendering their prescribed stimulant medication. Verbal intimidation would be the least serious of the potential problems; physical and sexual assaults are also likely. In addition to the likelihood of the targeted inmate's potentially being injured, correctional staff responding to the assault can also be injured. This is another prison problem that would not be eliminated by prohibiting the use of controlled substances in prison, but such medications would add to the problem. (For those readers who are unfamiliar with prison culture, there are no secrets; you cannot prevent the inmate's medications from becoming known eventually.)

### **Reason 6: Security**

Inmate intoxication, illicit trading, and assaults present serious management problems for correctional security staff. Each of these acts represents a significant rule infraction and disrupts the orderly operation of the institution, in addition to presenting physical safety threats for staff.

### **Reason 5: Challenges for Nursing**

Essentially all psychotropic medications are directly administered by nursing staff in prisons. Storage, inventory, administration, and handling of controlled substances add significant nursing time to a medication process that is already time consuming. Further, preparation time is prolonged by requiring crushing the medication or using special preparations such as liquids intended to minimize the likelihood of diversion. Further, unless extended-release preparations are utilized, multiple daily doses are required, adding to the burden of medication delivery.

### **Reason 4: Direct and Indirect Costs**

Many correctional systems are struggling to meet the cost of psychotropic medications on existing formularies, and some have cut corners by limiting access to various formulations or specific medications. Expanding the formulary with a controversial controlled substance could come at the expense of fur-

ther limiting medication treatment options for prisoners requiring antipsychotic, antidepressant, or mood-stabilizing medications. In addition to direct costs, the additional nursing time associated with medication inventory, preparation, and administration are not insignificant, nor is the associated security cost associated with searches, writing, and processing rule infractions and staff and inmate injuries.

**Reason 3: Available Alternatives**

Appelbaum’s protocol includes treatment with stimulants only after failure of a trial of one or more nonstimulant agents. Unfortunately, at least one agent often prescribed as an alternative, bupropion, is a well known drug of abuse in the prison population and has actually been removed from the formulary in some systems, notably California.<sup>4</sup> Atomoxetine, a nonstimulant medication approved for treatment of ADHD in children and adults, may be a useful option. However, perhaps the best alternative would be optimizing use of behavioral treatments for the disorder as the skills acquired could be utilized in the community after release. Many inmates would have a difficult time securing continuity of stimulant medication upon release for many reasons, not the least of which is the lack of a prescription benefit in many states and lack of community prescribers able and willing to prescribe controlled substances to persons with a history of felony conviction and substance abuse.

**Reason 2: Fostering Malingering**

Use of stimulants in correctional facilities raises the probability of drug-seeking or manipulation to obtain the medication. The protocol advanced by Appelbaum attempts to weed out malingerers by documenting diagnostic criteria, psychological testing, required participation in adjunctive nonmedication therapies, and trials of nonstimulants. However, each of these steps can be sidestepped or bypassed by the manipulative inmate. For the less skillful manipulators, these steps require a very time-consuming process for mental health staff of seeking historical documentation, corroborating accounts of functional impairment, and psychological testing with limited resources, which leads to the number one reason to limit the use of controlled substances in prison.

**Reason 1: Overwhelming of Psychiatrist Sick Call by Drug-Seeking Inmates**

Psychiatric time in correctional facilities is often limited for a variety of reasons, including difficulty recruiting physicians to work in them. Psychiatric clinics are often essentially medication management visits with little time for other therapeutic interventions, functional assessments, or corroboration of inmate self-report with other mental health or correctional staff. Systems are already stretched to the limit. The addition of stimulant medications to the adult prison formulary could further overwhelm psychiatric medication management clinics and further compromise the time available for treatment of other serious psychiatric disorders such as schizophrenia and affective disorders.

**Conclusion**

Implementing a treatment protocol for the use of stimulant medications in adult prisons where there has been none previously and stimulants are on the formulary is certainly an appropriate administrative and clinical step. The ready availability of stimulants without oversight or treatment protocol is strongly discouraged, given the challenges related to their addictive potential and security concerns. However an off-formulary mechanism to access them combined with monitoring controls and objectively measured clinical response to treatment may be appropriate in adult facilities.<sup>5</sup> Perhaps the best practice would be to permit access to stimulant medications via a non-formulary request approval process that incorporates many of the elements in the previously proposed protocol as part of that approval and continuation process.

**References**

1. Appelbaum KL: Attention deficit hyperactivity disorder in prison: a treatment protocol. *J Am Acad Psychiatry Law* 37:45–9, 2009
2. American Psychiatric Association: *Psychiatric Services in Jails and Prisons* (ed 2). Washington, DC: American Psychiatric Association, 2000
3. Adler LA, Newcorn JH, Spencer TJ, *et al*: Best practices in adult ADHD: special considerations. *CNS Spectr Suppl* 13(Suppl 15): 1–16, 2008
4. California Dept. of Corrections and Rehabilitation formulary: Available at: [www.cphcs.ca.gov/docs/projects/CDCR\\_Formulary\\_200810.pdf](http://www.cphcs.ca.gov/docs/projects/CDCR_Formulary_200810.pdf). Accessed October 2008
5. Burns KA: Psychopharmacology in correctional settings, in *Clinical Handbook of Correctional Psychiatry*. Edited by Scott C. Washington, DC: American Psychiatric Press, 2005, pp 89–108