Prisoners' Legal Services
A Project of the West Coast Prison Justice Society

July 17, 2017

To: Anuradha Marisetti
Deputy Commissioner, Pacific Region
Correctional Service Canada
VIA E-MAIL: [redacted]

cc: Don Head
Commissioner
Correctional Service Canada
VIA E-MAIL: [redacted]

Dear Ms. Marisetti:

RE: Insufficient Access to Methadone and Suboxone Treatment

We are writing to ask that you immediately address what we believe is inhumane treatment of federal prisoners suffering from opioid addictions. In particular, we are concerned about woefully inadequate access to Opioid Substitution Therapy ("OST") and the abrupt and inhumane discontinuation of medication for patients who do receive OST in federal prisons across BC.

Prisoners' Legal Services ("PLS") has heard from more than 30 clients over the last several months who struggle with opioid addiction but have been waiting months—and some even years—for treatment, or who have been cut off their life-saving medication after allegations of diversion with no meaningful opportunity to defend themselves or exploration of alternatives to termination. Some clients have been cut off their medications cold-turkey, without a taper and without any medication to manage withdrawal.

As you know, opioid addiction is a public health crisis, both in our communities and in prisons. As Commissioner Head reported to the Standing Committee on Public Safety and National

Security, 80% of prisoners have a serious substance abuse problem upon admission.[1] Most newly admitted prisoners report using drugs recently, and 1 in 10 report injection drug use in the months prior to admission to custody.[2]

The Correctional Investigator reviewed 105 incidents of overdoses in Correctional Service Canada ("CSC") facilities between 2012/13 and 2014/15, 39 of which involved Fentanyl, heroin or other opiates.[3] Research also suggests that a significant number of people who die of overdoses in the community have been released from correctional facilities within the last year.[4]

Rates of trauma among prisoners are also particularly high,[5] and supports such as trauma counselling or drug counselling are scarce. Our clients report using drugs in order to cope with past trauma or mental health issues that they are otherwise unable to manage while in prison.

The inability to receive treatment for drug addiction also significantly compromises prisoners' ability to meet their correctional goals—thereby running counter to CSC's core mandate to "assist[in] the rehabilitation of offenders and their reintegration into the community."[6] Some clients report that their ability to get parole is compromised because they cannot get treatment, or that they breach parole when back in the community because of drug addiction issues. Clients also report institutional charges as a result of drug use.

Many clients report to PLS that they are looking for help to stop using drugs and are afraid of overdosing, but that they are unable to get the help they need. Some clients have even explained that they feel the only way to get treatment in prison is to overdose.

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[1] As cited in "House of Commons, Standing Committee on Public Safety and National Security, Drugs and Alcohol in Federal Penitentiaries: An Alarming Problem" (April 2012), p. 9. Online: http://www.ourcommons.ca/Content/Committee/411/SECU/Reports/RP5498869/securp02/securp02-e.pdf.
[2] Fiona Kouyoumdjian, Andrée Schuler, Flora I. Matheson and Stephen W. Hwang, "Health status of prisoners in Canada," *Canadian Family Physician* Vol 62 (March 2016). Online: http://www.cfp.ca/content/cfp/62/3/215.full.pdf.
[3] "Annual Report of the Office of the Correctional Investigator 2015-2016" (June 30, 2016). Online: http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20152016-eng.aspx
[4] Kendra Stephenson, "High rate of drug overdose deaths among adults recently released from incarceration: study," St. Michael's Hospital, (July 6, 2016). Online: http://www.stmichaelshospital.com/media/detail.php?source=hospital_news/2016/0706
[5] Nancy Wolff, Jing Shi, and Jane A. Siegel, "Patterns of Victimization Among Male and Female Inmates: Evidence of an Enduring Legacy" (2009) Violence Vict. 24(4) at 469-484. Online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3793850/.
[6] Corrections and Conditional Release Act S.C. 1992, c. 20, s. 3(b).

Under Section 86 of the Corrections and Conditional Release Act ("CCRA"), CSC is required to provide essential health care to all federal prisoners, and methadone and Suboxone are not only essential but life-saving medications for many.

However, we are concerned, based on numerous client reports, that large numbers of federal prisoners in BC who need OST treatment are not receiving it because of insufficient resources—an unacceptable response to an acute medical need.

We are also concerned that those who are able to obtain treatment are being cut off their medications—particularly Suboxone—based not on individual medical need but as a form of punishment. Clients report that termination of medication is a routine response to accusations of diversion, which clients have no meaningful way to defend themselves against, and that physicians do not consider alternatives to involuntary taper.

The Supreme Court of Canada has reinforced on multiple occasions that "Drug dependence is a protected ground of discrimination in human rights law."[7] As such, CSC has a duty to accommodate prisoners who suffer from addiction, as this is a disability under *the Canadian Human Rights Act*,[8] and the failure to do so is also a violation of their rights under s. 15 of the *Canadian Charter of Rights and Freedoms*.

Further, the denial of OST and the practice of terminating medication exposes prisoners to preventable harm and suffering by increasing the risk of withdrawal symptoms, infection, overdose and death. These practices violate prisoners' rights to life, liberty and security of the person guaranteed by s. 7 of the *Charter* when decisions are made to deny OST without procedural fairness.

As the Federal Court held in *Drennan v. Canada*, the duty to accommodate a person's disability and respect his or her human rights "is all the more important in the case of a prisoner, who has no choice as to his living arrangements, and as such is in a uniquely vulnerable position."[9]

Our concerns are outlined in greater detail below, followed by stories of 33 clients who have called our office in recent months to raise these issues. We request that you immediately investigate both the individual cases and the systemic issues we highlight, and take immediate action to remedy the problems we have identified.

We would welcome the opportunity to discuss these issues further and be part of the development of solutions. Given the urgency of the situation, we hope to hear from you within

[7] *Stewart v Elk Valley Coal Corporation* 2017 SCC 30, para. 58.
[8] *Canadian Human Rights Act*, R.S.C., 1985, c. H-6, s. 5.
[9] *Drennan v. Canada (Attorney General)*, 2008 FC 10, para. 41.

two weeks about how CSC plans to address our concerns. If we do not hear back or our concerns are not addressed, we will advise our clients to pursue legal action.

1. *Lengthy Wait Times for OST*

PLS has heard from several clients who struggle with opioid addictions and have been attempting to access OST for prolonged periods of time, some for years. They include prisoners within weeks of release and prisoners battling Hepatitis C. They also include prisoners who transferred institutions for the purpose of getting treatment, only to find themselves placed on another waiting list at their new institution.

Waiting lists are further swelled by prisoners who, as detailed below, are cut off their medication and are waiting for an opportunity to get on again.

We appreciate that CSC must have sufficient staff and resources to safely manage its OST program. However, for people with opioid addictions, OST is essential health care and can mean life or death for prisoners who actively use drugs. It must be provided to everyone in custody who needs it.

The inability to get treatment can also compromise a person's ability to meet the goals of their correctional plan, achieve parole, and be successful upon release into the community. In addition to meeting the medical needs of prisoners, CSC must facilitate their rehabilitation, and is failing to do so when it makes treatment so hard to obtain.

Providing sufficient access to OST would also reduce the risk of diversion by reducing the demand for obtaining Suboxone and methadone illicitly. Indeed, we have heard that some prisoners buy these medications to treat themselves when they are unable to get on the OST program, which can put them in danger and expose them to institutional sanctions.

We ask that CSC immediately devise a plan to meet the demand for methadone and Suboxone treatment in all federal facilities so that anyone who would benefit from OST treatment can access it in a timely fashion. This may include allocating new funds for the hiring of additional medical staff to administer treatment, among other things.

Twelve stories from prisoners who have been unable to access OST treatment are attached as Schedule A. A short selection is reproduced below.

a. *Select stories of prisoners waiting for OST treatment*

MacKenzie Carroll is incarcerated at Mountain Institution. Mr. Carroll has Hepatitis C and has been on the waiting list for methadone since approximately July 2016. A grievance response

from Mountain Institution's warden confirms that Mr. Carroll was second on the waitlist as of December 30, 2016, but that the OST program was significantly beyond capacity. Mr. Carroll was told he could transfer institutions in order to get treatment, but is unable to do so because of incompatibles. In a written grievance, Mr. Carroll described "every second of every day" while he waits for OST treatment as an "insurmountable struggle." He went on to write: "I am still constantly struggling each hour of every day with my addiction and have been doing all that I can on my part but I am losing this internal battle…I am trying to do my best but I am losing, I NEED HELP, NOW! There is nothing else left for me, I reach out for help as I am supposed to instead of using, and I am being refused help…it is pushing me out into harm's way…I need to be put on the OST Program now before something really bad happens to me, PLEASE!"

Joel is incarcerated at Kent Institution. He reports that he has been on the OST waitlist in both Kent and Mountain Institution for three years. Mr. has been a heroin user for over 10 years, and reports that he has overdosed in the past. He explains that without OST, using drugs is the only way he can function inside the institution. He reports seeing positive changes of friends on Suboxone, and that he wants to make change in his life as well. Mr. is set for release in mid-July and fears that he will not be able to control his addiction when he's out. He fears becoming a victim in the fentanyl crisis and feels like his two options upon release are "dying or going back to jail." Mr. 's requests to simply talk with the OST physician about options to help treat his addiction have been denied.

Luc Vo has been incarcerated at Matsqui Institution for the past six months and has been waiting for OST treatment since he arrived. Mr. Vo reports that, prior to his current sentence, he was on methadone and remained drug-free for 11 years. He reports that he relapsed in 2015 after getting into a car accident and losing his job. He reports that since relapsing in 2015, he has overdosed twice, including once in an incident in a provincial facility in Ontario in which the four other prisoners he used drugs with died.

In the course of his drug use, Mr. Vo reports that he has overdosed a total of six times, two of which resulted in him being pronounced dead. Despite Mr. Vo's best efforts to engage with the institution and explain his overdose history, including in conversations with the warden, he reports that the institution insists that his case is not a priority. He also reports being told to "shoo" by healthcare staff, which made him feel like an animal.

2. *Excessive and Inhumane Discontinuation of OST*

In addition to those who have been waiting excessive periods of time for treatment, we have also heard from numerous clients who managed to get OST, only to find themselves accused of attempting to divert their medication and involuntarily tapered—or cut off cold turkey. These issues seem to be especially widespread with respect to Suboxone.

Clients report no meaningful opportunity to tell their side of the story or consideration of alternatives, and some report no opportunity to even consult with a physician. Many clients report being falsely suspected of diversion, and others admit to saving their medication for a variety of reasons that do not warrant an automatic taper—including because they are being muscled and in order to better control their own dosing.

While we understand that CSC wishes to curb diversion, the danger posed by cutting countless people with serious drug addictions off life-saving medication, we believe, is untenable. Further, if everyone who needed OST were able to access the program, the demand for illicit Suboxone would drop considerably. As such, CSC's widespread practice of terminating the medications of prisoners accused of diversion is arbitrary and "exacts a constitutional price in terms of rights, without furthering the public good that is said to be the object of the [policy]."[10]

CSC's September 2016 "Specific Guidelines for the Treatment of Opiate Dependence" ("OST Guidelines") make clear that involuntarily terminating a patient's medication "will not be used as a form of discipline and will only be considered as a last resort in situations of persistent noncompliance with the Methadone/Suboxone Maintenance Treatment Agreement [] or where past and/or current behaviour indicate a significant risk of harm to other offenders or staff within the OST."[11]

The OST Guidelines go on to explain that, prior to an involuntary taper, the person's Intervention Team must meet "to ensure that all reasonable measures to improve the situation and possible alternatives to involuntary taper are considered."[12]

The OST Guidelines further require CSC to "demonstrate procedural fairness when considering involuntary tapers from OST."[13]

However, reporting from numerous clients, as outlined below, indicates that there is widespread noncompliance with both the spirit and the letter of the OST Guidelines, and that the standards outlined therein fail to protect patients from being denied essential medical treatment.

Many clients have expressed that they do not wish to return to illicit drugs, but their inability to access treatment may force them to do so and they fear the result could be deadly.

[10] *Carter v. Canada* (Attorney General), 2015 SCC 5, para. 83.
[11] Correctional Service Canada, "Specific Guidelines for the Treatment of Opiate Dependence (Methadone/Suboxone), September 2016" ("OST Guidelines"), Section 10.
[12] OST Guidelines, Section 10.2.
[13] OST Guidelines, Section 10.

Twenty-one stories of prisoners who have been involuntarily tapered or cut off their OST medications are included as Schedule B. Below is an outline of the common problems their stories highlight, followed by a small sampling of prisoner accounts that represent many of the issues raised below.

a. No standards of proof

Many clients who have been involuntarily tapered off OST report that the taper was triggered by an observation of "suspicious" behaviour by a nurse or correctional officer—such as white residue in the patient's mouth, the patient coughing into his hand or shirt, or the patient wiping his mouth.

While these behaviours may appear in people attempting to divert their medication, they are also common among people who are taking their medications appropriately. For instance, until recently, Suboxone tablets were crushed, so it is not surprising that residue might be seen in a patient's mouth, especially since Suboxone dissolves at a different rate for every person. We also understand from clients that some patients still chew their tablets, and one client has reported being encouraged to do so by a nurse. And certainly coughing and wiping one's mouth are normal human behaviours.

Some clients report being searched following the alleged incident, with no diverted medication found. Other clients report being permitted to leave without comment, only to find later that they were suspected of diversion.

Very few of these clients report being institutionally charged. As such, they have no opportunity to see the evidence against them—and from conversations between PLS and chiefs of healthcare, it seems that in many cases no evidence exists beyond the initial observation by staff. Nevertheless, an accusation by one staff person suffices, in many cases, to cut off a patient's access to medication.

Even clients who are institutionally charged may have had their dosage reduced significantly or ended entirely by the time their charges are heard.

This is an unacceptably low standard of evidence, and does not comport with the principles of fundamental justice required by Section 7 of the *Canadian Charter of Rights and Freedoms*. It means that any behaviours that *could* be suspicious are considered conclusive evidence of nefarious acts. It requires no physical evidence of diversion or even evidence of intent to divert, but simply the word of a staff person—who can make mistakes or jump to conclusions just like any of us. Staff need not be acting maliciously for this to happen—all people make errors, and it can be difficult to know, in the absence of other information, whether, say, residue in a patient's mouth is because of intent to divert or simply human biology. In our submission, no

one should be denied the right to security of the person without a basic level of procedural fairness.

In contrast, BC Corrections' Health Care Services Manual requires "Documented proof of diversion by the patient … before medication is discontinued." The manual further states that "Diversion of medication is an indication for the physician or nurse practitioner to consider a change in the patient's treatment plan, up to and including the discontinuation of prescribed medication."[14]

b. No meaningful opportunity to be heard or challenge unfounded accusations

The lack of standards of proof are compounded by the lack of any meaningful opportunity to challenge unfounded accusations of diversion. While most clients report meeting with the OST physician following an accusation of diversion, most if not all have already begun a taper before the meeting happens.

Clients report that the meeting with the physician is pro forma at best, and at worst involves patients being called "junkies" and made to feel worthless. They report feeling that the doctor's mind was made up from the outset, and that the doctor would always trust the word of a nurse or correctional officer over a prisoner, no matter the circumstances. Some clients report the physicians using language to that effect.

Clients were also unaware of the physician considering any evidence, despite the OST Guidelines' requirement that "[a]ll available relevant information and evidence related to the offender's behaviour and incidents in question must be provided to the physician for review and consideration."[15] If physicians did consider evidence, it was not provided to clients to review and respond to.

Clients also report that once they have been accused of diversion, the "conviction" becomes part of their medical file and is used against them in the future—so if a second allegation is ever made, that person is already considered suspect because of past (unproven) behaviour.

Particularly concerning are stories from clients who had no opportunity to meet with physicians at all. PLS has heard from several clients at Matsqui Institution who report that discontinuation of medication is ordered without any consultation by the physician—and that they are simply informed by the correctional staff not to bother returning the next day for their medication. One client at Kent Institution also reported that he had no opportunity to see a physician.

[14] British Columbia Adult Custody Division, "Health Care Services Manual" section 7.18(1) and 7.18(3) (revised March 2013).
[15] OST Guidelines, Section 10.2.

This is especially troubling since it is impossible for the physician to interview the prisoner and consider his version of events, as required by the OST Guidelines, if they do not actually speak to the patient. Further, it indicates a troubling involvement of security staff in medical decision-making.

c. No consideration of alternatives to discontinuation of OST

The OST Guidelines require a meeting of the Intervention Team "to ensure that all reasonable measures to improve the situation and possible alternatives to involuntary taper are considered."[16] However, not a single client mentioned consideration of alternatives or *any* measures to improve the situation prior to a taper being ordered, despite the fact that some clients have even suggested additional restrictions on their medications.

Most clients described discontinuation as a first resort rather than a last resort. As such, it appears that OST termination decisions are not being made based on the individualized medical needs of each patient, but are a routine response to accusations of diversion—a clear violation of the requirement that terminating a patient's mediation may "not be used as a form of discipline."[17]

Further, most clients had never even heard of an Intervention Team, much less had had that team meet to consider their case. Not a single client mentioned anyone participating in the meeting about their taper besides the physician and sometimes a nurse, who was generally described as keeping quiet or agreeing with the doctor. Nor did clients mention other relevant people – such as parole officers, correctional officers, elders, psychologists, or others – being consulted by the physician. One client reported that he requested to have his parole officer and the MAI present but the physician refused and said their perspectives would not matter to him.

Clients report physicians saying that because they had been "caught" diverting, they had no choice but to discontinue their medication. Chiefs of healthcare shared similar perspectives with PLS, saying that patients had to be cut off because they had been diverting their medication.

This attitude implies that *anyone* who even attempts (successfully or not) to divert his Suboxone for *any* reason represents a completely unmanageable risk to the safety of the institution, which is simply too broad a standard, especially considering that there is no remedy for prisoners who are falsely accused.

[16] OST Guidelines, Section 10.2.
[17] OST Guidelines, Section 10.

Indeed many of the cases below involve allegations by healthcare or correctional staff that prisoners still had medication in their mouths when staff felt it should be dissolved. Even in cases where this type of situation *does* represent an attempt to divert medication, it does not represent diversion itself – and a nurse could simply instruct the person to wait longer for the medication to dissolve and then do another mouth check, for instance, to address this issue.

Further, even clients who are saving their medication have a variety of reasons for doing so. Some are being muscled, and the institution must not punish them by taking away their medication. Others report holding onto doses in order to control their own dosing, not with the intention of selling or sharing their medication. But these issues cannot come to light if meaningful conversations are not held before taper decisions are made.

If it is truly too dangerous to maintain a person on his OST or to consider alternatives to discontinuation, that danger must be specific to the individual and based on concrete evidence. And it must be balanced against the danger of separating a person with a serious opioid addiction from what is, in many cases, the only resource available to him to address his addiction.

d. Inhumane tapers

The OST Guidelines state that "the rate of involuntary taper must be humane," and that "clinical management of withdrawal symptoms must be offered."[18] However, PLS has heard from many clients who had their doses cut significantly at the outset, and/or who experienced rapid tapers. Chiefs of healthcare have argued to PLS that the immediate slashing of dosing is legitimate because patients have been caught diverting, but because no proof of diversion is required, people who have legitimately been taking their medication are experiencing rapid and inhumane tapers and suffering severe withdrawal symptoms as a result. Even people who *do* divert may have been taking their medication much of the time, meaning that a rapid taper would be inhumane for them too.

In addition, PLS has heard from several clients at Matsqui Institution who report, quite disturbingly, that they have been cut off their medication cold-turkey, with no taper at all. This is absolutely inexcusable. Clients report that medication is discontinued immediately following an alleged act of diversion – before the physician could possibly have an opportunity to review evidence or consider alternatives. As mentioned above, patients are given no consult with the physician. The implicit conclusion is that every patient who acts suspiciously must have been diverting the entirety of his medication consistently over the course of many days or even weeks, which is simply an indefensible position.

[18] OST Guidelines, Section 10.4.

e. Problematic and inconsistent administration practices

PLS has heard from clients about OST administration practices, especially with respect to Suboxone, that seem to create an environment in which accusations of diversion can flourish.

For example, we understand that at several Pacific Region institutions, patients receive their Suboxone and then sit in a common waiting area for approximately 20 minutes while their medication dissolves. However, at Kent Institution, we understand that no waiting area exists; instead, patients receive their Suboxone one by one, and each person stands in front of the nurse waiting for his medication to dissolve. Clients report waiting only 2-5 minutes, which is not a sufficient amount of time for Suboxone to dissolve in many people, and feeling like they have to hurry up because everyone else is waiting behind them. One client has reported that he chews his medication to make it dissolve faster, and another reported being encouraged to chew his by a nurse in order to hurry up.

While we are pleased that Suboxone pills are no longer crushed in CSC institutions, we are concerned that this practice at Kent makes it especially likely that patients will be found to have Suboxone residue in their mouths, leaving them vulnerable to unfounded diversion accusations.

f. Select stories of prisoners cut off OST treatment

Below is a small selection of stories from prisoners who have had their OST medications involuntarily terminated that demonstrate many of the issues outlined above. Many more are included as Schedule B.

Austin Curtin is incarcerated at Matsqui Institution. Mr. Curtin reports being on Suboxone for approximately three months without incident. One day, a nurse spotted something white in Mr. Curtin's mouth and suspected him of diverting. Mr. Curtin only found out about the accusation on the next day when a different nurse confronted him in the medicine line about the previous day's allegations. Mr. Curtin explained that he had been eating hardboiled eggs moments before going to take his medication both that day and the previous day, and reports that he spit some out to show the nurse. He was allowed to leave without further issue, but was approached by a nurse later in the day who informed him that he was cut off his medication with no taper.

Mr. Curtin did not get an opportunity to defend the accusation against him, and only managed to see a physician five weeks after his medication was discontinued after putting in several requests.

Mr. Curtin reports that he experienced heavy sweats, cold shakes, diarrhea, stomach cramp, headaches, insomnia and restless arms and legs, but despite numerous healthcare requests, he

received no help managing his withdrawal symptoms. He reports that these symptoms were so debilitating that he could not leave his cell, and that he lost his job as a result.

Mr. Curtin is also concerned that this diversion accusation will impact his ability to get to a minimum security institution. He reports that while he was on Suboxone he no longer had relapse and reoffending hanging over his head, but that now his confidence has been stripped away, and that he is concerned about exposure to negative influences.

3. Policy Changes and Remedies

Based on the information above and the stories attached, we urge CSC to immediately undertake the following:

i. Initiate treatment for all clients mentioned in Schedule A.

ii. Eliminate all OST waiting lists and make the program available to all federal prisoners who could benefit from it without delay. We recognize this likely requires a new allocation of resources and staff, and encourage CSC to follow the lead of BC Corrections, which has increased the number of provincial prisoners receiving OST threefold over the past year.[19]

iii. Ensure all federal institutions are fully complying with all aspects of the OST Guidelines as they relate to involuntary tapers, including but not limited to:

- Ensuring meaningful Intervention Team meetings that include all relevant players. These must happen in every case *prior* to a taper being ordered, and must truly explore alternatives;
- Ensuring that all involuntary tapers are last resorts and that taper schedules are humane; and
- Ensuring that any discontinuation of medication is not used as a punishment and is medically appropriate.

iv. Amend the OST Guidelines to require proof of diversion and provide for procedural fairness for prisoners accused of diversion in order to bring the policy in line with Section 7 of the *Charter*.

If a patient has not been charged with a disciplinary infraction for the diversion, he must be given a meaningful opportunity to confront evidence against him, defend himself against the allegations, and have his case decided by an impartial party.

[19] Paul Webster, "British Columbia is saving lives by giving drugs to opioid-addicted prisoners," *National Observer* (June 23, 2017). Online: http://www.nationalobserver.com/2017/06/23/news/british-columbia-saving-lives-giving-drugs-opioid-addicted-prisoners.

If a prisoner is not found guilty of diversion through a fair process, an involuntary taper should not be permitted. And even if a prisoner *is* found guilty of diversion, the Intervention Team must make every effort to maintain that person on his medication *prior* to considering a taper—and such efforts must be documented in writing and discussed with the patient.

v. Further amend the OST Guidelines to clarify that medication decisions must be driven by medical need and clinical criteria. In rare cases where the potential for diversion represents an unmanageable health risk, it must be clear and well-documented why the threat of diversion cannot be managed by the institution in this individual case.

vi. Investigate each of the cases outlined Schedule B, as well as any others from the last 12 months that follow a similar pattern. Evaluate, using appropriate standards of evidence and procedural fairness as outlined above, whether diversion accusations can be substantiated. If not, medication should be resumed immediately. And if so, the physician should review the case in consultation with the patient and Intervention Team and determine—based on medical appropriateness—what alternatives to involuntary taper are available.

Thank you for your consideration. We await your written reply. As mentioned above, due to the urgency of this matter, we look forward to hearing from you within two weeks about how CSC plans to address our concerns, and we will advise our clients to pursue legal action if these concerns are not addressed.

Yours truly,

PRISONERS' LEGAL SERVICES

Nicole Kief
Legal Advocate