September 17, 2026

Talal Dakalbab
Commissioner, Correctional Services Canada

Marie Doyle
Assistant Commissioner, Health Services, Correctional Services Canada

Louis Dumulon
A/Assistant Commissioner, Health Services, Correctional Services Canada

Dear Commissioner Dakalbab, Assistant Commissioner Doyle, and Acting Assistant Commissioner Dumulon:

RE: Removal of Medications from National Formulary

We write to express alarm at CSC's decision to remove a number of medications commonly used to treat depression, Attention Deficit Hyperactivity Disorder (ADHD), and other conditions from its National Formulary (Formulary)[1] without any meaningful consultation with patients,

[1] Correctional Service Canada, "Updates for Certain Depression and Attention Deficit Hyperactivity Deficit (ADHD) Medications" (March 2026).

external subject-matter experts, or civil society organizations serving people in federal prisons and without an adequate evidentiary basis for doing so.

These are across-the-board restrictions affecting all patients, being implemented without any consideration of individualized need or how patients have been benefitting from their medication. This approach is contrary to principles of person-centered care and will further erode the already mistrustful relationships between many incarcerated people and their health providers.

It is also contrary to Canada's commitments to reconciliation with Indigenous Peoples. Indigenous people, and Indigenous women in particular, are grossly overrepresented in federal custody, meaning these restrictions are likely to fall disproportionately on them. The Truth and Reconciliation Commission's Call to Action 18 calls on governments to recognize and implement the healthcare rights of Indigenous people, and Call to Action 19 calls for measurable action to close health outcome gaps between Indigenous and non-Indigenous people, including specifically on mental health and addictions. Restricting access to evidence-based mental health and addictions treatment in a setting where Indigenous people, and Indigenous women, are so significantly overrepresented runs directly counter to these commitments. Due diligence is plainly absent here.

We urge CSC to change course, as outlined below.

Previous Formulary Changes – Delisting of Suboxone

In February 2026, many of our organizations wrote to express concern about changes to the provision of Opioid Agonist Treatment (OAT) for individuals living with Opioid Use Disorder (OUD) — specifically, the delisting of Suboxone (a daily tablet) from the Formulary and the forced transition of hundreds of patients to Sublocade (a monthly injection). These concerns were based on conversations with incarcerated people across Canada, who repeatedly reported being abruptly switched without warning, explanation, or opportunity to consult with their prescribers. Many reported a variety of painful and debilitating side effects, and described feeling that their bodily autonomy had been violated.

More than 150 addictions medicine experts, including clinicians and researchers, also shared their concerns in a letter dated December 15, 2025 that the change was not evidence-based or in line with best practices in addictions medicine. These letters are attached for reference.

Despite this broad-based request to pause and consult, CSC declined to change course, and data shows that participation in the OAT program has dropped dramatically.[2] In the midst of a

[2] According to CSC's "Opioid Agonist Treatment: March 2026" report, there were only 2,565 people on OAT across all institutions, compared to 3,443 one year prior (March of 2025).

fatal overdose crisis and toxic drug supply — which disproportionately impacts people in prison — this is not the direction CSC should be going.[3]

New Formulary Changes – Delisting of Common Depression and ADHD medications

In March 2026, we were made aware that bupropion, used to treat Major Depressive Disorder, among other things, would be removed from the Formulary as of May 1, 2026. We were also made aware that, beginning October 1, 2026, immediate-release psychostimulants used to treat ADHD (Ritalin and Dexadrine) would also be removed, and that long-acting psychostimulants (Foquest and Vyvanse) would be restricted to patients with a confirmed ADHD diagnosis and involve "regular follow-up with health care providers".

None of our organizations were consulted about these changes, and we are not aware of any consultation processes involving patients or external subject-matter experts.

Bupropion, which also goes by the brand name Wellbutrin, is commonly used alone or in combination with other medications for the management of depression, smoking cessation, obesity, ADHD and stimulant use disorder. The Canadian Network for Mood and Anxiety Treatments recommends bupropion as a first-line treatment for depression,[4] and it is the optimal treatment for some patients. It is particularly favourable for individuals experiencing challenges with weight management, fatigue, cognitive difficulties, and those with inadequate response to other medications.

Current Canadian guidelines on smoking cessation also recommend bupropion as an effective, evidence-based option. There is also evidence that bupropion is associated with a reduction in amphetamine-type stimulant cravings.[5] And while evidence on the use of bupropion to treat ADHD is evolving, it indicates possible benefit.[6]

Some of our organizations have received phone calls from distressed patients who have had or will have the medication they rely on discontinued. We have heard reports about patients having their bupropion discontinued without a taper, without the opportunity to transition to a different medication, and without any information about what side effects to expect. As with Suboxone, these discontinuations did not consider whether the patient was benefitting from the medication, whether other alternatives existed to treat their conditions, or the impact on the patient of this change.

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[3] The burden of drug overdose deaths among correctional populations: implications for interventions. Benedikt Fischer, Elnaz Moghimi and John Weekes. CMAJ December 16, 2024 196 (43) E1414-E1416.

[4] Lam RW, Kennedy SH, Adams C, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2023 Update on Clinical Guidelines for Management of Major Depressive Disorder in Adults. *The Canadian Journal of Psychiatry*. 2024;69(9):641-687.

[5] Bakouni H (2023). Bupropion for treatment of amphetamine-type stimulant use disorder: A systematic review and meta-analysis of placebo-controlled randomized clinical trials. Drug and Alcohol Drug Dependence 253(1).

[6] Verbeeck W (2017). Buproprion for attention deficit hyperactivity disorder (ADHD) in adults. Cochrane Database Systematic Reviews.10: CD009504.

This is not patient-centered or trauma-informed care. Nor is it community-equivalent care, which CSC is statutorily obligated to provide under s. 86 of the *Corrections and Conditional Release Act*.

For individuals who have been stable on a medication, discontinuation often leads to significant destabilization and recurrence of the symptoms for which it was initially prescribed. This can have a particularly harsh impact on incarcerated people, who are often subject to punitive measures for displaying dysregulated behaviour, such as an increase in security classification, disciplinary charges, placement in the Structured Intervention Unit, conflict with other incarcerated people and/or staff, loss of employment, loss of family visits, or other consequences. Discontinuing a stable antidepressant can have especially serious consequences, including suicide or overdose.

While some patients may find suitable alternatives, others will not. And even for those who eventually become stabilized on another medication, the often lengthy and discouraging process of trial and error can itself cause harm — particularly in a prison setting where conditions are often harsh and not conducive to mental wellbeing.

Lack of Transparency or Evidentiary Basis

The information CSC has provided to patients and stakeholders about the reasons for these new Formulary changes falls dramatically short of what is required to justify decisions of this magnitude, particularly given the context of documented power imbalances between CSC staff and those who are incarcerated.[7]

We have reviewed CSC's March 2026 document entitled "Correctional Service Canada: Updates for Certain Depression and Attention Deficit Hyperactivity Deficit (ADHD) Medications", which states that the delisting of bupropion was "based on a review of relevant clinical guidelines and safety considerations". This is not an explanation; it is a conclusion. No detail was included about the review, such as what evidence or clinical guidelines were relied upon, what the review found, who conducted it, or if any conflicts of interests were considered. Patients and stakeholders are expected to trust that this process was rigorous and evidence-based, without information that would allow that claim to be tested or verified.

The document similarly states that changes to the availability of psychostimulants was "informed by a review of clinical evidence and guidelines for diagnosing and treating adult ADHD", but again, this is a bare assertion, not a rationale. The same fundamental questions go unanswered.

We have heard repeatedly from incarcerated people about the difficulties they face getting assessments for conditions like ADHD and PTSD in federal custody, so the restriction of certain

[7] See for instance research summarized in Stevens, L., & Schultz, W. J. (2024). Canadian correctional officers, institutionalization, and the social impacts of prison work. *Incarceration: An International Journal of Imprisonment, Detention and Coercive Confinement*, *5*.

medications to people with a diagnosis raises serious additional concerns. It is unacceptable to condition access to necessary medication on a diagnostic process that CSC itself has failed to make reasonably accessible.

We have not received any details about whether CSC is tracking or will track the outcomes and impacts of these changes on patient health, institutional incidents, overdose rates, patient-physician relationships or other indicators, and if so whether that information will be publicly available. This is a significant and troubling gap. CSC cannot respond to legitimate concerns about the impact of its own policy changes, nor demonstrate that those changes have not caused harm, without collecting and reporting this data.

This gap is compounded by the absence of any indication that CSC is collecting or reporting distinctions-based, sex- and gender-disaggregated data on the impacts of these Formulary changes. Without this data, CSC cannot know, and cannot tell us, how these changes are affecting Indigenous people, women, gender-diverse people, or other distinct populations who may be disproportionately impacted. Given the well-documented overrepresentation of Indigenous people, and Indigenous women in particular, in federal custody, this is not a minor omission — it is a fundamental failure to understand who may be harmed by CSC's own decisions.

Security Considerations Dictating Care

We are aware that CSC considers the medications being de-listed to be medications that are commonly shared without authorization among incarcerated people (what CSC refers to as "diversion"). However, CSC has never shared any documentation or data to demonstrate the existence or features of this phenomenon, and it is unclear what information, if any, exists beyond rumour, anecdote, and conjecture.

Specifically, CSC has provided no information about how often medication sharing is occurring, who is sharing medication, why they are doing so, what specifically is being shared, whether people who give away their medication also sometimes take it as intended (and whether they benefit from it), who is receiving the medication and why, or any other information that would actually define the problem to be solved.

Without this information, it is impossible to know whether the concerns driving these Formulary changes reflect the behaviour of a small number of patients or a widespread pattern; whether sharing is happening out of necessity, coercion, generosity, or something else entirely; or which medications are actually implicated. Responding to this uncertainty by delisting medications for every patient in the federal system, regardless of their individual circumstances, history, or clinical needs, is a blunt and disproportionate response to a problem CSC has not even clearly defined. It punishes the entire patient population for the alleged conduct of a subset whose size, motivations, and impact remain entirely unknown.

Nor has CSC explained why they believe removing these medications from the Formulary will reduce diversion. Indeed, it could simply increase diversion of other medications or drive people to unregulated drugs that are more toxic or dangerous.

Notably, medication sharing is not a phenomenon unique to correctional settings. Existing research indicates that sharing and borrowing of prescription medication is common in the general population as well, with reported prevalence varying widely depending on the country and medication in question.[8] CSC has not explained why medication sharing in a correctional context warrants a categorically different, more restrictive response than it does elsewhere.

Perhaps most critically, CSC has not offered any information or evidence about the relationship, if any, between unauthorized medication sharing and adverse outcomes on an aggregate level. If there is evidence that prescription medication sharing is driving overdose deaths or institutional violence, for instance, CSC has not shared or cited it. There are in fact a variety of reasons medication sharing could *reduce* harmful outcomes, including reducing reliance on toxic unregulated drugs and/or helping people manage withdrawal, pain or other symptoms that lead to distress, anger, conflict, and violence.

Further, any potential benefit of delisting medications must be weighed against the negative impacts on people who were taking and benefitting from these medications.

We understand CSC conducted a clinical review of OAT administration prior to delisting Suboxone, but despite repeated inquiries we have not been able to obtain any information about what the review entailed or its findings. We have received even less information on the rationale or evidence base for these other Formulary changes.

CSC's approach suggests that these Formulary changes are driven primarily by institutional security concerns rather than the health and well-being of patients. This is a false dichotomy. The health and well-being of incarcerated people is not at odds with institutional safety and security — it is foundational to it. People who have access to the medication and care they need are better able to manage their mental health, regulate their emotions, and engage meaningfully with daily life — all of which reduce the likelihood of the kinds of distress and conflict that leads to institutional incidents in the first place. Many people who are incarcerated are also trauma survivors, and behaviour that CSC may interpret as a security concern is often a trauma response or a symptom of an unmanaged mental health condition. Effective, individualized care addresses the root cause of that behaviour; abruptly removing it does not.

It is unacceptable that CSC is allowing vague, unexplained security concerns to override sound medical judgment and dictate health policy, compromising patient care in the process. This is inappropriate and a fundamental breach of the principles of healthcare independence, and

[8] See for instance Dawson S, Johnson H, Huntley AL, Turner KM, McCahon D. Understanding non-recreational prescription medication-sharing behaviours: a systematic review. Br J Gen Pract. 2024 Feb 29;74(740):e183-e188 and Song S, Kim S, Shin S, Lee Y and Lee E (2022) Evaluation of Prescription Medication Sharing Among Adults in South Korea: A Cross-Sectional Survey. Front. Pharmacol. 13:773454.

appears to have no basis in evidence. By prioritizing narrow security considerations over sound medical care, CSC risks undermining the very safety and security it seeks to protect.

Inconsistency with Standards and Guidelines

CSC's recent Formulary changes run counter to the principles outlined in recent standards and guidelines involving CSC.

For instance, CSC partnered with the Health Services Organization to develop new Correctional Health Services Standards, which were released in 2024 and will be used for CSC's next accreditation.[9] These Standards speak extensively to the concept of *individualized* care plans, which are not possible when common treatments are simply eliminated in a "one-size-fits-all" approach that does not consider the impact on or needs of individual patients.

We are aware there is a process for prescribers to make non-formulary requests for individual patients, but CSC records demonstrate these are mostly not approved. Indeed, two-thirds of the requests made by physicians for patients to remain on Suboxone since its de-listing in October 2025 have been denied.[10] In addition, there is no transparency around this process for patients, who do not receive a copy of the request, the decision, or the decision-making criteria.

The Correctional Health Services Standards are also unequivocal in their assertion that people in custody have the right to:

- Make decisions about what happens to their body *(HSO 1.1.13)*
- Make informed decisions about their care and provide consent *(HSO 1.1.1)*
- Be engaged to participate in their care — throughout their care *(HSO 1.1.3)*
- Have their decisions about their care respected, acknowledging the client is an expert in their own needs *(HSO 1.1.4)*

The Standards also state that CSC organizational leaders and teams respect, promote, and protect the distinct rights of First Nations, Inuit, and Métis Peoples (HSO 2.1).

CSC has also confirmed its commitments to patient-centered care in a variety of forums, including in its 2022 to 2023 Departmental Plan.

Further, in June 2026, the Mental Health Commission of Canada (MHCC) released *Finding New Pathways: An action plan for criminal justice and mental health in Canada*.[11] This action plan

[9] *HSO Correctional Health Services Standards, 2024*
[10] See CSC "Sublocade Bi-Weekly Updates – March 31, 2026", which indicates that from October 16, 2025 to March 30, 2026, CSC physicians made 28 non-formulary requests for Suboxone and only 9 were approved.
[11] Mental Health Commission of Canada, *Finding New Pathways: An action plan for criminal justice and mental health in Canada* (2026). Online: https://mentalhealthcommission.ca/wp-content/uploads/2026/05/National_Action_Plan.pdf.

highlights the need for care that is evidence-based, patient-centered, and recovery-oriented. It also calls for primary mental health care in prison to include "Individualized treatment plans that address people's unique needs". Again, CSC's Formulary changes are not in line with these principles.

The MHCC action plan also calls for prison healthcare to be transferred from correctional ministries to ministries responsible for health, and for prison health providers to act in full clinical independence. This aligns with the requirements of the United Nations *Standard Minimum Rules for the Treatment of Prisoners* (the *Nelson Mandela Rules*), which are also incorporated into the Correctional Health Services Standards. However, health services for people in custody are not provided independently of CSC and, as described above, the decision to remove medications from the Formulary appears to reflect the enmeshment of correctional priorities and healthcare decision-making in a way that compromises patient care.

Our Asks

We collectively call on CSC to:

1. Immediately pause any further changes to the National Formulary and restore the medications that have been removed pending a comprehensive review of the recent changes.

2. Undertake a comprehensive review, in collaboration with external experts, of the de-listing of Suboxone and bupropion, and the proposed changes to the availability of Ritalin, Dexadrine, Foquest, and Vyvanse. The review should include an analysis of the impact of these changes on patient health, patient-physician relationships, patient satisfaction, overdose incidents, institutional violence, and other relevant indicators. The results must be shared with stakeholders, including the signatories to this letter.

3. Initiate meaningful consultations with stakeholders regarding these changes to the Formulary, including and especially broad engagement with incarcerated and formerly incarcerated people living with Opioid Use Disorder, depression, ADHD, PTSD, or other relevant conditions.

4. Provide the organizations listed below with clarity on how CSC arrived at the decision to proceed with these Formulary changes and how the changes are being implemented, including:

    a. any research CSC relied on to support the delisting of bupropion and changes to ADHD medications (we are aware of the research CSC has cited related to OAT, though we do not agree that it supports the delisting of Suboxone);

b. detailed information about any clinical or other internal reviews undertaken by CSC to inform the Formulary changes, including what specific information was considered and what the review(s) concluded;

c. details about the internal consultation and decision-making processes that led to these Formulary changes, including the involvement of or considerations raised by non-Health Services CSC staff;

d. details of any consultations CSC did with patients or external subject-matter experts, researchers, or clinicians prior to these changes;

e. details about the non-formulary request process, including the decision-making criteria for Suboxone, bupropion, Ritalin, Dexadrine, Foquest and Vyvanse, and clarification about whether all of these medications are eligible for a non-formulary request;

f. information about the availability of ADHD assessments for people in custody without a confirmed diagnosis, especially those currently on Vyvanse and Foquest;

g. details about any outcomes CSC is tracking or plans to track in relation to these changes, and whether the results will be shared publicly; and

h. clarification on what role concerns about unauthorized medication sharing played in the Formulary changes, the details of those concerns, and what if any information CSC has about the relationship between prescription medication diversion and overdoses, institutional violence, or other patient or institutional safety concerns.

Finally, we call on CSC to fully separate healthcare decision-making from operational interests by pursuing the transition of health services for people in federal custody to the Ministry of Health and/or provincial health authorities, in line with the UN *Mandela Rules* and the MHCC Action Plan.

Thank you for your consideration.

Sincerely,

Aboriginal Legal Services

ARCH Disability Law Centre

Canadian Association of Elizabeth Fry Societies

Canadian Civil Liberties Association

Canadian Mental Health Association

Dalhousie University Health Justice Institute

East Coast Prison Justice Society

HIV Legal Network

Native Women's Association of Canada

PATH (People's Advocacy and Transformational Hub)

PASAN

Prison Health Research Council

Prisoners' Legal Services

Queen's Prison Law Clinic

St. Leonard's Society of Canada

St. Michael's Hospital's Family Health Team's Health Justice Program

The John Howard Society of Canada

The Salvation Army St. Catharines Booth Centre Community Residential Facility

Tracking (In)Justice

University of Manitoba Community Law Centre - Prison Law Clinic

Dr. Jennifer Wyman, Clinical Programs Lead, META:PHI

Art Rasmusson, Past President of the Ontario Halfway House Association

cc: The Hon. Gary Anandasangaree, Minister of Public Safety
The Hon. Marjorie Michel, Minister of Health
Valerie Phillips, Interim Correctional Investigator, Correctional Investigator of Canada
Charlotte-Anne Malischewski, Chief Commissioner, Canadian Human Rights Commission
The Hon. Kim Pate, Senator
The Hon. Yvonne Boyer, Senator
The Hon. Dr. Wanda Thomas Bernard, Senator
The Hon. Bernadette Clement, Senator
Jenny Kwan, MP
Gord Johns, MP