



FRACTURED CARE:

PUBLIC HEALTH OPPORTUNITIES IN
ONTARIO'S CORRECTIONAL INSTITUTIONS



JohnHoward
SOCIETY OF ONTARIO

ABOUT THE JOHN HOWARD SOCIETY OF ONTARIO

The John Howard Society of Ontario (JHSO) is a leading criminal justice organization advancing the mandate, “effective, just and humane responses to crime and its causes.” We work towards our mission through the delivery of services to those in conflict with the law and at-risk, both adult and youth, provided by our 19 local offices who are active in communities across the province. In 2003, JHSO’s provincial office established its Centre of Research, Policy & Program Development (the Centre) to contribute to the evidence-based literature and policy discourse in order to further advance our mandate.

Local John Howard Society (JHS) offices provide services in a broad continuum of care from prevention through aftercare. Programming is sensitive to and reflective of the unique needs of the community it serves. JHS is often the first point of contact for programs and services for people who have mental health issues and who are justice-involved. JHS has a reputation for providing services that are accessible, welcoming, and safe for those who have experienced the criminal justice system.

JHS staff conduct assessments to identify individual strengths, needs and risk factors. Evidence-based services target the criminogenic risks and needs and the social determinants of health to ensure that the services are responsive to the specific client and his/her circumstances. When a person has mental health issues, staff adjust their case management approach in order to ensure that service delivery targeting identified criminogenic factors is responsive to and addresses a person’s mental health needs. JHS services aim to reduce the risk of criminal behaviour while building on an individual’s strengths. Our offices maintain an open-door policy offering long-term follow-up to clients who have accessed services.

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INTRODUCTION

We are facing a growing health crisis in Ontario's correctional institutions,¹ and this crisis extends far beyond institutional walls. People incarcerated in provincial correctional institutions are returning to our communities – often after a short stay² – with unmanaged physical and mental health conditions. Beyond the ethical and legal obligations to provide adequate health care in correctional institutions,^{3,4,5,6} the health of incarcerated individuals is an intrinsic component of the health of communities; with the vast majority of people in our correctional institutions returning to our neighbourhoods sooner rather than later. The provision of health care in provincial correctional institutions is therefore a matter of vested interest for all Ontarians and for the protection of Ontario's health care system as a whole.

The aim of this paper is to start a discussion about the administration of health services in Ontario's correctional institutions. It will highlight both the challenges of the current model as well as some of the policy reforms required to address those challenges. This paper will also clarify how these challenges are also opportunities to strengthen both the health of the public and the health care system. Other jurisdictions have adopted an integrated approach to health services in correctional institutions, and Ontario will benefit greatly by adopting a similar approach. This paper strengthens the case for health care services in Ontario's correctional institutions to integrate with Ontario's larger provincial health care system.

¹ For the purposes of this paper the term 'correctional institution' represents all correctional centres, detention centres, jails, and treatment centres under the operation of the Ministry of Community Safety & Correctional Services of Ontario.

² 75.5% of people sentenced to provincial custody in Ontario serve a sentence of 3 months or less. Source: Ministry of Community Safety and Correctional Services' 2014-2015 Adult Profile. 2015. Source: Email correspondence from MCSCS. [MCSCS 2015].

³ Canada Health Act (R.S.C., 1985, c. C-6).

⁴ Corrections and Conditional Release Act (S.C. 1992, c. 20).

⁵ UN General Assembly, Basic Principles for the Treatment of Prisoners : resolution / adopted by the General Assembly, 28 March 1991, A/RES/45/111. Retrieved from: <http://www.un.org/documents/ga/res/45/a45r111.htm>

⁶ Lines, R. "From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons." *International Journal of Prisoner Health*. 2(4) (2006): 269-280.

ONTARIO'S CORRECTIONAL HEALTH CARE SYSTEM: A BRIEF OVERVIEW

The *Canada Health Act* (CHA)⁷ sets out the criteria provinces and territories must meet in order to receive funding through transfer payments from the federal government.⁸ The CHA promotes the primary objective of Canadian health care policy, which is “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.”⁹ This objective does not apply to individuals who are incarcerated in federal facilities, where individuals serve sentences of two years or more.¹⁰ However, this objective does apply to those who are held in provincial correctional institutions, more specifically, those who are detained before a bail hearing or trial (on remand) or serving sentences of less than two years.¹¹

The province's responsibilities in providing health services under the CHA apply equally to those in provincial correctional institutions as they do to those living in communities.¹² In other words, the CHA does not mandate that health services in correctional facilities are to be delivered differently or by a different provincial body than the health services for people living outside of correctional institutions. However, in Ontario the delivery of health services in provincial correctional institutions is bifurcated from the rest of the provincial health care system. Currently, while the provision of health care for individuals not living in correctional facilities falls under the responsibility of the Ministry of Health and Long Term Care (MOHLTC), the provision of health care in provincial correctional institutions falls under the responsibility of the Ministry of Community Safety and Correctional

⁷ *Canada Health Act* (R.S.C., 1985, c. C-6).

⁸ The criteria under the *Canada Health Act* which provinces must meet in order to receive transfer payments include— but are not limited to — the following: public administration, comprehensiveness, universality, portability, and accessibility.

⁹ *Canada Health Act* (R.S.C., 1985, c. C-6, s. 3.).

¹⁰ The *Canada Health Act* (R.S.C., 1985, c. C-6, s.2) excludes “a person serving a term of imprisonment in a penitentiary” as an insured person. Moreover, the *Corrections and Conditional Release Act* (S.C. 1992, c. 20, s.2) defines a penitentiary as any facility or land that is operated by the Correctional Service of Canada. The administration and standards of health care for individuals incarcerated in federal correctional institutions is the responsibility of the Correctional Service of Canada, which is regulated by the *Corrections and Conditional Release Act*.

¹¹ Mental Health Strategy for Corrections in Canada: A Federal-Provincial-Territorial Partnership. 2012. Accessed 04/04/2016 at: <http://www.csc-scc.gc.ca/health/092/MH-strategy-eng.pdf>

¹² *Ibid.*

Services (MCSCS).¹³ The *Ministry of Correctional Services Act*¹⁴ stipulates that the Superintendent of each provincial correctional institution is responsible for the management of health care in their respective institution, ensuring access to health care professionals where applicable. Designating Superintendents at each institution the responsibility of managing the health of incarcerated individuals creates a unique set of difficulties.

There are exceptional challenges associated with providing health services in correctional institutions. Security concerns, staffing limitations, and the large number of individuals caught in the proverbial revolving door of pre-trial detention¹⁵ impede efficient access to quality health care. The challenges are further compounded by the administrative requirements for Superintendents to maintain a parallel health care system. For example, since MCSCS is responsible for the health care provided in provincial correctional institutions - instead of MOHLTC - the health care system in Ontario's correctional institutions lacks the human resource pool, service planning experience and expertise, and integrated vision that drives the rest of the health care system.

There are three key issues underlying the current state of health care in Ontario's correctional institutions:

1. Incarcerated populations have a higher prevalence of acute and chronic health conditions compared to the general population;
2. Health care services in provincial correctional facilities are delivered by a parallel yet unequal health system;
3. The cyclical movement of staff, visitors, and incarcerated populations continuously entering and exiting correctional institutions has serious implications for public health.

Several jurisdictions around the world, including two in Canada, have begun to resolve these issues by integrating health care services in correctional institutions under their respective ministries of health.¹⁶ This paper will provide a brief overview of these key issues and discuss how integrating health care in correctional institutions with the rest of the Ontario health care system is an opportunity for both MOHLTC and MCSCS to further their goals in effective health care and service to all Ontarians.

¹³ Ministry of Correctional Services Act R.R.O. 1990, REGULATION 778

¹⁴ *Ibid.*

¹⁵ The Canadian Civil Liberties Association. Set Up to Fail: Bail and the revolving door of pre-trial detention. Published July 2014 Retrieved from: https://ccla.org/dev/v5/doc/CCLA_set_up_to_fail.pdf

¹⁶ Hayton P, Boyington J. "Prisons and health reforms in England and Wales." *Am J Public Health*. 96 (2006):1730-1733. [Hayton 2006]

KEY CHALLENGES

1. INCARCERATED POPULATIONS HAVE A HIGHER PREVALENCE OF ACUTE AND CHRONIC HEALTH NEEDS

There is limited health data available on persons in Canadian correctional institutions, and even less data specific to Ontario.¹⁷ However, international data shows that incarcerated populations have significantly higher rates of acute and chronic physical and mental health conditions compared to the general population.¹⁸ That incarcerated populations in Canada also experience poorer health outcomes is reflected in research findings¹⁹ and in the reports of the Canadian Correctional Investigator.²⁰

Marginalized populations face a multitude of barriers to accessing health services in our communities, and those entering correctional institutions are

more likely to have undiagnosed or unmanaged health conditions. Factors such as economic and social disadvantage, unstable housing, addiction, and mental health conditions not only make individuals more likely to come in contact with police and the criminal justice system,²¹ but also have a direct impact on health outcomes and access to health services.²² Incarcerated populations reflect a disturbing overrepresentation of those with mental health issues,^{23,24} those with a history of sexual and/or physical abuse,²⁵ and individuals with addiction and substance

¹⁷ For reviews of Canadian data see Kouyoumdjian FG, Schuler A, Hwang SW, et al. "Research on the health of people who experience detention or incarceration in Canada: a scoping review." *BMC public health*. 15 (2015):419; and Kouyoumdjian, Fiona, et al. "Health status of prisoners in Canada Narrative review." *Canadian Family Physician* 62(3) (2016): 215-222.

¹⁸ Fazel, Seena and Jacques Baillargeon. "The Health of Prisoners." *The Lancet*. 2011; 377 (9769):956-965.

¹⁹ Robert D. "Understanding health care utilization in custody: situation of Canadian penitentiaries." *J Correct Health Care* 10 (2004): 239-56. [Robert 2004]

²⁰ Sapers, H. Annual report of the Office of the Correctional Investigator 2013–2014. Ottawa, Ontario: The Correctional Investigator of Canada. Published June 27 2014 Retrieved from: <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf> [Sapers 2014]

²¹ Hartford, K., Heslop L., Stitt L., and J. S. Hoch. "Design of an algorithm to identify persons with mental illness in a police administrative database." *International Journal of Law and Psychiatry*. 28 (2005): 1–11.

²² Mikkonen, J., & Raphael, D. *Social Determinants of Health: The Canadian Facts*. Toronto, Canada: York University School of Health Policy and Management. Published May 2010.

²³ The John Howard Society of Ontario. Unlocking Change: Decriminalizing Mental Health issues in Ontario. 2015. Retrieved from: <http://www.johnhoward.on.ca/wp-content/uploads/2015/07/Unlocking-Change-Final-August-2015.pdf>

²⁴ Chaimowitz, G. "The Criminalization of People With Mental Illness: A Canadian Psychiatric Association Position Paper." *The Canadian Journal of Psychiatry*. 57(2) (2012): 1-6. Retrieved from: <http://publications.cpa-apc.org/media.php?mid=1268>

²⁵ Dirks, D. "Sexual revictimization and retraumatization of women in prison." *Women's Studies Quarterly* 32 (2004): 102-115.

use issues.^{26,27} A recent study in an Ontario correctional institution found that 32.2% of incarcerated individuals did not have access to primary care providers 12 months prior to their incarceration, compared to the general rate in Canada of only 15%.²⁸ Studies in

the U.S. found that 80% of incarcerated individuals with a chronic physical health condition had not received routine medical care before their incarceration, and were instead likely to have used Emergency Departments as their source of primary health care.²⁹

BY THE NUMBERS

IN CANADIAN CORRECTIONAL INSTITUTIONS:

- The rate of **HEPATITIS C** is **28%** compared to **0.8%** in the general population.
- The rate of **HIV** is **1.2%**, which is **7-10** times higher than the Canadian population.
- The rate of **MENTAL HEALTH ISSUES** are **2-3** times more common than in the general population.
- Individuals **DIE OF NATURAL CAUSES** **15** years younger than people living in communities.

Sources:

- Public Health Agency of Canada *Hepatitis C in Canada: 2005-2010 Surveillance Report*. 2013-04-03 Accessed 11/08/2015 at http://publications.gc.ca/collections/collection_2012/aspc-phac/HP40-70-2012-eng.pdf
- Sapers 2014, *supra* note 20 at 4

²⁶ Sapers 2014, *supra* note 20.

²⁷ The National Centre on Addiction and Substance Abuse at Columbia University. Behind Bars II: Substance Abuse and Prison Population. Published February 2010. Retrieved from: <http://www.casacolumbia.org/addiction-research/reports/substance-abuse-prison-system-2010>

²⁸ Green, Samantha, Jessica Foran, and Fiona G. Kouyoumdjian. "Access to primary care in adults in a provincial correctional facility in Ontario." BMC research notes 9(1) (2016): 1.

²⁹ Greifinger, R. B. (2007). "Thirty years since *Estelle v. Gamble*: Looking forward, not wayward." In R. B. Greifinger, J. Bick, & J. Goldenson (Eds.), *Public health behind bars: From prisons to communities* (pp. 1–10). Dobbs Ferry: Springer [Greifinger 2007]

BY THE NUMBERS:

PREVALENCE OF ILLNESS AND INJURY FOR FEDERALLY-SENTENCED MEN

- **80%** have a serious **SUBSTANCE ABUSE** problem
- Over **16%** are diagnosed with **LATENT TUBERCULOSIS**
- Over **6%** are living with **DIABETES**
- **20%** have **CARDIOVASCULAR** conditions
- **15%** have a **RESPIRATORY** condition
- Over **6%** have **UROLOGICAL** conditions
- Over **34%** have a **HEAD INJURY**
- Over **64%** are **OVERWEIGHT** or **OBESE**
- Over **19%** have **BACK PAIN**
- **14%** have **ASTHMA**
- Over **8%** have **HYPERTENSION**
- Over **8%** have **ARTHRITIS**

Sources:

- *Sapers 2014, supra note 20*
- *Stewart L.A., Nolan A, Sapers J, Power J, Panaro L, Smith J. Chronic health conditions in inmates. CMAJ Open 2015;3:E97–102*

Not only are incarcerated persons more likely to have unmet health needs, but the conditions of correctional institutions themselves have a negative impact on the health of incarcerated persons. Overcrowding has become a chronic issue in Ontario's correctional institutions.^{30,31,32} Double-bunking, where two people share a cell meant for only one person, has become the norm. This practice has been shown to promote violence^{33,34} which beyond causing acute injury can also lead to post-traumatic stress disorder (PTSD)³⁵ and traumatic brain injury (TBI).³⁶ This overcrowded environment is also conducive to the transmission of communicable conditions such as Methicillin-Resistant Staphylococcus Aureus (MRSA). MRSA is a drug-resistant bacteria which is easily spread among individuals living in close quarters, and represents an ongoing public health concern in hospital and community health settings.³⁷ In sum, men and women in correctional institutions are

more likely to have poorer health upon entering facilities, and the carceral environment itself exposes them to additional risks and poorer health outcomes.

The complex health care needs of Ontario's incarcerated populations show not only an urgent need for reform, but an opportunity to realize improved public health and health resource management. Through prevention, screening, early intervention, management and treatment programs there is an opportunity to bring hard-to-reach populations who are temporarily housed in correctional institutions into the health care system. This will not only improve individual and public health outcomes, but also foster stability and sustainability in the health care system through early intervention and increasing access to primary health care services in place of acute episodic intervention.

³⁰ Sapers 2014, *supra* note 20.

³¹ Office of the Auditor General of Canada. 2014 Spring Report of the Auditor General of Canada. Ottawa Ontario Published 2014. Retrieved from: http://www.oag-bvg.gc.ca/internet/English/parl_oag_201405_04_e_39335.html#hd5b

³² The Canadian Press. Nearly half of Ontario's jails are overcrowded. CBC News. July 28, 2013. Retrieved from: <http://www.cbc.ca/news/canada/toronto/nearly-half-of-ontario-s-jails-are-overcrowded-1.1358212>

³³ Stone L. Conservatives 'won't be afraid' to double-bunk in Canada's prisons. Global News. May 6 2014. Retrieved from: <http://globalnews.ca/news/1314497/conservatives-wont-be-afraid-to-double-bunk-in-canadas-prisons/>

³⁴ Russel, A. & Cain, P. Rough justice: The human cost of Ontario's crowded, violent jails. Global News, November 19, 2014. Retrieved from: <http://globalnews.ca/news/1676765/rough-justice-the-human-cost-of-ontarios-crowded-violent-jails/>

³⁵ Anderson RE, Geler T, Cahill SP. "Epidemiological associations between posttraumatic stress disorder and incarceration in the National Survey of American Life." *Criminal Behaviour and Mental Health*. (2015).

³⁶ John Howard Society of Ontario Factsheet: Traumatic Brain Injury and the Criminal Justice System: Impacts and Best Practices. 2014. Retrieved from: <http://www.johnhoward.on.ca/wp-content/uploads/2014/10/Fact-Sheet-29-TBI-CJS-magazine-style.pdf>

³⁷ MRSA stands for Methicillin-resistant Staphylococcus aureus. For more information please see <http://www.phac-aspc.gc.ca/id-mi/mrsa-eng.php>

2. A PARALLEL YET UNEQUAL HEALTH SYSTEM

Under the CHA there is no distinction between a person incarcerated in a provincial correctional institution and a person living in the community. The province has an equal duty to provide care to individuals living in either an institution or the community. This principle of equity is reflected not only in Canadian legislation, but also in international agreements ratified or endorsed by Canada such as the United Nations Standard Minimum Rule for the Treatment of Prisoners.^{38,39}

UNITED NATIONS BASIC PRINCIPLES FOR THE TREATMENT OF PRISONERS, PRINCIPLE 9:

“Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”

Unfortunately, both the Federal Office of the Correctional Investigator and the Ontario Ombudsman consistently report that the delivery of and access to health services in correctional institutions has

remained the primary reason incarcerated individuals file a complaint with the Investigator's office.^{40,41} The lack of human resources and the underutilization of health technologies are some of the underlying reasons why these shortcomings in delivery and access to health services in Ontario's correctional facilities exist.

LACK OF HUMAN RESOURCES

The 2014-2015 Ontario Ombudsman report noted the serious difficulties MCSCS was experiencing in retaining adequate staff for medical units in a new detention centre in Toronto.⁴² Though statistics on staffing vacancies are not available for provincial institutions, these challenges are reflected in data from federal correctional institutions. In 2013 the Federal Correctional Investigator reported a vacancy rate for all health care positions to be just over 8.5%.⁴³ Nearly one-third of all psychologist positions were reported vacant or ‘under filled’;⁴⁴ the highest vacancy rate was in Ontario with 29% of psychologist positions empty.⁴⁵

³⁸ UN General Assembly, Basic Principles for the Treatment of Prisoners : resolution / adopted by the General Assembly, 28 March 1991, A/RES/45/111. Retrieved from: <http://www.un.org/documents/ga/res/45/a45r111.htm>

³⁹ Correctional Services Canada (*Archived web content*) United Nations Standard Minimum Rules For the Treatment of Prisoners 1975. Last Modified 2015-03-05. Accessed August 11, 2015 at: <http://www.csc-scc.gc.ca/text/pblct/rht-drt/07-eng.shtml>

⁴⁰ Sapers 2014, *supra* note 20.

⁴¹ Andre Marin. Annual Report 2014-2015 of the Ontario Ombudsman. 2015.

<http://www.ombudsman.on.ca/Files/sitemedia/Documents/AR14-15-EN.pdf> [Marin 2015]

⁴² *Ibid.*

⁴³ Sapers, H. Annual report of the Office of the Correctional Investigator 2012–2013. (2013). Ottawa, Ontario: The Correctional Investigator of Canada. Retrieved from:

<http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20122013-eng.pdf>

⁴⁴ Underfilled positions were those filled by non-licensed staff unable to deliver the same range of services as a licensed psychologist.

⁴⁵ Sapers 2014, *supra* note 20.

The impact of these vacancies and under resourcing can lead to a lack of access to health care in Ontario's correctional institutions. The recently opened Toronto South Detention Centre faced difficulties surrounding the hiring and retention of health care staff, which resulted in the state-of-the-art medical units remaining closed even after the facility had become operational.⁴⁶ Without sufficient staff to open and maintain the infirmary, the facility resorted to placing patients in need of care in segregation cells.⁴⁷ This practice of isolating incarcerated persons with physical or mental health issues not only creates barriers in access to adequate medical care, but further exposes these individuals to the deleterious effects of segregation.⁴⁸ This practice is also a violation of the MCSCS policies for segregation⁴⁹ and infringes on basic human rights.^{50,51,52}

A lack of human resources in correctional institutions has also been

cited as a cause for individuals newly-admitted being denied access to their prescribed medications for weeks as they waited to be assessed by a physician.⁵³ The Ontario Ombudsman report also included several specific incidents where individuals reported they were not receiving the necessary pharmaceuticals to treat a range of conditions, including cancer and post-operative pain.⁵⁴ This dangerous practice exposes multiple populations to risk - not just the individuals in need of medication but also the rest of the incarcerated population and correctional staff - by allowing conditions to destabilize or worsen. In some cases the effects of interrupted medication can seep into the community. For instance, research has found incarceration to be associated with a non-adherence to, interruptions in, or discontinuation of highly active antiretroviral therapy (HAART) for HIV.⁵⁵ Discontinuation or interruption of HAART presents a particular risk to public health due to the

⁴⁶ Marin 2015, *supra* note 41.

⁴⁷ *Ibid*

⁴⁸ Smith, P.S. "The effects of solitary confinement on prison inmates: A brief history and review of the literature." *Crime and Justice*. 34(1) (2006): 441-528.

⁴⁹ Ministry of Community Safety and Correctional Services. Inmate Information Guide for Adult Institutions. Published March 2015 Retrieved from:

<http://www.mcscs.jus.gov.on.ca/stellent/groups/public/@mcscs/@www/@com/documents/webasset/ec168130.pdf>

⁵⁰ Dempsey, A. Ontario Review of psychiatric wait times in Jail Kept Secret. The Toronto Star. Published Jan 15 2015. Retrieved from: <http://www.thestar.com/news/canada/2015/01/15/ontario-review-of-psychiatric-wait-times-in-jail-kept-secret.html>

⁵¹ At the time of writing, the Ontario Human Rights Tribunal is reviewing the case of Jamie Simpson, who was placed in solitary confinement for more than 75 days without adequate treatment:

<http://www.thestar.com/news/insight/2015/01/23/toronto-jail-inmate-says-he-was-sent-to-solitary-for-having-hiv.html>

⁵² The Ontario Human Rights Commission. Landmark settlement addresses needs of inmates with mental health issues in Ontario Prisons. 2013. Retrieved from: http://www.ohrc.on.ca/en/news_centre/landmark-settlement-addresses-needs-inmates-mental-health-issues-ontario-prisons

⁵³ White, P. New inmates denied medicine due to drug-plan flaw: prison ombudsman.

The Globe and Mail. Published Thursday, Apr. 30, 2015. Retrieved from:

<http://www.theglobeandmail.com/news/national/processing-delays-leave-new-inmates-without-prescriptions-for-weeks/article24177961/>

⁵⁴ Marin 2015, *supra* note 41.

⁵⁵ Small, W. Wood, E. Betteridge, G., Montaner, J., Kerr T. The impact of incarceration upon adherence to HIV treatment among HIV-positive injection drug users: a qualitative study. *AIDS Care*. 21(6) (2009):708-714.

role it plays in reducing the risk of transmission.

Health care professionals such as physiotherapists, occupational therapists, and dieticians play a key role in providing effective, comprehensive care for both acute and chronic conditions. They are present in every sector of Ontario's health care system. While there is access to these health care professionals in provincial correctional institutions⁵⁶ it can be limited⁵⁷ and is often provided only for acute treatment needs. The absence or underutilization of therapeutic expertise can severely limit the treatment options available to health staff working in correctional institutions, including the treatment of some of the most common conditions such as chronic pain. Access to an interdisciplinary health care team is particularly important in a correctional institution where the availability of pharmaceutical therapies may be restricted.

Compounding this poor access to health professional is the inability of incarcerated individuals to self-care for less serious conditions. For example, they cannot purchase over-the-counter medications or make changes to their diet. As a consequence of their legal status individuals lose these opportunities to participate in

maintaining their health and wellness, and must turn to health professionals for help with many ailments.⁵⁸ As a result this population not only has a greater need for service, but a greater dependency on medical services to address their health needs.

UNDERUTILIZATION OF HEALTH TECHNOLOGIES

Another major limitation of the separate health care system in correctional institutions is the underutilization of the vital health service technologies that have been made a priority by MOHLTC. Despite the provincial government's significant efforts to support the implementation of electronic health records (EHR) across the province, MCSCS has not implemented electronic health record keeping in their provision of services in correctional institutions.⁵⁹ This has tremendous impacts on both the effectiveness of care and population health monitoring and surveillance. Without electronic records, communication regarding patient health information between correctional staff and external medical institutions is difficult and inefficient. A lack of digital health information also makes monitoring and surveying the health trends in communities with correctional institutions difficult. Since analysis and trends are not identifiable, the medical

⁵⁶ For example, the Toronto South Detention Centre included contracts for both physiotherapy and dental services in its recruitment of health care staff. See Dempsey A. Year-old superjail only now hiring medical staff for infirmary. The Toronto Star. Published on January 10, 2015. Retrieved from:

http://www.thestar.com/news/world/2015/01/10/yearold_superjail_only_now_hiring_medical_staff.html

⁵⁷ Statistics are not available for provincial facilities, however CSC employs 1400 health professionals, including 943 nurses (67%), and 390 psychologists (28%), leaving less than 5% for all other health professions, including physicians. See Sapers 2014, *supra* note 20.

⁵⁸ Robert 2004, *supra* note 19.

⁵⁹ Response to email enquiry to the Ministry received 24/07/2015.

services provided in correctional institutions continue to be delivered primarily through an ‘episodic’ or a reactive care model, rather than a proactive or primary health care approach.⁶⁰

The separation of health services in correctional settings is a serious fracture

in Ontario’s health care system where both patients and intervention opportunities are lost. Disregarding health care in correctional institutions as a key component of the health care system as a whole creates challenges in maintaining standards of care, and fosters indifference for the impact these gaps in services have on communities.

3. TRANSIENT POPULATIONS: IMPLICATIONS FOR PUBLIC HEALTH

The current conditions and health services in correctional institutions has a direct impact on public health. As previously mentioned, the vast majority of people in our provincial correctional institutions will be returning to our communities – and soon. This reality makes the health issues and conditions

in Ontario’s correctional institutions a public health concern. Each year thousands of individuals spend a short amount of time in correctional institutions and then return to our communities (i.e., remand), carrying with them the health effects of their time inside.

BY THE NUMBERS:

REMANDED (Awaiting Sentencing or Trial):

- In 2014-2015 there were **46,593** admissions to Ontario correctional institutions.⁶¹
- In 2010-2011 the median length of stay for people on **REMAND** was **7 days**.⁶²

SENTENCED:

- In 2014-2015 there were **25,256** admissions to Ontario.⁶³
- **75.5%** of people sentenced to provincial correctional institutions received a sentence of **3 MONTHS OR LESS**.⁶⁴

⁶⁰ The Ontario Ministry of Social Services and Corrections refers to it as a “Functional Model of Health Care”; however, no other information was available about the definition or attributes of a “Functional Model”. Response to email enquiry to the ministry received July 31, 2015.

⁶¹ MCSCS 2015, *supra* note 2.

⁶² Statistics Canada, Data Table for Chart 5: Median Number of Days Spent by Adults in Remand, by Province and Territory, 2009/2010 and 2010/2011 (Ottawa: StatCan, 11 Oct 2012). Retrieved from: <http://www.statcan.gc.ca/pub/85-002-x/2012001/article/11715/c-g/desc/desc05-eng.htm>

⁶³ MCSCS 2015, *supra* note 2.

⁶⁴ *Ibid.*

As noted earlier, the conditions in correctional institutions, such as overcrowding, increase the spread of communicable diseases. For instance, the prevalence of Hepatitis C Virus (HCV) in Canada's federal correctional institutions is nearly 30%,⁶⁵ and research has shown that HCV is prevalent largely due to injected drug use in correctional facilities.⁶⁶ The potential spread of communicable diseases demonstrates an urgent need for increased harm-reduction programming⁶⁷ and access to related health services⁶⁸ to prevent infections from being passed between individuals inside and beyond institutional walls.

RE-ENTRY AND COMMUNITY HEALTH

In other cases, the impacts of poor health among incarcerated populations are complex and systemic, making them more challenging to identify but no less vital to address. For example, the lack of access to health services for incarcerated individuals affects the utilization of health care resources in communities once individuals

return from correctional facilities.⁶⁹ The lack of access to health services also impacts the process of re-entry and rates of recidivism,⁷⁰ which have their own unique repercussions on community health.^{71,72}

Individuals leaving correctional institutions with health problems (physical, mental or substance use related) are more likely to face challenges to re-entering their communities. A longitudinal study across the U.S. found individuals who had health problems at the time they were released from correctional facilities were less likely to secure stable housing, be involved in raising their children, find and maintain employment, have adequate income levels, and were more likely to require public assistance programs compared to those who left correctional facilities without health problems.⁷³ A two pronged approach which addresses health needs in correctional institutions and transition care to community services upon release will support the re-entry process, and

⁶⁵ Public Health Agency of Canada Hepatitis C in Canada: 2005-2010 Surveillance Report. 2013. Retrieved from:

http://publications.gc.ca/collections/collection_2012/aspc-phac/HP40-70-2012-eng.pdf

⁶⁶ Snow KJ, Younge JT, Preen DB, Lennox NG, Kinner SA. "Incidence and correlates of hepatitis C virus infection in a large cohort of prisoners who have injected drugs." *BMC Public Health* 14 (2014): 830b. [Snow et al 2014]

⁶⁷ John Howard Society of Ontario. Harm reduction and prisoners: mitigating risk and improving health. Fact Sheet 28. 2009. Retrieved from: <http://www.johnhoward.on.ca/wp-content/uploads/2014/09/facts-25-harm-reduction-and-prisoners-mitigating-risk-and-improving-health-march-2009.pdf> and Sapers 2014, *supra* note 20 at 4.

⁶⁸ Snow et al 2014, *supra* note 66.

⁶⁹ Wohl, David A., et al. "Intensive case management before and after prison release is no more effective than comprehensive pre-release discharge planning in linking HIV-infected prisoners to care: a randomized trial." *AIDS and Behavior* 15(2) (2011): 356-364.

⁷⁰ Visser C.A., Mallik-Kane K. "Reentry Experiences of Men with Health Problems." In R. B. Greifinger, J. Bick, & J. Goldenson (Eds.), *Public health behind bars: From prisons to communities* (pp.434-460). 2007 Dobbs Ferry: Springer [Visser and Mallik-Kane 2007]

⁷¹ Dumont, D. M., Allen, S. A., Brockmann, B. W., Alexander, N. E., & Rich, J. D. "Incarceration, community health, and racial disparities." *Journal of Health Care for the Poor and Underserved*. 24(1) (2013): 78-88.

⁷² Schnittker, J., Massoglia, M., & Uggen, C. (2011). "Incarceration and the health of the African American community." *Du Bois Review: Social Science Research on Race*, 8(1) (2011): 133-141.

⁷³ Visser and Mallik-Kane 2007, *supra* note 70.

invariably reduce the risk of recidivism.^{74,75} Successful re-entry is further tied to community health and wellbeing by mitigating the negative health impacts experienced by the family members of incarcerated individuals. Ailments reported by the family members of incarcerated individuals include chronic physical health conditions⁷⁶ and mental health issues.⁷⁷

From a health systems perspective, early interventions for acute and chronic conditions are essential to alleviate the burdens produced by illnesses. More specifically, early health interventions help to reduce both the severity of illness and the degree of medical intervention required to treat a condition once it has worsened. The more serious a condition, the more resources that are required to treat it. Failing to adequately address health concerns in correctional institutions, and provide early intervention upon release, defers treatment. Without access to primary care services in correctional institutions and upon release

health conditions can worsen, leading the treatment itself to also become more costly.⁷⁸ Rather than allow conditions to deteriorate and the costs for treatment to escalate, there needs to be processes to screen and deliver early medical interventions in correctional institutions. This early screening coupled with a transition to primary health care services upon release can provide co-ordinated and cost-effective care to improve treatment outcomes and costs across the system as a whole.

Comprehensive and integrated health services in correctional institutions present a unique and invaluable opportunity to protect the health of the public and the health care system. The following section shows how other jurisdictions have successfully integrated health services in correctional institutions, and how Ontario can improve access while protecting the public health care system by adopting a similar approach.

⁷⁴ Fu, Jeannia J., et al. "Understanding the revolving door: individual and structural-level predictors of recidivism among individuals with HIV leaving jail." *AIDS and Behavior*. 17(2) (2013): 145-155.

⁷⁵ Davis L.M., et al. Understanding the Public Health Implications of Prisoner Reentry in California. RAND. 2009. Retrieved from: http://www.rand.org.proxy1.lib.uwo.ca/content/dam/rand/pubs/technical_reports/2009/RAND_TR687.pdf

⁷⁶ Lee H, Wildeman C, Wang EA, Matusko N, Jackson JS. "A heavy burden: the cardiovascular health consequences of having a family member incarcerated." *Am J Public Health*. 104(3) (2014):421-427.

⁷⁷ Wildeman C, Schnittker J, Turney K. "Despair by association? The mental health of mothers with children by recently incarcerated fathers." *Am Sociol Rev*. 77(2) (2012): 216-243.

⁷⁸ Lambrew, Jeanne M., et al. "The effects of having a regular doctor on access to primary care." *Medical care*. 34(2) (1996): 138-151.

A WAY FORWARD:

INTEGRATING HEALTH CARE IN CORRECTIONAL INSTITUTIONS WITH THE ONTARIO HEALTH CARE SYSTEM

EXPERIENCES ACROSS OTHER JURISDICTIONS

The separation of health care in correctional institutions from the provincial health care system is a relic of administrative policy that has not served Ontario well. In 2003, the World Health Organization issued the Moscow Declaration. This stated that health in correctional facilities must be considered an integral component of a country's public health system, and recommended integration between ministries of health and of correctional services.⁷⁹ This charge has been taken up by several jurisdictions around the world through the transfer of responsibility of health services in correctional facilities to their respective Ministries of Health.^{80,81}

These jurisdictions include Norway, France, New South Wales (Australia), England, Scotland, and Wales, as well as Nova Scotia and Alberta in Canada.^{82,83}

While there are challenges to measuring the impacts of these transitions,⁸⁴ the available research shows that the integration of health services in correctional facilities with community health care systems has positive impacts. Health systems that have implemented a transfer of responsibility for health services in correctional facilities have consistently reported system-wide improvements. In Nova Scotia, the transfer of responsibility for health services in provincial correctional institutions to the Ministry of Health has improved continuity of care for men and women moving from correctional institutions to the community.⁸⁵ This transfer of responsibility has also expanded programming, improved the health and well-being of the correctional population, reduced health care costs, and reduced the rates of recidivism in

⁷⁹ World Health Organization. Moscow Declaration October 24, 2003.

⁸⁰ Hayton 2006, *supra* note 16.

⁸¹ Paul Christopher Webster. "Integrating prison health care into public health care: the global view." *CMAJ* (2013): 185:554. [Webster 2013]

⁸² Hayton 2006, *supra* note 16.

⁸³ Webster 2013, *supra* note 81.

⁸⁴ Challenges include a lack of available baseline data, the high turnover of prison populations, variability in implementation models, and other system-wide factors.

⁸⁵ Strang R, van den Bergh B, Gatherer A. "Future directions for the health of incarcerated women in BC." *British Columbia Medical Journal*. 54 (2012): 514-517.

Nova Scotia.⁸⁶ Finally, the changes in Nova Scotia helped to address issues around the recruitment of medical staff while increasing transparency in service delivery.⁸⁷

In England and Wales the transfer of health services in correctional facilities to the National Health Services (NHS) has resulted in a significant overall improvement in services. Prison Health Performance and Quality Indicator reports show improvements in patient safety, clinical governance, financial governance, alcohol services, care program approach, Hepatitis B vaccination, and indicators around Hepatitis C.⁸⁸ This change has improved service planning and transparency through the implementation of public local health delivery plans for each correctional facility in England.⁸⁹ Finally, transferring responsibilities in England and Wales has helped with the recruitment and retention of high-quality health care professionals working in correctional settings.⁹⁰ The majority of the general practitioners working in correctional settings do so on a part-time basis, and this reduces isolation among professionals who work in correctional facilities, which hindered the appeal to working in such environments.⁹¹

In 2004, England's Department of Health and the International Centre for Prison Studies invited representatives from health services in jurisdictions where health ministries were responsible for health services in correctional facilities. These representatives came from jurisdictions such as England and Wales, France, Norway and New South Wales. They unanimously noted that integrating health services in correctional facilities with the larger health care system had improved standards of care and service delivery, continuity of care, access to community services, the recruitment and quality of medical staff, and resulted in more effective health policy overall.⁹²

The experience of jurisdictions that have implemented a transfer of responsibilities illustrate not only an opportunity to improve the efficiency and efficacy of health services in correctional facilities, but also to leverage correctional settings as an environment to address mental, physical and social health needs, provide health education, and to promote the adoption of healthy behaviours that can be carried back to communities.

As noted throughout this paper, members of marginalized communities are grossly overrepresented in incarcerated populations. Many of the same determinants that impact their

⁸⁶ *Ibid.*

⁸⁷ Webster 2013, *supra* note 81.

⁸⁸ Department of Health. Prison Health Performance and Quality Indicators Annual Report 2011. 2012. Retrieved from: <https://www.gov.uk/government/publications/prison-health-performance-and-quality-indicator-report-and-guidance>

⁸⁹ Hayton 2006, *supra* note 16.

⁹⁰ *Ibid.*

⁹¹ *Ibid.*

⁹² International Centre for Prison Studies Prison health and public health: the integration of prison health services. 2004. Report from a conference. Accessed 23/07/2015. Retrieved from: http://www.prisonstudies.org/info/downloads/health_service_integration.pdf

interaction with the correctional system also affect their health outcomes and access to primary health care services. Incarcerated populations not only experience disproportionately high rates of physical and mental health conditions, but are also significantly less likely to receive regular health care either before incarceration⁹³ or after their release.⁹⁴ Pilot studies have demonstrated how the planned transitioning of health care from correctional facilities to community health services effectively engages individuals with primary health care services, and reduces the rates of emergency department use.⁹⁵ Including correctional institutions in the planning and delivery of community health services is an incredible opportunity to strengthen public health and the health

care system. Integrating health systems leverages correctional institutions as an environment to bring individuals – especially those who face barriers to access – into the health care system.

Giving the opportunity for individuals who are incarcerated to improve health and programming in their own environment can produce transformative change. In a British Columbia women's correctional facility women not only led health research,⁹⁶ but also developed and implemented programming to address identified health needs.⁹⁷ Integrating health care in correctional institutions can therefore empower individuals from marginalized backgrounds to improve their health outcomes.

ONTARIO'S OPPORTUNITY

Ontario's Action Plan for Health Care is centered on the '*Right Care in the Right Place at the Right Time*.'⁹⁸ An important foundation of Ontario's Action Plan for Health Care is a recognition of early intervention as an investment in patient outcomes and in cost savings to the health care system. The current

approach to the administration of health services in Ontario's correctional institutions undermines the opportunity for early intervention and integration of services, which MOHLTC advocates.

In Ontario, the Local Health Integration Networks (LHINs) are responsible for the planning, integration, and funding of

⁹³ Greifinger 2007, *supra* note 29.

⁹⁴ Wang EA, Hong CS, Shavit S, Sanders R, Kessell E, Kushel MB. Engaging individuals recently released from prison into primary care: a randomized trial. *Am J Public Health* 2012; 102(9):e22-9.

⁹⁵ *Ibid.*

⁹⁶ Martin RE, Murphy K, Hanson D, Hemingway C, Ramsden V, Buxton J, Granger-Brown A, Condello L-L, Buchana M, Espinoza-Magana N, Edworthy G, Hislop TG. "The development of participatory health research among incarcerated women in a Canadian prison." *Int J of Prisoner Health*. 5(2) (2009): 95–107.

⁹⁷ Martin RE, Adamson S, Korchinski M, Granger-Brown A, Ramsden VR, Buxton JA, Espinoza-Magana N, Pollock S, Smith M, Macaulay AC, Condello LL, Hislop TG. "Incarcerated women develop a nutrition and fitness program: participatory research." *International Journal of Prisoner Health*. 9(3) (2013): 142-150.

⁹⁸ Ontario's Action Plan for Health Care. (Ministry of Health and Long-Term Care). 2012. Retrieved from: http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf [Ontario Action Plan 2012]

health care services in their respective regions. In December 2015, the MOHLTC released a discussion paper entitled, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*⁹⁹. This paper signals the MOHLTC's commitment to further strengthening the role of the LHINs in Ontario. It also identifies the integration of health services and population health, and the elimination of inequities in access to health care as central objectives.

Considering MOHLTC's direction, it seems an opportune moment to consider the impact of integrating and restructuring health services in correctional institutions under the MOHLTC's responsibility. It is at this local level where systems may be most effectively responsive to the needs of

incarcerated populations, and it is also where the benefits of intervention will be directly experienced by communities. Ontario's LHINs are well-positioned to design, implement, and maintain effective and comprehensively integrated health services that include provincial correctional institutions.

The MOHLTC is undertaking a transformational change of our health care system. Including the provision of health care in correctional institutions within this larger vision is an opportunity to improve the quality and value of health services in correctional institutions, as well as to leverage these settings as an environment to push forward and achieve tangible results for the MOHLTC's four key goals:¹⁰⁰

ACCESS

- An opportunity to bring hard-to-reach populations who are temporarily housed in correctional institutions into the health care system.
- Ensure patients receive the *right care, at the right time, in the right place*¹⁰¹ through coordinated, comprehensive health system planning that includes the health needs of incarcerated Ontarians.
- Improve health and reduce system costs by fostering access to primary care services.

CONNECT

- Help LHINs maintain and monitor the health and journey of individuals from vulnerable backgrounds who often fall through the cracks.
- Deliver better coordinated and integrated care for vulnerable populations who often have more complex needs than the general population.
- Ensure seamless transition from health services in correctional institutions to the appropriate care in the community.

⁹⁹ Read the John Howard Society of Ontario's response to the proposal at: <http://johnhoward.on.ca/wp-content/uploads/2016/03/MOHLTC-Response-Prison-Health-Care.pdf>

¹⁰⁰ Ontario Action Plan 2012, *supra* note 98.

¹⁰¹ *Ibid.*

INFORM

- Provide information and education for individuals in correctional institutions to make the right decisions about their health. Not only with regards to prevention but also where they can obtain physical and mental health support in their community upon their release.

PROTECT

- Promote sustainability in the health care system by fostering equitable access to health care and increased utilization of primary health care in place of acute episodic intervention.
- Protect public health through prevention, screening, and effective intervention for communicable conditions.

The importance of MOHLTC's role in any way forward for health care in Ontario correctional institutions cannot be overstated. The MOHLTC has the vision, experience, and expertise to plan and produce comprehensive and integrated health services. Nearly all of the people incarcerated in Ontario's correctional institutions will return to communities, hence, MOHLTC will ultimately bear the costs for any short-comings in health services in correctional institutions. In other jurisdictions, correctional facilities have been integrated as components of local health service planning and delivery.¹⁰²

The MOHLTC is working to break down silos between sectors and institutions within the health system,¹⁰³ recognizing that isolation and segmentation of services comes at a great human and financial cost. It is essential that the justice sector is recognized as a key partner in ensuring the health and well-being of Ontarians. Integrating health care in correctional institutions with the larger health care system is an opportunity to not only effectively manage health care resources, but to better protect and manage the health of Ontarians.

¹⁰² Hayton 2006, *supra* note 16.

¹⁰³ For example see: HealthLinks (<http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx>) and Bundled Care (Integrated Funding Models) (<http://health.gov.on.ca/en/pro/programs/ecfa/funding/ifm/default.aspx>)

CONCLUSION

The aim of this paper is to start a discussion about the administration of health services in Ontario's correctional institutions. By recognizing some of the challenges with the current model alongside the experiences of other jurisdictions, solutions and opportunities for Ontario can begin to materialize.

The current model of health services in Ontario's correctional institutions does not meet the needs of the population it serves. The reactive system of health services in correctional institutions is unsuitable for the exceptionally high and complex needs of incarcerated populations. This fractured delivery model for health care is also ill-equipped to ensure continuity and transition of care into community services. These gaps and short-falls in service delivery

come at great risk and expense to the province and our communities.

Ontario's correctional institutions present an unparalleled opportunity for effective and sustainable intervention with system-wide impacts. To realize this change the administrative policies that artificially isolate the health needs of individuals who are incarcerated from those in communities must be recognized and re-examined. The MOHLTC is working to implement a system-wide vision of integrated, effective, and equitable health care for all Ontarians. This vision cannot be realized without the integration of health care across sectors; the time to explore innovative health policy change for Ontario's correctional institutions is now.



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