



Transforming Health Care in Our Provincial Prisons

**Final Report of Ontario's Expert Advisory Committee on
Health Care Transformation in Corrections**

Message from the Chair

On behalf of my colleagues on the Expert Advisory Committee on Health Care Transformation in Corrections, we are pleased to submit our final recommendations to the Ministries of Health and Long-Term Care and Community Safety and Correctional Services.

The Committee has worked hard to build upon the best evidence available and the experience of multiple stakeholders to make recommendations that, if implemented, would greatly improve the health and well-being of those individuals who are incarcerated in Ontario's correctional facilities.

We would also like to acknowledge that Ontario's correctional system benefits from the work of highly skilled and dedicated health care providers who work alongside their partners in the correctional service. With strong leadership from government, and a commitment to ensuring these frontline workers have the right tools and support to do their jobs well, the health and safety of all Ontarians will be improved.

We believe that this is an important moment for Ontario. The time is right to develop improved systems of health promotion and health care in the context of a restructured correctional system, which will not only provide better health outcomes but also reduce recidivism and reincarceration to the benefit of all.

We have heard from other governments across Canada and the world who have taken on this challenge, and we believe Ontario is well-positioned to make smart investments in how it delivers health care in correctional services.

We have appreciated this opportunity to provide recommendations to both ministries for consideration of implementation.

Regards,



Dr. Jeffrey Turnbull
Chair

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Acknowledgements

The Expert Advisory Committee on Health Care Transformation in Corrections (Committee) would like to thank officials at the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Community Safety and Correctional Services (MCSCS), particularly the Correctional Health Care Transformation Secretariat at MOHLTC, for their hard work and dedication in organizing the meetings and supporting the work of the Committee. In addition, the Committee would like to thank the guest speakers and experts who contributed to the discussions at the meetings, including:

- Dr. Bob Bell, Deputy Minister, MOHLTC
- Sam Erry, Deputy Minister, Correctional Services, MCSCS
- Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation, MOHLTC
- Patrick Dicerni, Assistant Deputy Minister, Strategic Policy and Planning Division, MOHLTC
- Nancy Sanders, Assistant Deputy Minister, Modernization Division, MCSCS
- Debbie Conrad, Assistant Deputy Minister, Strategic Policy, Research and Innovation Division, MCSCS
- Lynn Norris, Assistant Deputy Minister, Modernization Division, Ministry of the Attorney General
- Janet Hope, Assistant Deputy Minister, Housing Division, Ministry of Housing
- Tatum Wilson, Director, Poverty Reduction Strategy Branch, Ministry of Community and Social Services
- Dr. Sarah Bromley, National Medical Director, Health in Justice, Care UK
- Henry de Souza, Director General, Health Services Sector, Correctional Service Canada
- Dr. Keith Courtney, Facilities Medical Director, Corrections Health Services, Alberta Health Services
- Andrew MacFarlane, Provincial Executive Director, Correctional Health Services, Provincial Health Services Authority, British Columbia
- Howard Sapers, Independent Advisor on Corrections Reform (Ontario)

We would especially like to thank those individuals with lived experience in the provincial correctional system who provided the Committee with thoughtful insights and perspectives on how to transform health care in corrections.

Membership



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Executive Summary

Currently, Ontario detains around 39,000 unique individuals each year in 25 correctional facilities located across the province, the vast majority of whom are remanded awaiting trial or sentencing (the remaining individuals are sentenced or being held on immigration-related matters).

For a variety of reasons – including weak ties to primary care, the labour market, and housing, low socio-economic status, and the impact of discrimination and intergenerational trauma – this population typically has complex and significant health needs, but is not receiving the right government interventions or supports.

As a result, Ontario's correctional facilities are mostly housing individuals with high rates of mental illness, substance use disorder, and infectious diseases. Despite this high level of need, correctional facilities are not equipped to provide consistent, equitable, or high-quality health care to this population.

Poor health not only negatively affects individuals, but also has more widespread negative economic impacts. Recent studies have shown that Ontarians who spend time in provincial custody utilize high-cost acute health services (e.g., emergency departments) at a higher rate than the general population, are less attached to primary care providers, and are not receiving appropriate preventive care. Moreover, poor health outcomes have also been shown to be associated with unemployment and recidivism.¹

Connecting people to more appropriate care is not only a matter of addressing individual needs, but also a way to support cost-effective health care. The recommendations contained in this report are centered on building a high-performing correctional health care system that promotes equal outcomes for people in custody, improves public health, and allows for more efficient spending of tax dollars.

This new approach will help to ensure the government has the capacity to implement the many and repeated recommendations from Coroners' inquests, the Ontario Human Rights Commission, Ontario's Independent Advisor on Corrections Reform, and individuals and community organizations that recognized the need for transformation long before this Committee came into existence.

Through strong government leadership and by building on effective partnerships with community organizations, Ontario has the opportunity to become a leader within Canada – and in the world – in correctional health care. To build a high-performing correctional health care system, we recommend the following:

Introduction

In May 2017, MCSCS announced a plan to transform the provincial correctional system in Ontario. In April 2018, as part of this overall corrections reform, the Ministers of MOHLTC and MCSCS established an Expert Advisory Committee on Health Care Transformation in Corrections (Committee) to provide advice on how to transform health care services within provincial correctional facilities in Ontario.

The Committee was given a mandate by the Deputy Ministers of MOHLTC and MCSCS to think big, be bold, and provide recommendations to government that would ensure that this population – often described as having among the most complex health and social service needs in the province – would have access to the right level of care and supports.

The Committee was asked to share their individual experiences with, and perspectives on health care and the criminal justice system, and to develop a final report with recommendations. These recommendations were to be informed by the latest research and data from Ontario, experiences of other Canadian and international jurisdictions in correctional health care transformation, and input

from various stakeholders and partners, including people with lived experience.

In light of the data, the stories from individuals with lived experience, and the common themes emerging from Coroners' inquests, Independent Reviews (most recently by Howard Sapers), and complaints to the Ombudsman, the Committee unanimously agreed that, while no small task, improving health care services in correctional facilities is both necessary and possible. This report contains advice and a series of recommendations on improving access to high-quality health care services for people in custody, including once they return to the community.

The report also paints a picture of who spends time in the government's custody. The data and personal stories reveal the impacts of social determinants of health, intergenerational trauma, and adverse childhood experiences, and remind us that, for many people, periods of incarceration are often brief disruptions within an otherwise challenging life.

those in custody are among the most vulnerable in our society, and it is critical that the government make immediate changes to better serve their needs.

The Committee also recognizes that those who work in correctional facilities across Ontario, including health care providers and correctional officers, are doing their best in an underresourced, challenging, and shifting environment, and we acknowledge their hard work and dedication. Although these recommendations are aimed at improving and transforming correctional health care, the report is not meant to be a criticism of those who are working in the current system; rather, we are proposing a path forward to better support all those who work within and are involved with the correctional system.

Finally, while the recommendations contained in this report focus on transforming health care services within the provincial correctional system, the Committee wishes to stress that diversion should be prioritized, where appropriate. Given that incarceration may negatively impact the health of individuals and communities, incarceration must and should be a last-resort option in the criminal justice system. The Committee particularly supports continued investments in targeted diversion programs that ensure people with mental illness, substance use disorders, and developmental disabilities receive appropriate care and supports rather than incarceration. We also encourage the Government of Ontario to continue working “upstream” in order to address the social determinants of incarceration through investments in affordable housing, employment opportunities, employment insurance, and other social services that can reduce criminal justice system involvement.

**Over the past decade,
there has been a
declining trend
in the number of total
admissions to Ontario’s
correctional facilities.**

**In 2006/07, there were
54,608 unique
individuals admitted
into provincial custody.**

**In 2016/17, 39,236
unique individuals
were admitted into
provincial custody, equal
to an approximate
26% decrease
in admissions over the past
decade.^{1,ii}**

¹ Due to the fact that a portion of individuals are admitted into custody more than once in a given year, there is a notable difference between unique individuals admitted and the number of total annual admissions into provincial custody. For instance, although 39,236 unique individuals were admitted into provincial custody in 2016/2017, overall, there were 58,087 total admissions. In 2006/2007, there were 54,608 unique individuals admitted into custody, but 78,831 total admissions.

Scope of Recommendations

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The Case for Change

Currently, Ontario's provincial correctional system is composed of 25 facilities, which, in 2016/17, housed 39,236 unique individuals (92% of whom were men), including: those who were being held while awaiting trial or sentencing (68.2%), those who were sentenced to sentences of up to two years less a day (28.2%), and those who were being detained on immigration-related matters (1.8%).ⁱⁱⁱ The facilities in which they find themselves vary widely in terms of age, capacity, and modern amenities, and range in size from 22 beds (Fort Frances) to 1,650 beds (Toronto South Detention Centre).^{iv} Additionally, only 27% of those who are remanded end up with a custodial sentence; the remainder are eventually released, or given a non-custodial sentence.^v

Health Care Status of People in Custody

Compared to the general population, individuals in the custody of one of Ontario's provincial correctional facilities typically have complex, often significant health needs requiring high-quality health care.² People in custody typically suffer from

higher rates of almost all health issues, are two to three times more likely to have a mental illness or experience problematic substance use, are up to five times more likely to have a serious mental illness, and have higher rates of intellectual and developmental disabilities (including Fetal Alcohol Spectrum Disorder), and acquired brain injury.^{vi} Among this population, HIV rates are approximately 20 times higher than the general population, and rates of Hepatitis C Virus (HCV) infection are close to 100 times higher.^{vii}

The poor health status of incarcerated Ontarians often has roots in marginalization, victimization, and discrimination. Those in custody have likely experienced family violence and/or had contact with the child welfare system. They are also more likely to have experienced racism, poverty, physical and sexual abuse, the trauma of colonialism (and other traumatic events), and to not have completed formal education.^{viii} Unemployment, homelessness, and housing precariousness are common, and directly contribute to higher rates of recidivism.^{ix}

² Most correctional facilities have health care infrastructure to treat minor illness and injury and provide spaces for examination and treatment. However, most specialist and acute services are provided outside the facility by appointment in the community or at an

emergency department. All 25 correctional facilities are Ontario Telemedicine Network-enabled.

Not surprisingly, many will have been in custody at least once before.³

Overrepresentation from marginalized communities is also a significant issue in Ontario's correctional system. In 2016/17, Indigenous peoples comprised 13.4% of the population in custody despite being only 2.8% of the Ontario population. Similarly, 12.6% of the correctional population was comprised of Black/African-Canadian individuals, despite being only 4.7% of the Ontario population.⁴

Women also face heightened challenges. Women represent only 8% of people in custody but have distinct and sometimes greater needs than the male population, including higher rates of traumatic histories, experiences of violence, self-harming behavior, HCV, mental illness, and substance use disorder.^x

Compared to the general population, individuals who spend any time in provincial custody have a life expectancy of 4.2 years less for men and 10.6 years less for women.^{xi}

Ontarians who spend any time in provincial custody have a higher death rate and die much earlier than the average Ontarian. Controlling for age, Ontarians who have been incarcerated are four times more likely to die than the general population, and almost twice as likely to die while in custody.^{xi} Between 2000 and 2012, 8.6% of people who had spent time in an Ontario correctional facility died while in custody or after

release. The most common causes of death among people who experienced incarceration are overdoses and heart disease, following by cancer and suicides.^{xiii} In 2017, 27 people died in custody, the highest number of deaths in custody per year since 2000 (data on the specific causes of death are not yet available).^{xiv} The consistently high death rate suggests that it is not simply the experience of incarceration that increases the risk of death, but rather that this population is likely at higher risk of death due to a variety of complex social, medical, and behavioural factors.

Health Care Utilization

Many of those entering custody will have had lower rates of attachment to primary care,^{xv} which may be a consequence of stigma, services not targeted to their needs, or a lack of individual motivation to seek help. When these individuals do interact with the health system, it is often in acute care settings. Previously incarcerated individuals find themselves going to a hospital at a higher rate than the general population, with four to seven times the rate of emergency department use, depending on the time period after release. The rate is also high for hospitalization in a psychiatric facility: within the first six days after release from prison, this population is hospitalized at a psychiatric facility 58 times more than the general population, and 12 times more at one to three months after release.^{xvi} This pattern of health care usage leads to poor outcomes and represents an ineffective and inefficient use of government resources.

Previous Calls for Action

Given these poor outcomes and the ineffectiveness of the current approach, there have been numerous calls to seize the opportunity to deliver high-quality, patient-centred care to Ontarians in custody.

The Ontario Human Rights Commission (OHRC) has been heavily involved in advocating for the protection of human rights in correctional facilities.

³ The number of individuals who cycle in and out of custody in Ontario is notable, with 49% of individuals who have been in custody in Ontario over the past ten years having been in custody more than once and 11.4% having been admitted more than five times.

⁴ This data is based on self-reported race/ethnicity. For example, Indigenous individuals can choose whether or not to self-identify as Indigenous; if they choose to do so, the data is recorded as such, simply based on their self-reporting.

The 2013 Christina Jahn settlement⁵ between the OHRC and MCSCS highlighted the overuse of segregation for those experiencing mental health issues and substance use disorders, and underlined a lack of health services, particularly for women.^{xvii}

The Office of the Ombudsman of Ontario has also been consistently engaged to respond to complaints regarding health care in correctional facilities. More than half of the complaints received from those in custody relate to problems with health care, principally around access to care and medications.⁶ Special Ombudsman reports have also investigated allegations of excessive use of force against people in custody and the problematic use of segregation. These reports found that not enough is being done to protect incarcerated individuals from violence or to treat those with mental health issues and developmental disabilities.^{xviii}

Numerous Coroners' inquests have also pointed to shortcomings in the provision of correctional health care, including a recent inquest involving the deaths of eight people in custody at the Hamilton-Wentworth Detention Centre between 2012 and 2016, one of the largest inquests in Ontario's history. Inquests have highlighted numerous actions that need to be undertaken, including improving continuity of care and access to care.

Due to this focus on the need for correctional health reform, MCSCS appointed Howard Sapers as the Independent Advisor on Corrections Reform to determine a path forward on segregation practices and recommendations to support comprehensive

corrections reform. Mr. Sapers' first report, *Segregation in Ontario*, detailed a lack of access to mental health care in particular, and pointed to a lack of resources and infrastructure to deliver appropriate care. His second report, *Corrections in Ontario – Directions for Reform*, offered possible action items to transform correctional health care, all of which were considered by our Committee and align with our own recommendations.

Human Resources Challenges

The challenges within correctional health care are not only faced by people in custody. MCSCS currently employs or contracts with approximately 723 health care providers⁷ to deliver services to the approximately 39,000 unique individuals in custody each year. These health professionals work in a difficult and complex environment, and are often removed from the broader health workforce and system.

39% of nurses in provincial correctional facilities suffer from emotional exhaustion.

Not surprisingly, this work environment results in high levels of stress. A 2011 study conducted by the University of Toronto found that 39% of nurses in provincial correctional facilities suffer from emotional exhaustion.^{xix} This stress is further exacerbated by inadequate staffing levels, a lack of sufficient training, and an absence of the modern, patient-centred infrastructure required to deliver

⁵ Ms. Jahn filed an application with the Human Rights Tribunal of Ontario alleging that she was placed in segregation for 210 days at the Ottawa-Carleton Detention Centre because of her mental health disabilities and that MCSCS discriminated against her by failing to accommodate her mental health-related needs. The Ontario Human Rights Commission intervened and as a result of the settlement reached in 2013, and a contravention application filed in 2017, MCSCS must undertake specific actions to better serve inmates with mental illness.

⁶ Complaints are dealt with at the facility level. Numbers should be interpreted with caution as not all complaints are verified and multiple complaints in reference to a single incident may be counted separately. This imperfect complaints system, along with the high volume of complaints, highlight the need for improved oversight and dispute mechanisms that would allow for faster and more proactive resolution of these issues, as discussed in recommendation #5.

⁷ The model of care employed in correctional facilities currently relies heavily on primary care services delivered by directly employed registered nurses, of which there are 402.6 Full-Time Equivalents (FTEs). Other directly employed health care professionals include: 27.0 Health Care Manager FTEs, 4.0 Nurse Practitioners, 14.3 Psychologist FTEs, 6.0 Psychometrist FTEs, 8.0 Manager of Social Work FTEs, 103.6 Clinical Social Worker FTEs, 12.0 Medical Clerk FTEs, 2.7 Pharmacist FTEs, 8.9 Pharmacist Tech FTEs, and 35.4 Psychiatric Nursing Assistant FTEs. Health care providers who are contracted to provide health care services include 48 Primary Care Physicians, 35 Psychiatrists, 3 Psychologists, 2 Nurse Practitioners, and 13 Dentists. (These numbers are accurate as of 2017/18.)

high-quality care (including technology such as an electronic medical/health record).

In addition to working in an especially challenging environment, correctional health care providers are often underpaid compared to their counterparts in other parts of the health system. As a result, MCSCS has experienced challenges with recruitment and retention, all of which negatively impact people in custody, who most require high-quality health care.

Numerous voices have called for clear action to support correctional health care practitioners. The OHRC has pointed to the need to provide more staffing in correctional facilities, particularly for mental health treatment, as well as enhanced training and infrastructure.^{xx} In *Segregation in Ontario*, Howard Sapers suggested that the lack of alternatives to segregation and insufficient health care staffing led to an overuse of segregation and poor quality care. Mr. Sapers also pointed to a need for increased health training for both health care practitioners and correctional officers.^{xxi}

“Health-care service shall consist of an interdisciplinary team with sufficient qualified personnel acting in full clinical independence.”

-United Nations Standard Minimum Rules for the Treatment of Prisoners (2015)^{xxii}

Inquests into deaths in custody have echoed these points. A lack of access to health care services, outdated or inadequate infrastructure, and insufficient staffing have been identified as contributing factors to the deaths of Ontarians in provincial custody.^{xxiii}

The World Health Organization has taken the lead on outlining a specialized need for health care practitioners in correctional facilities. This includes

a requirement for an interdisciplinary care team model with sufficient coverage of mental health, substance use, vision care, and dental care.^{xxiv} Current coverage in these areas in Ontario is limited, and needs to be addressed.

The Need for Systems-Level Transformation

In Ontario, there has also been clear advice to government that systems-level transformation is needed. The OHRC, Howard Sapers, Coroners’ inquests, and the Ombudsman of Ontario have underlined failings in the model of care, especially for those experiencing mental health and problematic substance use, as well as problems associated with aging. They have all pointed to the lack of integrated, consistent correctional health care across the province, insufficient transparency and oversight, the lack of coordination with the broader health system, and the gaps in continuity of care, information-sharing, and funding of services.^{xxv}

In 2016, the Ottawa-Carleton Detention Centre Task Force released a report that outlined an action plan to improve the health and safety of staff and people in custody. It recommended a comprehensive system-wide review of health care services and the transfer of responsibility for health care services to MOHLTC in the long term.^{xxvi} Howard Sapers’ report, *Corrections in Ontario – Directions for Reform*, also included system-level recommendations to transform health care in correctional facilities, including examining different models of care and transferring responsibility for health care to MOHLTC.^{xxvii}

Correctional Health Care in Other Jurisdictions

Many jurisdictions have undertaken evaluations of correctional health care services and found that poor linkages between correctional health and the broader health system have contributed to worse health and reintegration outcomes for people in custody. Commonly cited challenges include inadequate health care quality oversight and monitoring, as well as poor information-sharing

among correctional facilities and community health care organizations.^{xxviii} There is also a lack of health research, public health involvement in correctional facilities, and limited health system planning for correctional facilities and people in custody. In general, health care best practices are not being implemented in correctional facilities, and as a result, services are often not of the same quality and/or standard as those found the community.^{xxix}

To address this fragmentation, some jurisdictions have chosen to transfer responsibility for health care in correctional facilities from their justice authority to their health authority, beginning with Norway in 1988, followed by France, England, Scotland, Australia, Italy, Finland, and Sweden.

This trend has also taken hold in Canada, beginning with Nova Scotia in 2003, followed by Alberta in 2010. In 2016, Quebec began a phased transfer process, with the majority of facilities having been transferred to the Ministry of Health and Social Services as of April 2018. In 2017, the B.C. Mental Health and Substance Use Authority took over

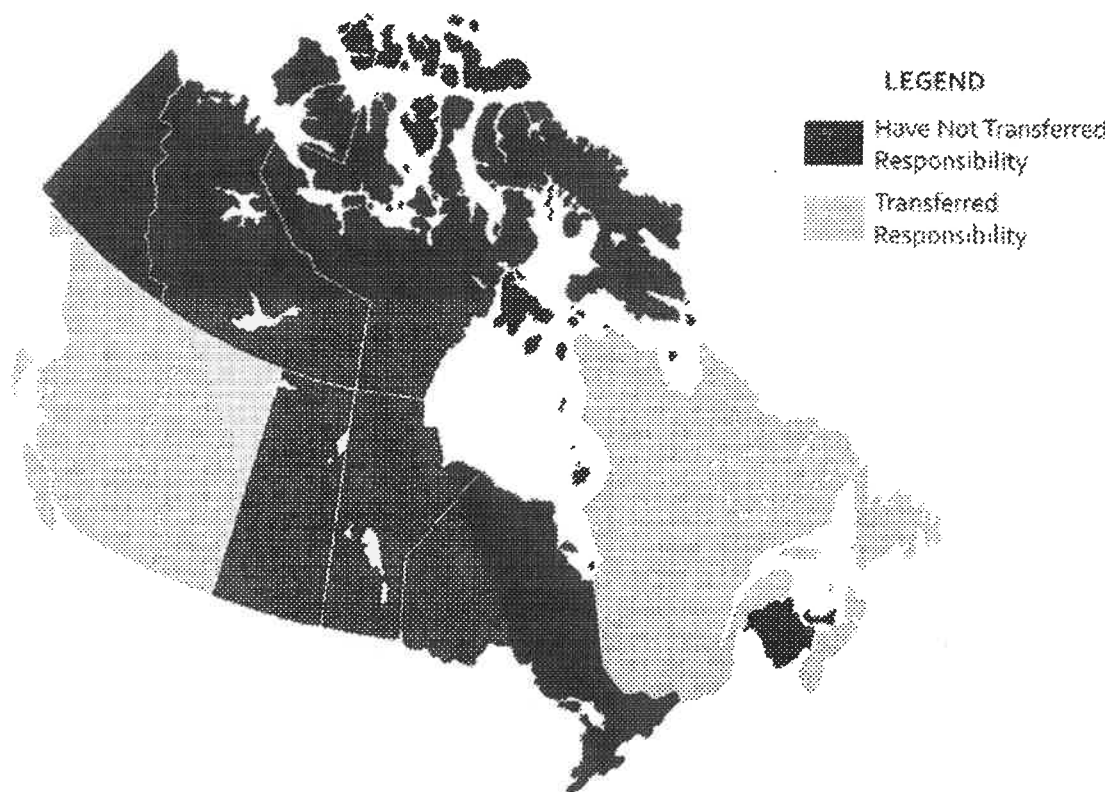
responsibility for correctional health, while Newfoundland committed to a transfer by 2021, following the recommendation of an all-party committee report on mental health.^{xxx}

By 2021, half of the provinces in Canada will have transferred responsibility for correctional health to their ministry of health.

Federally, in 2007, Correctional Service Canada created a Health Services Sector Division to oversee health care services in its facilities and improve the quality of care delivery.^{xxxi}

As with jurisdictions internationally, correctional health care transformation in Canada has been driven by a desire to improve services, particularly around continuity of care, mental health, and problematic substance use.^{xxxii}

Map of Transfers to Ministries of Health (Canada)



Summary

Transforming health care in correctional facilities represents a significant opportunity to provide health and social services to a marginalized and vulnerable population with complex health needs. It is an opportunity to provide better care to those Ontarians who need it most.

Almost all of those in the custody of Ontario's provincial correctional facilities will quickly return to their communities and continue to live as our neighbours.^{8, xxxiii} The vast majority will return to these communities within a month.^{xxxiv}

65.4% of people in provincial custody are released within one month; 84% are released within three months.

Investing in health care for the correctional population improves overall public health and prevents the exacerbation of expensive health care issues down the road. By addressing preventable health problems, we can further reduce the burden on our already stretched hospital capacity by providing proper care in custody and connecting this difficult-to-reach population with cost-effective community health and social services. An investment in correctional health can also avoid costly future interactions with police, courts, and the correctional system.

Improving the health of people in custody and addressing the social determinants of health, through, for example, investments in affordable housing and employment supports, are crucial for reducing rates of reincarceration and recidivism.

Health improvements have been linked to higher success rates for reintegration into society.^{xxxv}

Health care transformation in our correctional facilities can therefore serve the twin goals of improving public health and improving public safety.

The government also has a legal and moral obligation to provide health care in its correctional facilities that is at least equivalent to the care provided in the community. In fact, given the needs and vulnerability of this population and in order to meet human rights obligations and act in the best interests of public health, correctional health care may need to be more extensive than what is available in the community.^{xxxvi}

Around the world, the importance of improving the health of the correctional population is increasingly being recognized and prioritized. In Ontario, we seem to be reaching a tipping point. The Committee strongly feels that the time is right for the government to join the movement and take concrete, transformative actions in order to enhance the delivery of patient-centred care, support health care practitioners working in these challenging environments, and reform the system to make it work better for all.

Health care transformation in our correctional facilities can therefore serve the twin goals of improving public health and improving public safety.

⁸ The average time in custody for those on remand is 40.2 days and the median time in custody is nine days, while for sentenced individuals, the average time in custody is 53.3 days and the median time in custody is 15 days. A significant proportion of those in provincial custody are there for less than one week. 37.8% spend between one and seven days in custody prior to release, and 65.4% are incarcerated for one month or less.

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**of the Freedom of Information and Protection of Privacy Act
de la Loi sur l'accès à l'information et la protection de la vie privée**

Key Recommendations

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“Diverse cultural needs pose a **major challenge**, but direct consultation with different groups of prisoners can help to get **an understanding of their needs** and how these might be addressed.”

-World Health Organization,
Prisons and Health (2014) ^{xxxvii}

The Committee believes that time in custody can become an opportunity for providing and connecting individuals with better health care than they previously accessed in the community. There are a number of reasons why people may not see a primary care provider, or choose not to go to a Community Health Centre or Aboriginal Health Access Centre to seek treatment for a health concern. If MOHLTC is unable to reach all individuals in need via these community mechanisms (if these people are falling through the cracks, so to speak), the Committee sees time in custody as a unique opportunity to connect these individuals with health care services to meet their needs.

general population. For instance, while Indigenous people make up 2.9% of Ontario’s total population, this group represents 13.4% of those in custody. Similarly, while Black/African-Canadian people make up 4.7% of Ontario’s total population, they represent 12.6% of those in custody (as of 2016/17). ^{xxxviii}

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Health equity is a particularly important concept in the context of provincial corrections where a significant proportion of the population belongs to racialized and other vulnerable groups. The percentage of persons in custody in Ontario who identify as Indigenous (First Nations, Métis, and Inuit) or Black/African-Canadian is high compared to the

The Committee also notes the unique health needs of women and transgendered people. These needs include reproductive health issues as well as complex substance use and mental health needs, including higher rates of post-traumatic stress

disorder, depression, and self-harming behaviour.^{xxix} Women in custody are more likely than women in the general population to have experienced violence and abuse, and are also more likely to have direct caregiving responsibility for dependents.^{xl} People in custody who identify as transgendered and/or are in the process of actualizing their gender identity require personalized health care services and accommodation. This includes being placed in a setting that is appropriate to their self-identified gender, having access to psychosocial supports, and having access to indicated medical treatments such as hormone therapy.^{xli}

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An improved correctional health care system will recognize and address the health impacts of inequities based on socioeconomic status, education level, geography, and cultural identity.

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Overrepresented Populations

As noted in the introduction, there has been a significant reduction in the number of people admitted into custody over the past decade. However, this decline is not consistent across groups: Indigenous admissions as a percentage of total admissions have increased from 9.4% to 13.4% over the past ten years, with a moderate increase in the total number of annual admissions of Indigenous individuals. (It should be noted that part of the increase may be as a result of more people self-identifying as Indigenous.) Although the total number of annual admissions of Black/African-Canadians has been steadily decreasing, the overrepresentation of Black/African-Canadians in custody has remained relatively stable as a percentage of total annual admissions over the past ten years.^{xlii}

Traditional Indigenous Health and Healing

MOHLTC's Indigenous Health Policy, *New Directions*, asserts that health policy for Indigenous people should be designed, developed, and delivered by Indigenous people, in keeping with their goal of self-determination and self-government.^{xliii}

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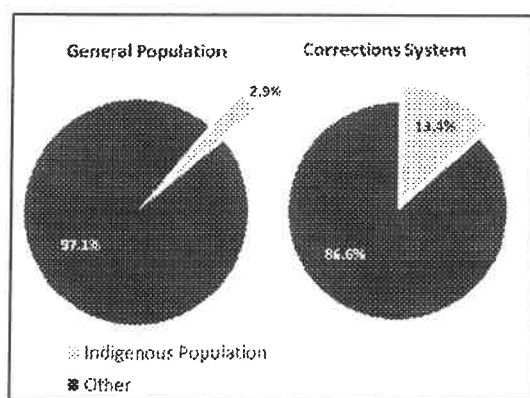
Indigenous health care and healing is holistic, and includes a focus on the physical, mental, emotional, spiritual, and cultural aspects of life. Some examples of traditional approaches to wellness include a connection to the land and access to land-based healing, and the use of traditional resources, healers, medicine people, midwives, and elders. The continuum of care is similar to a Western approach, and includes health promotion, prevention, treatment, and rehabilitation. Some examples of traditional medicine and healing

practices include (but are not limited to) sweat lodges, sweetgrass ceremonies, smudges, receiving teachings from elders, and talking circles.

Traditional medicine can be defined as herbal or other preparations used by a medicine person for healing purposes. Traditional resources might include: natural resources such as sweetgrass, tobacco, sage, cedar, herbs, or plants, and physical resources, such as pipes, pouches, and bowls used by a person or a group.^{xliv}

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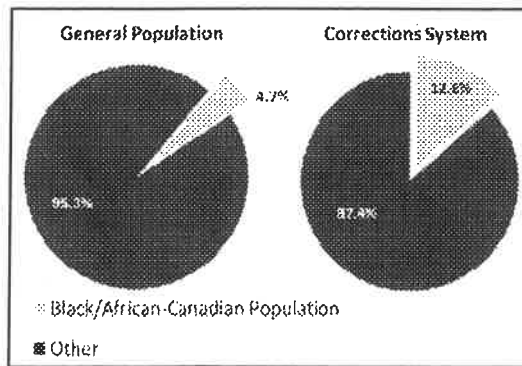


The Committee also understands and respects the fact that each Indigenous community's relationship with traditional medicine and healing is unique. The best path forward to ensuring Indigenous people in custody have appropriate access to traditional healing practices and medicines is through strong partnerships among correctional facilities, Local Health Integration Networks (LHINs), Indigenous health care providers and organizations, and Indigenous communities across the province.

Health Care for Black/African-Canadian Individuals

Despite making up only 4.7% of Ontario's total population, Black/African-Canadians represent 12.6% of those in custody (as of 2016/17).^{xlv} There are complex socioeconomic and historical reasons for this overrepresentation of Black/African-Canadian individuals (individuals of African and Caribbean origin) in the criminal justice system. These reasons include anti-Black racism, high levels of involvement of Children's Aid Societies and high numbers of children in care, lower levels of educational attainment and higher education, lower employment rates, a higher risk of precarious employment, and living in marginalized neighbourhoods.^{xlvi} As a result of these complex factors, rates of poverty among Black immigrants in Ontario increase consecutively between first, second, and third generations – the only population group with this trajectory in the province.^{xlvii}

The same social factors that lead to increased rates of incarceration have similarly negative impacts on this population's health. Black/African-Canadian individuals experience differences in rates of illness, access to care, and health outcomes compared to the general population.^{xlviii} This is, in part, due to the impact of social determinants of health, but also because interventions are not developed specifically for Black/African-Canadian populations and therefore, may have different impacts.



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"The **over-representation** of Indigenous peoples in our correctional system is just one symptom of centuries of **colonialism and discriminatory treatment...** Although many of the underlying issues are systemic, the impact on individual lives, families, and communities is **intensely personal.**"

-Howard Sapers, *Corrections in Ontario: Directions for Reform* (2017)^{xlix}

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Currently, health care services within Ontario's correctional facilities are reactive: they typically provide a minimum level of required services geared toward episodic care, crisis management, and emergency care, while lacking in follow-up care, patient engagement, and continuity of care. Additionally, despite the high prevalence of chronic and infectious diseases among people in custody, chronic and infectious disease management pathways are lacking. Care and staffing models are not standardized, with little data on population health needs to ensure needs-based allocation of resources. When people in custody receive excellent health care, it is as a direct result of the dedication and professionalism of individual health care staff as opposed to a consistent, adopted model of care within and across all 25 provincial correctional facilities.

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The Committee recognizes that this model of care, once effectively implemented, may offer a higher level of care than is often available to individuals in the community. However, due to the fact that the determinants of health reflect the determinants of incarceration, and that individuals in custody have poorer health status, a high level of care is critical to promoting outcomes that are equitable to those in the community.

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TABLE 1: ODSP HEALTH CARE SERVICES

TYPE OF COVERAGE	EXTENT OF COVERAGE
Prescription Drugs	<ul style="list-style-type: none"> • Coverage for prescription drugs listed in the Ontario Drug Benefit Formulary
Dental	<ul style="list-style-type: none"> • Basic dental services (additional services if the individual's disability, prescribed medications, or prescribed treatment affects their oral health)
Vision	<ul style="list-style-type: none"> • Routine eye examinations (once every two years) • Assistance with the cost of prescription eyeglasses and eyeglass repairs
Medical Supplies	<ul style="list-style-type: none"> • Diabetic supplies (e.g., syringes, alcohol swabs, and blood glucose monitors) • Surgical supplies, surgical dressings, and incontinence supplies

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Despite these typically short stays, initiating treatment while in custody should still be a priority. Research has shown that initiating certain health care treatments (e.g., opioid substitution therapy, birth control) in the weeks prior to release from incarceration had much better outcomes than referring people in custody to providers at the time of release (even when these referrals led to treatment).^{li}

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Currently, there is very limited access to in-patient acute mental health care for women and remanded men; instead, they may be placed into segregation, placed in separate living units within the facility, or transferred to a general hospital setting that has neither the resources nor the expertise to care for people in custody with acute mental health needs.

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Research shows that supporting people in custody through discharge and reintegration planning is critical to reducing recidivism, reincarceration, and

homelessness, and to improving health.^{lii} Currently, Ontario's correctional facilities lack sufficient numbers of dedicated discharge planning staff, and as a result, individuals in custody are neither consistently referred nor supported in their reintegration into the community.

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The Committee recognizes that discharge planning and reintegration are not useful without community supports being both available and willing to accept people who have been in custody. To address this, MOHLTC should dedicate resources to incentivize community providers, such as Family Health Teams, Community Health Centres, Aboriginal Health Access Centres, Nurse Practitioner-Led Clinics, Rapid Access Addiction Medicine Clinics, and Rapid Access Addiction Clinics, to provide care for individuals re-entering the community from custody, including initiating relationships with people while in custody

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The short amount of time individuals typically spend in a provincial correctional facility, in combination with their complex health and social service needs, demands that people in custody are provided with seamless, wraparound services. Spending time in custody is disruptive enough without also having to face avoidable gaps in continuity of health care, the absence of necessary social services, or the loss of attachments to the community.

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Government Interventions

The government has direct responsibility for setting expectations for how correctional facilities plan and deliver services, and can also influence the approach to health care planning at the local level. The following are areas for improvement that can be accomplished through policy changes by the provincial government.

care providers in the community, depend on hospitals to act as partners in the delivery of health care for this population. Anecdotal evidence also suggests that, after a person is discharged back to the correctional facility from a hospital, some hospitals are unwilling to share any health information with regulated health professionals in correctional facilities, even with the person's consent, due to a misperception that they are "correctional" staff and therefore not part of the circle of care.

It is also the expectation of the Committee that the LHINs and sub-LHIN regions receive direction from the government to work toward building strong partnerships with Indigenous communities within their catchment areas, and that these partners be involved in facilitating connections to appropriate elders and healers within the region, as well as Indigenous-run health care and healing services.

Addressing Misconceptions about Correctional Health Care Capacity

The Committee heard that there is a certain level of misunderstanding among some health facilities in the community (e.g., hospitals) about the kind of health care available on site within a correctional facility. We heard that it is not unusual for hospitals in Ontario to refuse to admit or to quickly discharge people who arrive at an emergency department in the custody of two correctional officers, while the person is experiencing an acute mental health crisis. This refusal may be due to stigma and/or based on a false assumption that, at least in prison, these patients will be safe and receive the care they need. The reality is that correctional facilities are not designed, staffed, or equipped to provide a full continuum of health care services, and, like health

Access to In-Reach Services and Connection to Social Service Supports

In-reach services are generally considered to be any kind of service or program that is provided by a community agency or organization within the correctional facility's secure environment (and that is complementary to in-house services being provided to people in custody). These services can help improve transitions back to the community and facilitate continuity of care across health and correctional systems.

A number of jurisdictions have experienced the benefits of facilitating in-reach services within a correctional facility. For example, the United Kingdom has experience with the use of mental health in-reach teams to deliver services in correctional facilities equivalent to those provided by a community mental health team. By aligning service delivery across systems, they learned that

the majority of clients had a history of contact with mental health services, and that many had previously been admitted to a hospital or detained under the *Mental Health Act*.^{liii} Anecdotally, in Ontario, members of the Forensic Early Intervention Service (FEIS) team have found a similar pattern regarding previous interactions with community mental health services.

In addition to mental health services, the use of in-reach services can be explored to address priority health care concerns within a correctional environment, such as infectious diseases (e.g., Hepatitis B and C, sexually transmitted infections (STIs)). A number of community organizations, such as Prisoners' HIV/AIDS Support Action Network (PASAN) and the Community AIDS Treatment Information Exchange (CATIE), as well as government programs, including regional HCV Teams and local public health units, have the mandate and/or expertise to deliver these programs in the community.

The Committee heard from some stakeholders that it can be difficult to partner with correctional facilities to provide services designed to support better health outcomes for patients in custody.

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Alignment with Social Services

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Through conversations with individuals with lived experience, the Committee heard how difficult it can be for people in custody to finalize applications for government identification, N-numbers (for Inuit individuals), or social assistance programs before they are released from custody.

This means that, despite the best intentions of health care staff or discharge planners to ensure clients leave facilities with the prescriptions they need, individuals being discharged may not have quick access to government programs that are suspended during custody (i.e., social assistance such as Ontario Works or the Ontario Disability Support Program, including drug benefits). While there is an option called 'rapid reinstatement' for individuals who find themselves with an immediate financial need, it requires a visit to a local Ontario Works office – which can be enough of a barrier to prevent an individual from initiating this process after time spent in custody.

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Access to Family and Friends

One of the most important pieces of advice provided to the Committee was that attachment to family and friends can be an important source of support for individuals in custody – both during incarceration, and during transitions back to the community. One study from the United Kingdom found that more than half of individuals returned home or moved in with family upon release; among the few who had employment upon release, they had primarily arranged it with the help of previous employers, family, or friends.^{liv} These are just two practical examples that demonstrate that family and friends are important support networks for individuals in custody.

The Committee recognizes this important relationship, and that a connection with family and community may be especially relevant for Indigenous individuals. While not all individuals have the benefit of positive social relationships, for those who do, the government must make space for family and friends to play a role in the health, healing, and rehabilitation goals of people in custody, and ensure access to this important source of support is protected and standardized in each facility.

**Attachment to
family and friends
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source of support
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both during incarceration,
and during transitions
back to the
community.**

Availability of Peer Support Programs

The Committee heard from individuals with lived experience that peer support provides a significant source of information and guidance for individuals trying to navigate their time in custody. Formal peer support could mean services provided by currently or previously incarcerated individuals. Since peers can often offer a greater sense of empathy and understanding, they can be effective partners in helping the correctional system build more trust with the population it serves. The importance of this kind of support is also reflected in academic literature, which has found that formal peer interventions can be an effective approach for addressing the health and social needs of people in custody.^{lv}

Evidence shows that when peers deliver health care-related information, it can have a positive impact on a variety of health outcomes for people in custody, including: increased knowledge of HIV and uptake of HIV testing; increased knowledge of STIs; beliefs, intentions, and reported increases in condom use; and, increased inclination to practice safe drug-using behaviours.^{lvi} There is also evidence underlining the ability of peer workers and trainers to improve mental health and well-being, enhance treatment adherence, and have a positive effect on reducing recidivism and engaging in health-promoting behaviours.^{lvii}

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Renewed Collaboration: Government and Community Services

The Committee understands that, in the past, some organizations and community service providers have had frustrating experiences with some correctional facilities. There have been real barriers that have prevented – or slowed down – their

efforts to connect with this population and provide people in custody with support and care. Where strong relationships have been formed, they can change depending on staff turnover, and the interests of people in custody can get lost in that transition.

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It is the hope of the Committee that a renewed commitment from the government to address some of these policy barriers will signal a true commitment to change.

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Correctional facilities face a number of ongoing and persistent challenges in recruiting and supporting health care staff. Some of these challenges include: a lack of centralized human resources planning; a “supply and demand” issue where the correctional system cannot compete in a competitive job market; lower compensation as compared to other health care settings; inconsistency in the “mix” of professionals in each facility; and, limited access to training, development, and career advancement opportunities. Health care staff also cite professional isolation, a lack of community of practice, a lack of modern infrastructure (e.g., paper charts vs. electronic medical/health records), and often, more remote geographic location in the province, as additional challenges.^{lviii}

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Adequate Resourcing

Access to care within correctional facilities is limited by staffing. Currently, less than half of the province’s correctional facilities provide access to 24-hour nursing coverage, seven days a week. The remaining facilities have varying hours of coverage with typically less coverage on weekends, despite the increase in admissions during this time. Together, high vacancy rates combined with insufficient coverage mean that access to health care programs and services is often challenging for people in custody, and poses a barrier to the implementation of new programs as well as improvements to existing programs.

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province had 438 full-time correctional nursing positions.^{ix} Of the 118 health care staff on contract, the majority are physicians (56%) and psychiatrists (39%). Dental and optometry services are available, but often limited. Despite high pharmacy needs, only four of the 25 facilities have access to pharmacists, while only two have technicians.^{ixi}

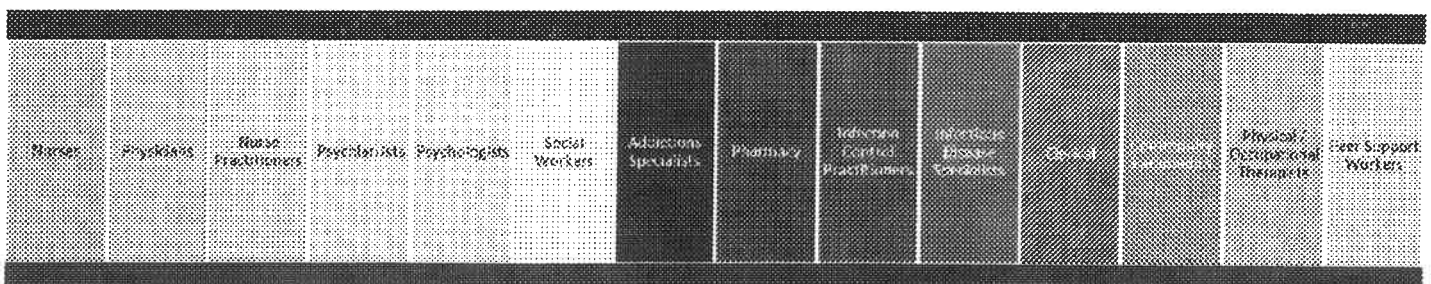
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Less than half of the province's correctional facilities provide access to 24-hour nursing coverage, seven days a week.

A Suitable Mix of Professionals

Dealing with a complex patient population requires health care professionals with a wide range of skills and expertise. Currently, however, the vast majority of correctional health care is being delivered by nursing staff; as of March 2018, the

Interprofessional Health Teams



Engaged, Well-Compensated, and Trained Health Care Professionals

Difficulties with recruitment and retention are common in correctional health care, and Ontario is no different. Providing care in a correctional facility is a demanding task. Factors that contribute to recruitment and retention problems include lower rates of pay (compared to colleagues working in the community), high reported levels of stress and burnout for health care providers, and a lack of professional training opportunities. On average, correctional nurses are paid at a lower rate than many of their counterparts working in hospitals, family health teams, and long-term care. While starting salaries for nurses in corrections begin at a higher wage rate than other health environments, hourly rates do not keep pace as nurses proceed through the wage grid.^{lxiii}

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working in hospitals,
family health teams, and
long-term care.**

Appropriate Infrastructure, Tools, and Physical Space

With the exception of the newer builds, most of Ontario's correctional facilities – such as the Brockville Jail, built in 1842 – were not designed to accommodate the requirements or expectations of modern health care services. In many facilities, accessibility, space, and privacy are limited.

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and a well-equipped health unit, but also a safe environment.

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The environment that correctional health care providers work in is not just about physical space

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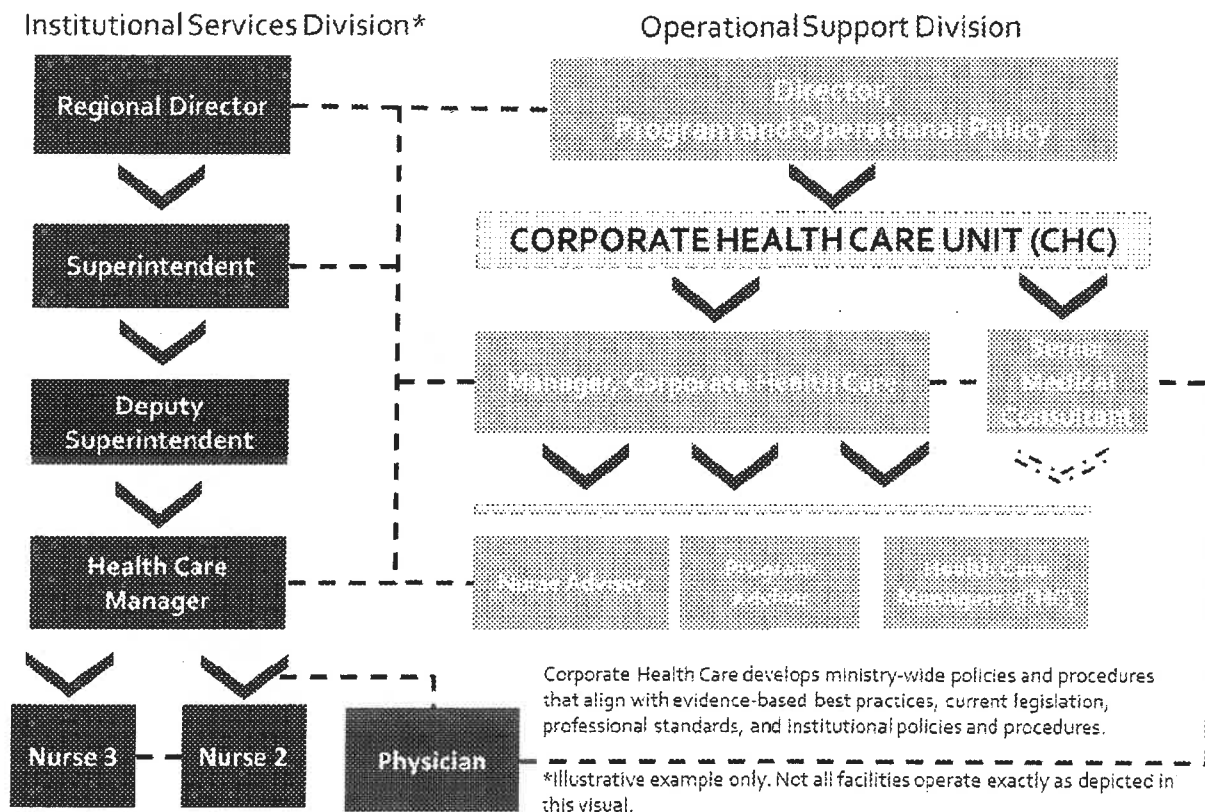
"MCSCS should undertake a full facility physical inspection to improve health and safety conditions, and create a more hygienic environment for inmates and staff...It would also establish a long-term, life cycle approach for the physical infrastructure."

*-Recommendation 39, Ottawa-Carleton
Detention Centre Task Force Action Plan^{lxiv}*

Under the current governance structure for correctional health care services in Ontario, health care staff report directly or indirectly to Superintendents of facilities. This often results in day-to-day decisions that are based on institutional needs rather than clinical considerations. Moreover, since MOHLTC plays no direct role in the delivery or oversight of correctional health care services, correctional facilities are often removed from the rest of the health system.

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Current Governance Structure



Organizational Changes Required

Currently, health care services in Ontario's provincial correctional facilities are governed and delivered by MCSCS. Each facility has a Health Care Manager (generally a registered nurse managing health care services and regulated professionals), who is in charge of the provision of health care services within the facility, and who reports to the Superintendent or a Deputy Superintendent. MCSCS has a Corporate Health Care Unit within its Operational Support Division that develops ministry-wide health care policies and procedures that align with evidence-based best practices, current legislation, professional standards, and institutional policies and procedures. Despite the fact that Corporate Health Care is tasked with providing oversight for professional practice, there are no direct reporting relationships between Corporate Health Care and health care staff in correctional facilities. According to numerous health care staff within correctional facilities, the channels of communication are disjointed and ineffective.

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"...inmates in Ontario receive health care services that are delivered and managed in isolation from those provided to virtually everyone else in the province..."

-Howard Sapers, *Corrections in Ontario: Directions for Reform* (2017)^{lxv}

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All health care services in Ontario's correctional facilities work with a paper-based system, and have not kept pace with advancements in the broader health care system. Correctional facilities across the province continue to struggle with aging infrastructure and technology. This slows down the provision of services, increases room for error, and creates barriers to ensuring continuity of care within and among correctional facilities, as well as with community providers. In addition, there is a lack of information and data, further preventing the ability to assess health care needs, plan for health care services, examine variations across the province, and measure the effectiveness and appropriateness of care and health outcomes.

An EMR contains a patient's medical history, including patient demographics, encounter details, current issues, patient consultation reports, and imaging and lab reports. Access to historical and up-to-date health information helps to give providers the information they need to deliver high-quality care. In addition, the health information collected can help health care staff track performance and drive quality improvement. EMRs in Ontario can also be configured so that health care providers can easily access provincial electronic health record data, including hospital

¹⁰ Health information systems refer to any system that captures, stores, manages, or transmits information related to the health of individuals or the activities of organizations that work within the health sector.

data, lab reports, prescribing history, etc. An HIS provides additional functionality with respect to the administrative needs of correctional health care services.

Transitioning from paper to digital health systems and records would greatly improve the quality and continuity of patient care by enabling the care team to more easily share patient records, lab results, prescription information, discharge summaries, etc., between the correctional facility and providers in the community. For a population with high rates of reincarceration and short durations of stay in custody, moving to a digital/electronic system will greatly ease transitions, support the health care team, improve patient experience, and keep pace with the broader health system and emerging trends in Ontario. Moreover, modernized health technology will enable data that is crucial to tracking outcomes associated with the model of care and allowing for the implementation of continuous improvement strategies.

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It is difficult to accurately assess the current quality of care in prisons due to a lack of relevant clinical data, audits, and quality improvement plans, as well as inconsistency in approaches to the provision of care across facilities.

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Currently, oversight mechanisms for correctional health care services in Ontario are only activated when a situation has gone far beyond the early intervention stage (e.g., inquests, a complaint from the Ontario Ombudsman, a human rights complaint, a complaint to the regulatory colleges, or a serious incident). In addition, oversight of health care in correctional facilities has the potential to fall under the jurisdiction of multiple entities, depending on the nature and severity of the complaint.

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Patient Complaints

The new *Correctional Services and Reintegration Act, 2018*, if proclaimed, will establish a formal complaints process that allows individuals to complain about the operation of correctional institutions or the provision of correctional services in correctional institutions.

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Resolving Disputes Among Staff

Currently, no formal process is planned or in place to resolve disputes that may arise as a consequence of conflicts between health care decisions and institutional decisions (such as a lack of security escorts to a community appointment).

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The Committee learned of many creative solutions that operational and health care staff have developed that balance clinical and security considerations; our recommendation will help to create an environment that promotes professional accountability among staff and fosters this type of creative problem-solving when health care and security issues conflict.

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"For instance, we found one inmate, Harry, naked and in a disheveled state in a dirty cell. He had been in segregation for more than 30 days. However, when we reviewed the relevant documentation, we found that successive segregation review forms referenced incorrect information, were virtually carbon copies of each other, failed to record his severe mental illness, and suggested that no actual review or update of his initial assessment had ever taken place."

-Ontario Ombudsman,
Out of Oversight, Out of Mind (2017)^{lxvi}

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“What this investigation has made abundantly clear is that vigorous and credible oversight mechanisms need to be put in place to enforce the regulation and policy, as well as to ensure respect for inmates’ human rights.”

-Ontario Ombudsman, *Out of Oversight, Out of Mind* (2017)^{lxviii}

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The relationship between health care and security staff deserves special and focused attention as part of the transformation of correctional health care services because it is both important for ensuring access to health care services, and challenging for staff and people in custody to navigate.

Correctional officers play a significant role in how individuals access health care while in custody. People in custody request visits to the health care unit via correctional staff, correctional staff may be first responders in an emergency, and correctional staff are the ones who escort patients to the hospital for assessment or treatment. The lack of trust between people in custody and correctional staff can act as a barrier to accessing non-emergency health care services.

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Another barrier to accessing health care services within the current correctional environment is the fundamentally different mandates of correctional officers and health care staff. Correctional officers have a responsibility to ensure facilities are safe environments and that security is upheld at all times, while health care professionals have an obligation to their profession to put their patients' needs first. The Committee acknowledges the importance and legitimacy of each group's professional obligations, but notes that, although this tension is inherent to correctional environments, it can and must be improved.

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To better understand how to improve this dynamic, the Committee explored two key concepts related to the tension of providing healing and health care services within a secure and often punitive environment.

Dual loyalty is defined by Physicians for Human Rights as the situation arising when “the loyalty to one’s professional oath and ethics comes into conflict with loyalties and obligations to a third party, in this case, the state and its security interests.”

The first concept is that of ‘dual loyalty.’ Dual loyalty is defined by Physicians for Human Rights as the situation arising when “the loyalty to one’s professional oath and ethics comes into conflict with loyalties and obligations to a third party, in this case, the state and its security interests.”^{lix} Dual loyalty does not mean that a health care professional must balance these competing interests, but rather that they must understand the explicit pressures and be able to work effectively and in line with the patient’s interests within a challenging environment.^{box}

Providing high-quality and patient-focused health care services within the current environment is difficult. Frequent lockdowns, outdated infrastructure, low prioritization of creating a therapeutic environment, and restricted access to certain treatments and medications are just a few examples of the consequences of security interests taking precedence over the health outcomes of individuals in custody.

The Committee believes that, while dual loyalty cannot be eliminated, it can be actively managed and addressed through strong leadership that endorses a culture of change, effective collaboration among staff, appropriate staffing levels to help minimize the use of lockdowns and to encourage the use of hospital visits, protected funding streams, and government policies that firmly establish a shared and protected goal of supporting the health and rehabilitation needs of this population.

Another barrier that can prevent individuals from accessing health care while in custody is the challenge of ensuring 'patient confidentiality' within a correctional environment. Patient confidentiality typically exists between a health care provider and their patient. However, in a correctional environment, there are legitimate security concerns that may influence – and limit – the ability of the system to maintain full confidentiality. For example, accidental or incidental disclosure of certain health conditions may happen in a correctional facility simply through the security coordination required to arrange visits with specialists or specific in-reach services related to chronic health conditions or diseases. Specific health concerns may also be relevant for making decisions regarding housing within particular parts of the facility.

The Committee heard from individuals with lived experience that this violation of confidentiality erodes client trust in health care and correctional

staff, which can discourage disclosure of important medical information and the use of health care services. The Committee recognizes that patients must always have the right to decide whether to consent to the sharing of health information with correctional officers and other staff who are not health information custodians. As a step forward, facilities could consider assigning dedicated correctional officers to work in the health care unit, and to accompany patients to medical appointments. This challenge can be further addressed by building a common understanding of consent and confidentiality rules among health care staff, correctional officers, and individuals in custody, and ensuring that relationship-building and cooperation are prioritized.

There is an opportunity to reframe the role correctional officers can play in contributing to the health and well-being of persons in custody. With appropriate training in de-escalation, mental health and substance use, workplace violence, and trauma-informed care, correctional officers can help facilitate effective health care delivery in prisons. In the pursuit of this joint objective (i.e., better health outcomes and access to health care services), a balance must be struck that creates conditions for a true partnership, while still respecting professional obligations.

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"According to the 2015 study of Italy's experience in reforming prison health services, a significant barrier to implementation was institutional inertia and the lack of commitment by prison administration to the reform process."

-MOHLTC, Research Evaluation and Analysis Branch Literature Review (2018)^{lxxi}

“Reforming health services for this population and transitioning responsibilities to the MOHLTC is a complex, multi-step process.”

-Howard Sapers, *Corrections in Ontario: Directions for Reform* (2017)^{xxii}

The recommendations and action items in this report have the potential to transform health care in correctional facilities and, if implemented, will result in significant system changes for the health and corrections sectors in Ontario.

Financial Impact

Critical to the success of any implementation plan will be a thorough assessment of the necessary project funding and dedicated human resources that will be required to deliver a transformed correctional health care system. We know from other jurisdictions that transformation efforts were often followed by increases to funding and FTE counts. Due to Ontario’s geographic size and high population density, it is expected that its process of transformation will require more funding and FTEs than what has been averaged from other jurisdictions (see additional details in “The Cost of Transformation” box on pages 45-46). More research will be needed to determine the Ontario-specific costs of implementing a new care model.

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The Correctional Transformation

Lessons Learned

Despite the uniqueness of Ontario's health care system in Canada, the Committee looked primarily to Alberta and British Columbia to provide a benchmark for the potential cost of transforming correctional health care services in Ontario. As was the case in these two provinces, the ability to make meaningful change will be intricately tied to the ability of the government to invest in – and commit to – a new approach. Beyond improving the quality of care available to this population, investments will need to be made to support a transformation of the current culture. Staff who work in this challenging environment deserve to have appropriate resources, education, and support, as well as strong leadership, to ensure transformation efforts lead to positive change for both people in custody and staff working within each facility.

A transformed correctional health care system will also require investments in clinical spaces and tools. Being able to provide more health care services on site will enable staff to work to the fullest extent of their professional scope. Ensuring that the care environment in correctional facilities is more closely aligned with clinical spaces in the community will demonstrate to both staff and patients that this new model of care is focused on holistic and proactive solutions, and is not a bare-minimum, second-tier system.

Cost of Transformation in Alberta and British Columbia

Ontario's current per capita budget for correctional health care is approximately \$7,894, totaling \$62M annually. This is roughly similar to British Columbia's pre-transfer, per capita spend, which ranged from \$7,778 to \$8,889.^{14,15}

After taking steps to improve their health care services, both Alberta and British Columbia now spend between \$12,417 and \$12,851, per capita, to

provide health care services to individuals in provincial custody. This represents an increase of approximately 40% in order to provide health care services to this population.^{16,17}

Limitations of Costing Information

There are significant caveats to using the information from Alberta and British Columbia as a benchmark to accurately quantify the potential level of required investment for Ontario. Given that the Committee does not know how these provinces arrived at the increased funding figures, nor upon what measures the initial funding was based, nor what quality measures or service levels were used as benchmarks or goals, the Committee has included these examples for context only. Although there are key similarities to Ontario, there are also key differences. Given the scale of operations in Ontario (i.e., significantly larger than in these two provinces), the Committee anticipates that implementation costs could very well be higher than a 40% increase to the current budget to achieve similar results. Without a detailed implementation plan and a comprehensive, Ontario-specific cost analysis, at this time, the Committee cannot provide specific advice on the exact level of funding required to transform correctional health care services in Ontario.

Potential Cost Savings

Just as the true costs of improving services are unknown, the potential cost savings that could be realized within the health and social service systems post-transformation are also unknown. There are clear benefits to investing in a healthier prison system, including the health and safety of the correctional officers and health care professionals who work directly with these clients. A healthier population would mean fewer escorted trips to the hospital, fewer mental health crises, and better-managed cases of withdrawal – all of

which cause strain for the individuals as well as the staff responsible for their safety and care.

There are also likely cost savings to be had in terms of what is spent on health care and social services for individuals who have been involved in the provincial correctional system at any point in their lives, and who have not received high-quality care or been well-connected to the community. It is likely that a transformed and more efficient system of care could result in overall cost savings to the government downstream, as well as a healthier population.

Given the strong linkages already established among the social determinants of health, the significantly lower health outcomes for this population, and the limited connections to primary

care providers in the community, the Committee recommends the government conduct a cost-benefit analysis that takes a systems approach to understanding the true costs and benefits for providing a different level of care to this population, taking the following into consideration:

- Reduction in emergency department visits;
- Impact of providing proactive health care (i.e., early detection and treatment) vs. costs associated with reactive care (i.e., emergency transport, hospital treatment, high-cost procedures, etc.);
- Impact of providing HCV treatment during incarceration, and potential for eradicating the virus from the province;
- Impact of reducing rates of STIs; and,
- Impact on average life spans and mortality rates.

Conclusion

The recommendations contained in this report provide a roadmap for bold changes to the provision of health care in Ontario's correctional facilities. Rather than address specific issues in a piecemeal way, these recommendations will help to build a high-performing correctional health care system that promotes equitable outcomes for people in custody, improves public health, and allows for more efficient spending of tax dollars. This new approach will also help to ensure the government has the capacity to implement the many and repeated recommendations from Coroners' inquests, the Ontario Human Rights Commission, the Independent Review of Ontario Corrections, correctional health care professionals, and individuals and community organizations that recognized the need for transformation long before this Committee came into existence.

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addressing these issues requires a profound culture change, moving away from a punitive incarceration model toward a correctional model that upholds health and health care as being critical to reducing reincarceration and recidivism, lowering costs, and above all, improving the health and well-being of individuals in custody, thereby benefiting the entire province.

Appendices

Glossary of Terms

For the purpose of the work of the Expert Advisory Committee on Health Care Transformation in Corrections, the following definitions have been agreed to by members, and supported in principle by MOHLTC and MCSCS.

Clinical Independence: *The assurance that individual regulated health professionals have the freedom to use their professional judgment in the care and treatment of their patients without undue influence by outside parties or individuals.*

Continuity of Care: *The coordinated, continuous management of health care and mental health care services that strives to ensure health needs are identified and addressed at each stage of an individual's journey through the justice/correctional system, and that any transitions are seamless.*

Health Equity: *An approach or lens that can be applied to providing health care or establishing health care goals that recognizes that different actions may be required to achieve similar outcomes for different individuals or groups due to the uneven distribution of health, economic, and/or social status.*

LGBTQ+: *An acronym that stands for lesbian, gay, bisexual, transgendered, and queer individuals, as well as others with diverse and fluid sexual orientations and gender identities (including, for example, two-spirited, or questioning individuals).*

Patient-Centred Care: *The concept that patients become partners in care, where their needs and circumstances are part of a mutually agreed-upon relationship and management plan.*

Population Health: *An approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups.*

Recidivism: *Defined in Ontario as a return to provincial correctional supervision on a new conviction within two years of completing probation, parole, a conditional sentence, or a provincial jail sentence of six months or more.*

Rehabilitation: *A planned intervention (i.e., program or treatment program) designed to support the development of pro-social behaviour, assist individuals and families with the healing journey, and reduce recidivism and reincarceration.*

Reincarceration: *A return to custody within a provincial correctional facility due to a charge (remand) or conviction. This includes returns based on administration of justice violations (such as probation and parole violations).*

Remand: *A state of being held while awaiting trial or sentencing. Individuals on remand are sometimes referred to as "legally innocent." Typically, an individual is remanded if they are considered high-risk (i.e., it is likely that they could commit a serious crime, interfere with the investigation, or fail to appear in court).*

Committee Membership

The Committee is comprised of 13 members (including the Chair) who represent a diverse membership including health care professionals, academics, an individual with lived experience, and those representing community organizations. Members were chosen for their knowledge, expertise, and perspectives.

Dr. Jeffrey Turnbull (Chair)

In addition to a B.Sc. (University of Toronto) and a Masters of Education degree (University of Western Ontario), Dr. Jeffrey Turnbull received his Doctorate in Medicine at Queen's University and later achieved specialty certification in Internal Medicine through the Royal College of Physicians and Surgeons of Canada in 1982.

Dr. Turnbull has been the Vice Dean of Medical Education at the University of Ottawa (1996-2001), the President of the Medical Council of Canada (1998-2001), the President of the College of Physicians and Surgeons of Ontario (2006-2007), and finally, the President of the Canadian Medical Association (2010-2011).

Dr. Turnbull has pursued an interest in poverty and its effect on health nationally and internationally. He is a founder, and currently the Medical Director of Ottawa Inner City Health for the homeless, which works to improve the health of – and access to health care for – people who are chronically homeless. As well, he has been involved in education and health services initiatives to enhance community and institutional capacity and sustainable development in Bangladesh, Africa, and the Balkans. Dr. Turnbull is the recipient of several national and international grants and awards, including the Order of Canada, the Order of Ontario, the Queen Elizabeth II Diamond Jubilee Medal, and an Honorary Degree of Law from Carleton University.

In addition to being a specialist in Internal Medicine, Dr. Turnbull was the Department Chair of Medicine at The Ottawa Hospital and University of Ottawa (2001-2008), the Chief of Staff at The Ottawa Hospital (2008-2017), and Chief, Clinical Quality for Health Quality Ontario (2014-2017). Dr. Turnbull also served as Senior Medical Officer for Correctional Service Canada (2011-2014). He currently holds the position of Health Equity Clinical Lead at Health Quality Ontario. He remains committed as a medical educator with special interests in "Poverty and Health Inequity" and associated health policy.

Dr. Gary Ing

Dr. Gary Ing, M.D., F.C.F.P., C.C.P.E., has been the Chief of Staff at the Windsor Regional Hospital since 1995. Dr. Ing has been a family physician since 1978 and also has experience as an emergency medicine physician (1978-1986).

Dr. Ing's previous professional appointments include Chief of the Department of Emergency Medicine (1979-1980) and Chief of the Department of Family Medicine (1987-1994), both at Windsor Western Hospital Centre. He also served as the Chair of the Board of Directors for the Ontario College of Family Physicians (1992-1993).

Dr. Ing has held many community appointments, including President of the Essex County Chinese Canadian Association (1983, 1984, and 1987) and Implementation Committee member of the Health System Reconfiguration Project for the Essex County District Health Council (1994), which led to hospital restructuring for the community. He has also served as a member of the Essex Kent Lambton Medical School Exploratory Committee (2000-2001), which led to the establishment of a Medical School Campus for the Schulich School of Medicine at the University of Windsor.

Dr. Ing is the recipient of the Life Membership Award from the Essex County Medical Society (2015), the Queen's Jubilee Medal (2003), and multiple Service Awards from the Essex County Chinese Canadian Association (1985, 1996, and 2003).

Dr. Verner Isaak

Dr. Verner Isaak is a primary care physician who has worked at Maplehurst Correctional Complex and Syl Apps Youth Centre since 1975. He also worked full-time as a family doctor in a clinic setting from 1966 until 2006. During his career, Dr. Isaak worked for two years (1973-1975) in a government hospital in the Democratic Republic of Congo in the position of Assistant Director of Community Medicine. He has additionally worked for short terms in Haiti, the Dominican Republic, Mexico, Burundi, and Malawi. While in practice, Dr. Isaak provided medical care and counseling services to students at Sheridan College for 40 years. Since 2005, he has travelled to prisons in 26 countries, at the invitation of local officials, to provide support to people in custody and their families.

Lindsay Jennings

Lindsay Jennings, who works at Prisoners' HIV/AIDS Support Action Network (PASAN), has a dynamic approach to the provision of support to prisoners and former prisoners who are striving toward their community integration goals. Her areas of interest include educating individuals about harm reduction/ overdose prevention, HIV/HCV workshops, and facilitating life-skills workshops with this marginalized population. Lindsay is a committed advocate who is passionate about bringing positive changes to those who are involved with the correctional and criminal justice systems by ensuring that substance use, mental health, and program needs are addressed as immediately as possible once they have been admitted to custody as well as throughout their incarceration. As a committee member of Lived Experience Advisory Group (LEAG) for the City of Toronto, she is also committed to working for community members alongside the City of Toronto to actively address poverty issues.

Shirley Kennedy

Shirley Kennedy is a registered nurse with more than twenty-nine years of experience in the correctional nursing sector. With MCSCS, Shirley's career in correctional nursing has spanned the continuum from frontline General Duty Nurse to Nursing Team Lead to Nursing/Health Care Manager. As a Senior Policy Analyst with MOHLTC, Shirley led several important initiatives that supported nursing recruitment and retention in the province. Shirley is a past president of the College of Nurses of Ontario, a current member of the Provincial Nursing Advisory Committee, and the current president of the Registered Nurses' Association of Ontario (RNAO)'s Ontario Correctional Nurses' Interest Group. Shirley is currently employed by the Ministry of Children and Youth Services as a Health Care Manager.

Heather Kerr

Heather Kerr holds a B.A. in Psychology/Law and Criminology and a Masters of Social Work Degree. She has over 25 years of experience in the mental health field, specializing in addictions, concurrent disorders, and post-traumatic stress disorder (PTSD). She has worked extensively with provincial and federal corrections as well as

program design and clinical consultation through her private practice. Heather has provided training in Ontario, across Canada, and in the United States. Heather is also an instructor at Wilfrid Laurier University.

Heather has been the Executive Director of Stonehenge Therapeutic Community for 15 years. Stonehenge is a modified therapeutic community founded in 1971 as a long-term residential treatment program for men and women with a history of acute chronic substance abuse and involvement with the criminal justice system. Stonehenge also offers a broad range of community programs across the harm reduction continuum including housing, drug court, rapid access addiction clinic, overdose response, outreach, community withdrawal, support coordination, and services for pregnant and parenting women.

Heather has held numerous leadership positions both locally and provincially. In 2012, Heather was seconded to the Waterloo Wellington Local Health Integration Network as Integration Lead – Addiction Services. She is currently on the Board of Directors of the International Community Corrections Association (ICCA) and is the Chair of the ICCA – Ontario Chapter. Heather is one of the founding members of the Canadian Association of Women's Criminal Justice Residential Options (CAROW). She is also on the Board of Directors of Addiction and Mental Health Ontario (AMHO).

Dr. Fiona Kouyoumdjian

Dr. Fiona Kouyoumdjian, M.D., M.P.D., Ph.D., C.C.F.P., F.R.C.P.C., is a Public Health Physician, Family Physician, and Epidemiologist. Since 2007, she has worked part-time as a Family Physician in a provincial correctional facility. Dr. Kouyoumdjian leads a program of research in the Department of Family Medicine at McMaster University that focuses on the health status and health care of people who experience imprisonment in Canada.

Dr. Kwame McKenzie

Dr. Kwame McKenzie is CEO of the Wellesley Institute. He is an international expert on the social causes of illness, suicide, and the development of effective, equitable health systems.

As a physician, researcher, and policy advisor, Dr. McKenzie has worked to identify the causes of illness and in cross-cultural health for over two decades. He is an active, funded researcher of social, community, clinical, and policy issues with nearly 200 academic publications, including five books.

In addition to his post at the Wellesley Institute, Dr. McKenzie is the Director of Clinical Health Equity at the Centre for Addiction and Mental Health (CAMH). He is also a full Professor in the Department of Psychiatry, University of Toronto.

Dr. McKenzie sits on the Boards of the United Way Toronto, the Ontario Hospitals Association, and Community Food Centres Canada. He is a Senior Fellow at Massey College. He is the Research and Evaluation Advisory Committee Chair and a senior advisor on Ontario's Basic Income Pilot.

Dr. McKenzie was a member of the Ontario Government's Mental Health and Addictions Leadership Advisory Council and sat on the Expert Advisory Group for Ontario's Homelessness Strategy alongside numerous other committees.

He has a respected track record for setting up award-winning services, training clinicians and researchers, offering clinical care to some of the most marginalized patients, and helping to develop health policy for governments in Canada, Africa, Europe, the Caribbean, and the United States.

Dr. McKenzie completed his medical training at the University of Southampton and was trained in psychiatry at the Maudsley Hospital and Institute of Psychiatry and Harvard University.

Donna Milne

Donna Milne graduated from the University of Toronto's Faculty of Nursing in 1973 with a B.Sc.N. Apart from five years as a Clinical Instructor in Psychiatry at the University of Toronto, most of her 43-year career in nursing was in Public Health, up to the last ten years with MCSCS. At the Simcoe Muskoka District Health Unit, Donna's role as a Public Health Nurse was primarily in the Sexual Health Program. As the health unit began to move toward Harm Reduction, she had the experience of working with a group of Public Health Nurses to develop, promote, and initiate the Needle Exchange Program in Simcoe County. Donna has completed Skills Enhancement Courses through Public Health with a focus on Epidemiology and Outbreak Management, and completed certification as a Non-Acute Care Infection Control Practitioner in 2012. From 2007 until her retirement in 2016, Donna was the Health Care Manager at Central North Correctional Centre, an 1,100-bed maximum security jail in Penetanguishene.

Mark Marsolais-Nahwegahbow

Mark Marsolais-Nahwegahbow is Ojibwe and a Band Member of the Whitefish River First Nations, located on Manitoulin Island. He has over 25 years of experience working in social services. He has held several positions within Indigenous organizations helping to develop and oversee First Nations justice programs and to ensure the courts and Indigenous people have a better understanding of the programming available to individuals facing bail, incarceration, diversion, and reintegration back into the community.

Mark has over 17 years of experience as a Case Manager with youth and adults in custody, in open and secure facilities. He has over nine years of experience with adolescents with mental illness legislated to a secure intensive treatment facility.

Mark is the founder of IndiGenius & Associates and is responsible for the daily activities of the company. He liaises with organizations and the courts on judicial matters pertaining to the preparing and writing of Sacred Stories (Gladue reports).

Mark has also partnered with Vancouver Community College and is a contracted Teaching Instructor for the Gladue Writing Training Program Pilot Project. He has designed the first intensive training curriculum for Gladue Writing in Canada and is working toward setting a national standard for writers.

Mark offers a wide range of Indigenous justice services, including research on community needs within the justice system, development and monitoring of restorative justice programs, Peacemaking and Sentencing Circles, and Gladue Training and Gladue Report-Writing Services. Mark is an IRSS Residential School Crisis Line Counsellor with Donna Cona, Indigenous and Northern Affairs Canada (Resolution Individual Affairs Sector).

Mark is the founder of Birch Bark Coffee Company, which is First Nations-led and -owned with a purpose to fix the "Boiled Water Advisories" on all reserves in Ontario and then across Canada. Portions of the proceeds from all coffee sales go to purchase custom home water purifiers that will give clean drinking water to every home for free. It is "Coffee Making a Difference."

Mark Parisotto

Mark Parisotto is the current Regional Director in the Eastern Region, Institutional Services with MCSCS. Mark has experience in various roles both in the field and in corporate office. In 1989, Mark began his career as a Correctional Officer at the Toronto Jail (TJ) and subsequently moved to Mimico Correctional Centre in 1992 for a few years. Mark returned to the TJ in 1997 where he became a Sergeant. In 2001, he took on an assignment as a Senior Staff Development Officer at the Ontario Correctional Services College but shortly thereafter moved on to become Deputy Superintendent of Operations at Maplehurst Correctional Complex (MHCC).

Following a variety of positions within Central Region, including Deputy Superintendent of Administration at both the TJ and MHCC as well as Superintendent at the TJ, Mark joined corporate office in 2009 as the Executive Assistant to the Director of what was then the Management and Operational Support Branch. After a few years, the field called him back and Mark returned to MHCC in 2011 as Deputy Superintendent of Administration and then Superintendent in December 2011.

Mark currently participates on the MERC Security Working Group sub-committee and is an active member of the Conestoga, Centennial, and Sheridan Colleges' program advisory committees.

Tina Kakepetum Schultz

Tina Kakepetum Schultz is a member of the Keewaywin First Nation and currently lives in Red Lake with her husband Peter Kakepetum Schultz. She has three sons, Jeremey, Kevin, and Blue Mason (Keewaywin F.N.) and is a proud Kokum of 10 grandchildren.

Tina has been the Health Director of Keewaytinook Okimakanak (Northern Chiefs Council) since 2014. She provides leadership and administrative direction in the management and development of Keewaytinook Okimakanak Health Services.

Tina previously worked as the Assistant Director of eHealth of Keewaytinook Okimakanak (KO) to ensure community and cultural practices are integrated into KO eHealth policies, programs, and services. She designs and delivers marketing strategies that ensure the KO eHealth brand is recognized and seen positively by stakeholders and potential stakeholders. Tina also works with KO and NODIN Mental Health Services to integrate Telemedicine and build clinical and educational capacity in the region.

Tina worked as the KO Telemedicine (KOTM) Community Engagement Coordinator in Balmertown, Ontario and was responsible for educating and promoting First Nations on the KOTM program. She acts as a liaison between KOTM, 26 First Nations communities, various government departments, and First Nations and Métis organizations.

Tina led a comprehensive communication strategy funded by Canada Health Infoway as part of a change management initiative. Tina is a member of the Chiefs' Committee on Health led by Sioux Lookout First Nations Health Authority since 2005.

Tina has worked with Indigenous people across Canada for the past 30 years within performing arts mediums of theatre, television, and film. Her play "Diva Ojibway" premiered in Toronto in 1994 as the first opera sung in the Oji-Cree language. She worked as a researcher and writer for the National Film Board for 10 years.

Dr. Sandy Simpson

Dr. Sandy Simpson is Associate Professor and Head of the Division of Forensic Psychiatry at the Department of Psychiatry, University of Toronto, and Chief of Forensic Psychiatry and Clinician Scientist at the Centre for Addiction and Mental Health (CAMH).

Dr. Simpson has served in directorial and advisory roles on the International Association of Forensic Mental Health Services, the International Academy of Psychiatry and Law, and the Canadian Academy of Psychiatry and Law, and is a member of multiple Committees of the American Academy of Psychiatry and Law. He is a member of the Editorial Board of Criminal Behaviour and Mental Health, the Canadian Journal of Psychiatry, and the International Journal of Risk and Recovery. He has over 100 refereed papers, book chapters, and monographs.

Dr. Simpson's academic, teaching, and research interests are in the area of the interaction of the law and people with serious mental illness (SMI): how we understand pathways to risk, into the criminal justice system, and for therapeutic intervention and recovery. He is committed to improved understandings, services, outcomes, and jurisprudence for persons with SMI who are criminal justice-involved. Dr. Simpson's clinical and service development activities are currently in correctional mental health, including in research and in international networks.

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