OMSA AÉMO
Ontario Medical Students Association
Association des étudiant·e·s de médecine de l'Ontario

POSITION PAPER

Health Care Reform in Canadian Corrections Facilities

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Approved: May 30th, 2021

INTRODUCTION

In many provinces and territories, including Ontario, health care for prisoners is not legislated under the provincial Ministry of Health. Federal and provincial offenders are excluded from the Canada Health Act and are not covered by Ontario's provincial health system. This creates a parallel - but unequal - system of care for one of society's most marginalized populations and is a concern for health equity in Ontario. This is an important issue that requires more attention, advocacy and education from the medical profession.

Current State of Incarceration in Canada

In 2017/2018, there were over 400,000 adult admissions to correctional services across Canada (1). On any given day, approximately 40,000 individuals are held in custody, including about 38,700 adults and 800 youth aged 12 to 17 (1). Of this number, approximately 64% are held in provincial/territorial custody serving sentences of *less than* two years, while the other 36% are held in federal custody serving sentences of *over* two years (1). In Canada, federal and provincial or territorial governments share jurisdiction over correctional institutions, with federal prisons being managed by Correctional Service Canada (CSC) and provincial/territorial prisons being managed by each jurisdiction's respective Ministry of Justice. Therefore, health care within institutions is managed by governmental authorities responsible for corrections, rather than health authorities. Exceptions to this are provincial facilities located within B.C., Alberta, and Nova Scotia, where health care delivery for inmates has been transferred to the respective ministries of health (2,3).

Despite the fact that incarceration rates in Canada have steadily declined between 2013 and 2018, overrepresentation of specific marginalized groups, including Black and Indigenous people, continues to persist (1,4). For example, in 2017/18, Indigenous adults accounted for 30% of adult admissions to provincial/territorial custody and 29% to federal custody, while only representing approximately 4% of the broader Canadian adult population[1]. In terms of cost, operating expenditures increased by 7% (after adjusting for inflation) in 2016/2017, despite fewer total individuals in custody overall (4). In 2017/2018, the cost of all adult correctional services in Canada totaled over $5 billion (4). With such immense financial investment in correctional services, it is critical that the public understands where funding is directed and how inmates are treated, especially with regards to health care.

Health and Incarceration in Canada and Ontario

Legislative/Legal Issues

The *Canada Health Act*, the federal legislation that ensures publicly funded health insurance for all Canadians, explicitly excludes inmates of federal penitentiaries (5). To fill this gap, the CSC is required to provide health care to federal inmates; as per the Corrections and Conditional Release Act (CCRA), they have a legal obligation to "... provide every inmate with (a) essential health care; and (b) reasonable access to non-essential health care" (6). This structure is mirrored in the provincial correctional system in Ontario, whereby health care for individuals in provincial custody is provided by the Ministry of Correctional Services and Community Safety (MCSCS), rather than the Ministry of Health (MOH) (7). Structuring health care delivery for incarcerated individuals in this manner is concerning for a variety of reasons. First, the professional standards that these services are expected to meet are unclear and not explicitly stated in the CCRA nor elsewhere. Furthermore, the extent to which these standards align with federal and/or provincial standards of health care delivery are equally unclear. This leads to a lack of transparency and accountability as to how health care ought to be delivered in correctional institutions. Second, tasking correctional services with the delivery of health care for those in custody, rather than tasking a Ministry of Health, is directly contrary to existing international recommendations. For example, the World Health Organization's Health in Prisons Programme recommends that prison health care and public health services should be integrated, and that health care services should *not* be under the jurisdiction of ministries of justice (8). Such recommendations are synthesized into the U.N. Standard Minimum Rules for the Treatment of Prisoners ("The Nelson Mandela Rules"), which constitute the universally acknowledged minimum standards for the management of correctional facilities and the treatment of prisoners (9). The incongruence between internationally recognized recommendations and the legal structuring of correctional health care delivery in Canada is cause for serious concern.

Social Determinants of Incarceration and Prison Health

Given the unique health challenges that inmates experience, ensuring equitable standards of care is crucial for reducing existing health inequities between this population and the rest of Canada (2). These health inequities are a direct result of social and structural determinants of health, such as: poverty, adverse childhood events, lack of access to health care prior to incarceration, poor nutrition, and barriers to education, including the school-to-prison pipeline (2). Indeed, a 2016 review discovered that at least half of inmates in Canada reported a history of physical, sexual, or emotional abuse. 15-20% of Indigenous persons in correctional facilities are residential school survivors. Additionally, more than 55% of persons admitted to federal institutions had less than a grade 10 education, compared to only 19% of the broader Canadian population who have not completed high school (2). The environment and stress of incarceration can further exacerbate existing physical and mental conditions. As a result, the health status of incarcerated individuals is poor compared to the rest of the Canadian population. Numerous studies have shown that prisoners have high health care needs, such as increased rates of respiratory illness, hypertension, diabetes, hepatitis C, chronic pain, substance use disorders, mental illness and obesity (2,10,11). An evaluation of CSC's health services in 2017 revealed that Canadian inmates experience elevated rates of communicable diseases, mental health conditions, and specific health concerns such as head injuries and back pain (12). Hepatitis C (HCV), tuberculosis, and HIV are the most common public health concerns, with the prevalence of HCV and HIV being 17% and 1% among

Canadian inmates, compared to only 1% and 0.3% in the general population (12). Furthermore, mental health conditions are among the most common conditions affecting federal inmates, including anxiety and mood disorders (12).

Furthermore, the inmate population in Canada is aging. In 2017/18, over a quarter of federal inmates were 50 years or older, a steady increase over the last ten years (12,13). This increase intensifies the need for specific health services in response to concerns related to aging, such as chronic health conditions (13). Inmates also experience elevated rates of mortality, as the average age at death for a federal inmate is about 60 years old, compared to the Canadian life expectancy of 78.3 for men and 83 for women (13**)**. This aging population will increase the need for specialized end-of-life care in correctional facilities, to which inmates currently have inequitable access compared to the general population.

Challenges with Health Care Delivery

The CSC has consistently failed in meeting the health care needs of their inmate population. Of all offender complaints received by the federal Office for Correctional Investigator (OCI) in 2017/18, health care was the most common, accounting for 14.3% of all complaints (see Figure 1) (14). This has consistently been the case since 2014/15, with the prison health care system receiving more complaints than even the conditions of confinement (14). Similar issues have also been noted in provincial and territorial correctional facilities, including in Ontario (15–17). Various reports have been commissioned to evaluate health and health care delivery in Canadian prisons (11,18). These have identified four key areas of concern: (1) inadequate access to resources, (2) challenges with hiring and retaining health care providers (HCP s), (3) insufficient clinical independence, and (4) lack of continuity between prison and community health care systems. These challenges create immense barriers for inmates to receive appropriate care, which only serves to worsen their health whilst incarcerated.

1. *Inadequate Access to Resources*

As discussed above, federal and provincial/territorial prisons have a duty to provide health care that is of equal quality and accessibility to that which is available in the community. However, this rarely occurs due to insufficient health care resources, particularly mental health and harm reduction resources. The mental health needs of inmates across the country are high (2,11). However, prisons are inadequately staffed and resourced to manage these needs. In a 2017 survey, only 56% of federal inmates with complex needs reported being “satisfied overall with the mental health services they were receiving” (18). While some attempts have been made to address this, including employment of mental health professionals in federal prisons and reducing segregation for maximum-security inmates with significant mental health needs, these have been largely insufficient in scale (19). This can lead to a lack of trauma-informed care and the excessive use of force for those in mental health distress. Indeed, 20% of all use of force incidents reviewed by the Office of the Correctional Investigator in 2018/19 occurred in treatment centres for inmates with mental illness, and 1 out of 10 incidents was deemed unnecessary and/or inappropriate (19).

The use of harm reduction measures, such as Opiate Agonist Therapy (OAT) and Needle Exchange Programs (NEPs), which are publicly funded and have long been shown to be effective at reducing high-risk behaviours, are still inconsistently available to inmates. Many correctional facilities have restrictions on such programs, and even in facilities that do allow these programs, evidence suggests they consistently fail to provide these services in a timely

manner, putting opioid-dependant inmates in acute withdrawal and at greater risk of use, relapse and overdose (20–22). For example, despite evidence suggesting prison NEPs are effective for reducing the spread of infectious diseases such as HIV and HCV, they are not currently available in most Ontario correctional facilities and are still being debated as recently as April 2020 in the Ontario Supreme Court (23). Lack of buy-in from prison administrators, punitive rules such as those that enact disciplinary measures against inmates found to be in possession of illicit drugs, and limited confidentiality when accessing these types of harm-reduction resources, also greatly limit their uptake and usefulness (21).

In addition to lack of health care resources, there is also a significant lack of health care providers in prisons. HCPs make up a small minority of CSC employees – fewer than 6% as of 2018 – and this number rarely includes medical specialists or allied practitioners, such as physiotherapists, occupational therapists and dietitians (18). This greatly limits interdisciplinary collaboration and reduces the therapeutic options that providers can offer inmates. Additionally, many prisons do not have 24/7 nursing care, making them unequipped to respond to medical emergencies. When inmates require care that cannot be supplied by the correctional health system, they need to be escorted into the community, a process that is often limited due to its cost. Indeed, 42% of federal offenders surveyed disagreed that "the appointments they received for their clinical health care issues were within a reasonable timeframe", reporting long wait times for specialist/community practitioners, dental care and optometry services (18).

2. *Challenges with Hiring and Staff Retention*

Given that the majority of correctional facilities in Canada operate a prison health care system that is completely disparate from the public health care system, recruiting and retaining HCPs is a significant challenge due to concerns around scope of practice in the prison system, licensing and accreditation challenges, issues with pay, and the terms and conditions of employment in institutions. As HCPs are contracted to work within the prison system, corrections authorities often note serious difficulties retaining adequate health care staff (18). In 2013, the Federal Correctional Investigator reported a vacancy rate of 8.5% for all health care positions, with the highest vacancy rates in Ontario federal prisons, where, for example, 29% of psychologist positions were empty (18). Such understaffing contributes to long-wait times for inmates and suboptimal treatment of physical and mental illnesses (18). This lack of human resources has even resulted in newly admitted individuals being denied access to prescription medications for weeks while they await assessment by a physician (18). This not only exacerbates chronic medical conditions, potentially destabilizing new inmates, but can also increase the risk of communicable diseases to other inmates.

3. *Limited Clinical Independence*

Another challenge facing HCPs working in the correctional health care system is a lack of full clinical independence, due to a phenomenon called "dual loyalty". Dual loyalty refers to a clinical role conflict between obligations to a patient and obligations to a third-party, such as an employer (24). Clinical independence can be severely restricted in the setting of prisons, as HCPs often report to correctional leadership. Under these circumstances, HCPs may feel pressure to disclose confidential medical information or hand over health records to prison administrators for forensic or security purposes. At times, HCPs have even been ordered to participate in matters of discipline, solitary confinement and the performance of body cavity searches with no clear medical indications (25). This puts providers in a challenging position, balancing their employer's wishes and the basic tenets of medical ethics. This also erodes trust

inmates may feel towards HCPs, harming the therapeutic relationship and reducing the overall quality of care.

Many resolutions have been passed by international bodies, including the UN and the World Medical Association, all of which highlight the need to ensure that health professionals have independence from the punitive functions of prisons (26,27). According to these documents, the sole task of HCPs working in prisons should be caring for the physical and mental health of inmates (26). However, hierarchical structures within many prisons make this almost impossible.

1. Lack of Continuity in Care

The fact that most correctional facilities in Canada are tasked with administering a health system that is separate from the public health care system means that inmates receive extremely disjointed health care. The lack of continuity between these two systems negatively affects individuals both when they enter and when they exit prison. For example, medications included in provincial drug plans are not always the same as those available through correctional formularies. This means that when inmates enter prison, they often have their medications changed or terminated, and when they are released, they are given limited medication supplies and no prescriptions for renewal (28,29). When these individuals leave incarceration, they often are not connected to a community physician, making them vulnerable to acute exacerbations of their chronic illnesses, particularly overdoses (30,31). This is evidenced by the fact that health care utilization by former inmates, particularly of emergency services, was significantly elevated in the 3-months following release, when compared to the general population (31). While the CSC has identified the importance of extensive discharge planning, a multitude of barriers continue to persist with regards to health care, such as obtaining provincial/territorial health cards and coordinating medical services in the community. A 2017 survey found that more than 50% of CSC staff involved in discharge planning reported “always or frequently experiencing challenges” (18). What’s more, in most provincial correctional facilities, where inmates are held for shorter and more variable amounts of time, discharge planning is much more limited and often absent altogether. Another major limitation of the correctional health care system is the underutilization of health care technologies, specifically the use of electronic medical records (EMR) (2). Poor standards of documentation and lack of discharge planning leaves many patients with little record of medical interventions and treatments established within the prison system, forcing physicians taking on the care of these patients to undergo an arduous and time-consuming process to retrieve medical records. This may consequently delay care and put patients at increased risk of mortality after their release.

In summary, despite an immense financial investment in the corrections system, people who experience incarceration continue to exhibit poor health, as well as high rates of recidivism (31). The system continues to be overwhelmed with challenges of caring for the ageing population of inmates, treatment of inmates with mental illness, and prevention of chronic and communicable diseases. These inequities will continue to persist as long as health care for prisoners in Ontario is administered by correctional authorities, rather than the MOH.

PRINCIPLES

The Ontario Medical Students Association (OMSA) makes its recommendations using the following guiding principles:

1. As OMSA, we seek to be a compassionate and empowered medical student body that advances health equity for all members of society, therefore we must advocate on issues of prison health that disproportionately affect Indigenous, Black and low socioeconomic communities. Therefore, transferring responsibility of health care services for inmates to provincial and federal ministries of health ensures that equivalent health care standards and procedures are delivered to this unique population. It is our duty to redefine how health care is provided in the prison system, which should center on holistic and preventative health care services, including mental health supports, and rehabilitation. With that said, this is only one step towards reimagining a system that emphasizes transformative justice, rather than violent and inhumane conditions of punishment.
2. It is imperative that, as future medical practitioners, we acknowledge inequitable systems of health delivery and continue to advocate for accessible, high quality, and non-discriminatory health care for prisoners. The OMSA has prepared the following concerns and recommendations to highlight and reconcile the poor quality of health care for prisoners.

RECOMMENDATIONS

The Ontario Medical Students Association recommends the following:

1. **That the OMSA publicly support the transfer of governance of health care provision from provincial and federal corrections services to the Ontario Ministry of Health by:**
    - Publicly advertising and promoting this position paper.
    - Establishing a social media campaign to explain the realities of health care within prisons.
    - Identifying prison health as a priority issue of advocacy for future advocacy events in the next 5 years.
    - Consider this topic for a future Provincial Day of Action.

The transfer of prison health care provision has a multitude of benefits, which have been actualized in other countries and in some Canadian provinces. In a report by the International Centre for Prison Studies, the change was spearheaded by public health professionals in medical associations and governmental bodies, advocating for better health provision (32). The main concerns expressed were the quality of care provided and the role of medical professionals in the prison environment - concerns that have also been highlighted in the Canadian context. Proponents for integration cite the following reasons for the transfer of care: 1) clinical independence, 2) improvement in public health measures, 3) building trust between medical staff and inmates, 4) better integration and continuity of care inside and outside of prison, and 5) improved staffing, training and research opportunities (32). Examples of barriers cited by the CSC include high costs, challenges of providing health services in prisons due to public perception and logistical issues, and fears of “operations officials [losing] control over psychologists”, creating situations where “correctional professionals report to Health Services” (33). This emphasizes that control, not rehabilitation, is the highest priority of our prison system and that reluctance to transfer care is based on the maintenance of power, not evidence. Additionally, logistical barriers are not as relevant to provincial prisons in Ontario, as healthcare governance can be easily transferred to existing provincial health systems, as has been shown in other Canadian provinces. While the transfer of health care governance for federal prisons may be more logistically challenging and there may be more upfront costs, this does not negate the potential for more long-term cost savings and more equitable standards of care. It is hypothesized the savings would come from a greater focus on health promotion and

prevention, restructured staffing, discounts from bulk purchasing, and better cooperation with other government health agencies.

Many countries have successfully integrated prison health care with the national public health system by transferring responsibility to national health systems. These include Norway, France, the United Kingdom, the Swiss cantons of Geneva, Vaud, Valais and Neuchatel, New South Wales in Australia, Italy, Kosovo, Catalonia in Spain, and Finland (32). In France, the transfer of care led to a new national institute for preventative medicine and health education (32). Transfers of care can also lead to new opportunities to carry out research and teach specialists/generalists about prison health. In New South Wales, prison-based nursing has seen substantial development as a nursing subspecialty, leading to the development of a graduate diploma in Correctional Nursing (32). From these examples, it is clear that the transfer of governance not only helps improve health outcomes, but also tackles the challenges of staff retention, training, and community connections.

With health care under the jurisdiction of health authorities, physicians can better advocate for better treatment of inmates with regards to punishment/isolation, diet and exercise, and the ill-effects of overcrowding. The transfer of care to provincial health authorities has started within Canada, beginning with Nova Scotia in 2003, followed by Alberta in 2010, a phased transfer in Quebec beginning in 2016, British Columbia in 2017, and Newfoundland committing to transfer by 2021 (28,34). Key improvements seen in British Columbia include: staffing of mental health nurses, concurrent disorder counsellors, access and transition nurses, increased resources to deliver OAT, ready access to lab/diagnostic imaging/pharmacy, chronic and infectious disease management, standardization of policies/procedures/protocols, and other supports (34). In Nova Scotia, the change allowed for better information technology management, ensuring the same quality of care for inmates as the general population, health-to-health sharing of information, and drug formulary participation aligned with best evidence-based practices (28). It is high time that Ontario follows-suit and transfers the care of its health care within its provincial correctional facilities from the Ministry of the Solicitor General to the MOH. Such a transfer would have broad positive impacts on people experiencing incarceration within Ontario and would also provide pressure to the CSC to look towards transfer of care within the federal correctional system as well.

2. **That the OMSA support prison health as a topic of advocacy to fulfill the CanMEDs Health Advocate role requirement in medical education curricula in Ontario by:**

- Collaborating with prison health experts to develop and publicize a handbook and/or online module for caring for those who are incarcerated. The educational materials will focus on social/structural determinants that put individuals at risk for incarceration (i.e. school-to-prison pipeline), and pertinent considerations and best practices when caring for incarcerated or formerly incarcerated patients.
- Support clinicians who work with incarcerated or formerly incarcerated individuals and collaborate with them to create clinical experiences and opportunities for students.
- Meeting with the AFMC to discuss opportunities to incorporate prison health into the medical curricula as part of the advocate role in CanMEDs.
- Collaborate with the academic representatives across Ontario to advocate for increased exposure to prison health as a topic within the formal undergraduate medical curriculum.

The transfer of health services has been advocated by other medical bodies, including the College of Family Physician Canada's (CFPC), whose position statement in 2016 supports the transfer of provincial, territorial and federal corrections health services to an external public

health authority (3). While feasibility studies around the transfer of care have been conducted by the CSC in the past, these studies have not been transparent and have given unsatisfying justification for why the transfer of care was ultimately not recommended (33). These recommendations have not been evidence-based.

We conducted an informal survey of Ontario medical schools, and only a few identified clinical opportunities for prison health. What's more, only one received a lecture that was related to incarcerated patients. To our knowledge, there is little to no curricula on prison health other than extracurricular activities. We are also not aware of any formal evaluation of medical curricula in Ontario that has specifically assessed the amount or content of prison health-related educational material. Early exposure to the unique needs of patients who are, or were formerly, incarcerated provides opportunities for students to engage in their advocacy skills and also to garner interest for this specialty in our health care system. Many individuals are not aware of opportunities or how one can get involved in providing care for incarcerated persons. We find this extremely concerning, given the myriad health disparities currently experienced by individuals who are, or who have been formerly, incarcerated.

CONCLUSION

The way health care is administered in Canadian correctional institutions has led to a parallel, but unequal system of care for one of society's most marginalized populations. With mounting evidence that inmates experience high morbidity and mortality, the inadequate delivery of health care within prisons only exacerbates the consequences of incarceration and the social determinants of health. Despite increasing health expenditures across provinces and territories and health care innovation occurring outside of the prison system, corrections services have often failed to protect the health of inmates. More troublingly, the current governance of health care in prisons under the CCRA is incongruent with the Minimum Standards of Care for Prisoners set out by the United Nations, of which Canada has been a committed member. The aforementioned guidelines describe that health care provision should be under the jurisdiction of health systems, rather than the justice system, to protect prisoners' well-being. The poor health outcomes of inmates are directly related to administrative challenges, poor human resourcing, and lack of prioritization of preventative medicine and public health. As highlighted above, health care delivery in Ontario prisons is currently inequitable and of poor quality. Therefore, we believe that it is critical that the OMSA promote the issue of prison health care as both an advocacy and educational priority for Ontario medical students.

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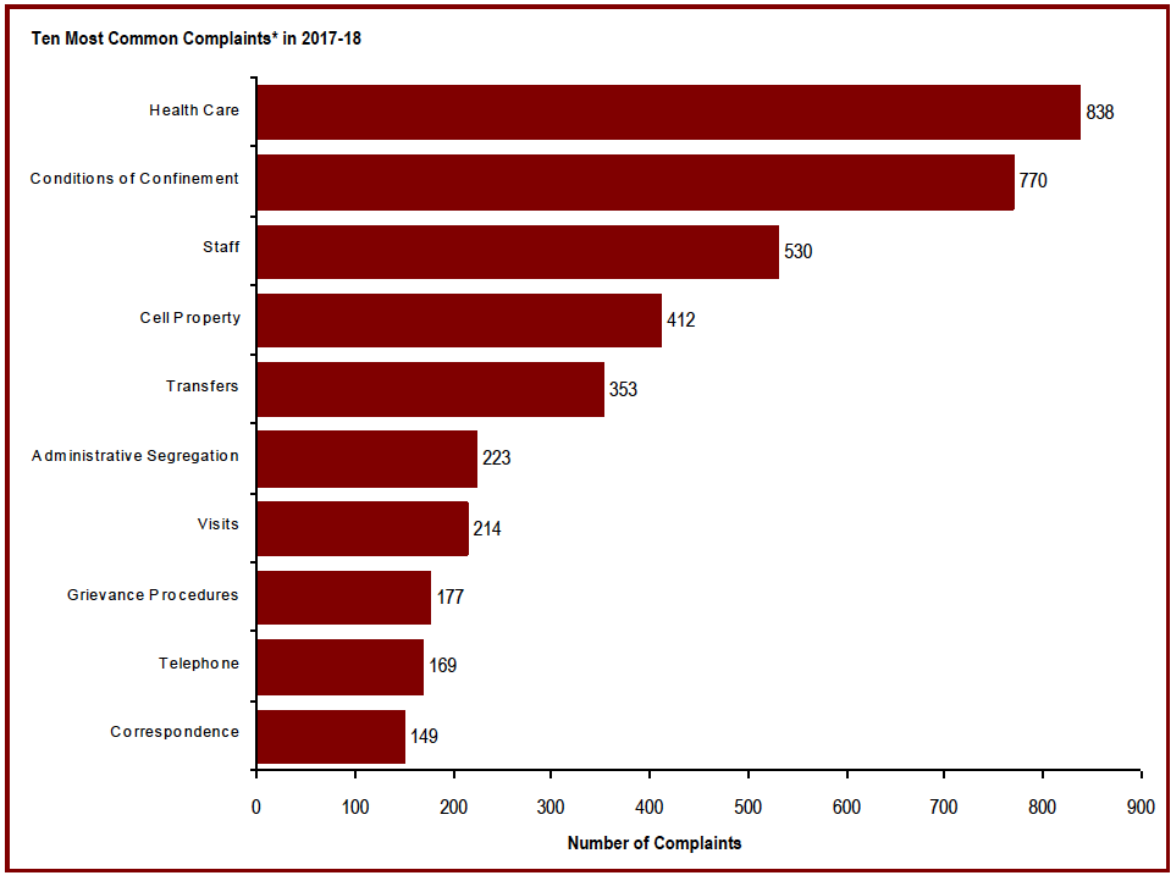
APPENDIX

Figure 1. 2018 Corrections and Conditional Release Statistical Overview
Source: Correctional Service Canada. Corrections and Conditional Release Statistical Overview [Internet]. Ottawa, ON: Correctional Service Canada; 2018. Available from:

https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ccrso-2018/ccrso-2018-en.pdf

HEALTH CARE IS THE MOST COMMON AREA OF OFFENDER COMPLAINT RECEIVED BY THE OFFICE OF THE CORRECTIONAL INVESTIGATOR

Figure B6



Source: Office of the Correctional Investigator.

- There were 5,846 complaints/enquiries received at the Office of the Correctional Investigator (OCI) in 2017-18.
- Health care (14.3%), conditions of confinement (13.1%), staff (9.0%), and cell effects (7.0%), accounted for 43.5% of all complaints.

Figure 2: Percentage of Institutional Health Services Staff who agreed that the new health services governance structure has resulted in improvements in the following areas

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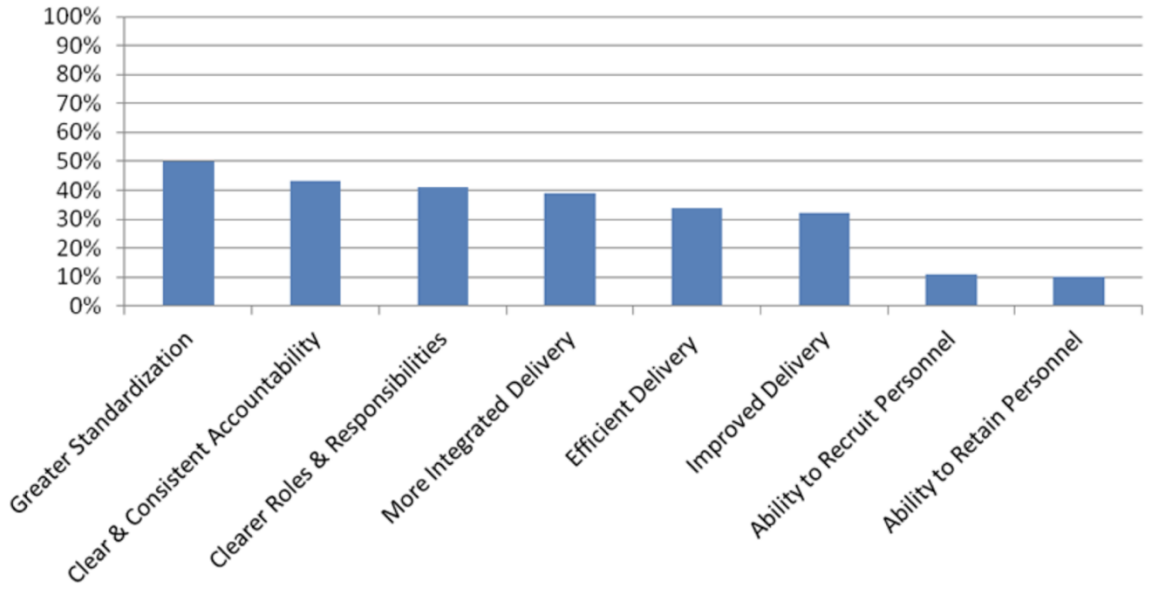

Source: Correctional Service Canada. Evaluation of CSC's Health Services [Internet]. Ottawa, ON. Correctional Service Canada; 2017. Available from: https://www.csc-scc.gc.ca/005/007/005007-2017-eng.shtml