Health Services Reviews in Canadian Federal Correctional Institutions and Healthcare Models in Correctional Institutions Internationally

An Environmental Scan

Date of Submission: 12/20/2023

Prepared By:
Marilyn Macdonald and Erin Langman

Contact:
Marilyn Macdonald

Email: marilyn.macdonald@dal.ca

Land Acknowledgement(s)

SPOR Evidence Alliance operates from the St. Michael's Hospital, Unity Health Toronto which is located on the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island.

We are grateful to have the opportunity to work on these lands.

Dalhousie University is in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq, governed by the Treaties of Peace and Friendship.

Funding Acknowledgement(s)

Aligning Health Needs and Evidence for Transformative Change (AH-NET-C): A JBI Centre of Excellence received funding from the Health Standards Organization for this environmental scan

The Strategy for Patient-Oriented Research Evidence Alliance (SPOR EA) is supported by the Canadian Institutes of Health Research (CIHR) under the Strategy for Patient-Oriented Research (SPOR) initiative.

.

Project Contributors

Dr. Marilyn Macdonald, Aligning Health Needs and Evidence for Transformative Change (AH-NET-C): A JBI Centre of Excellence, School of Nursing, Faculty of Health, Dalhousie University
Erin Langman, Aligning Health Needs and Evidence for Transformative Change (AH-NET-C): A JBI Centre of Excellence, School of Nursing, Faculty of Health, Dalhousie University
Dr. Andrea C. Tricco, Li Ka Shing Knowledge Institute of St. Michael's Hospital; University of Toronto
Dr. Crystal Dieleman, School of Occupational Therapy, Dalhousie University
Ali Hammoud (trainee), Dalhousie University

Table of Contents

Abbreviations and Definitions

Abbreviations

CSC	Correctional Service Canada
HSO	Health Standards Organization
DHSC	Department of Health and Social Care (United Kingdom)
NHS	National Health Service (United Kingdom)
USMP	Unité de Soins en Milieu Pénitentiaire (France)
UHSI	Unité Hospitalière Sécurisée Interregionale (France)
UHSA	Unités Hospitalières Spécialement Aménagées (France)
VTH	Unit for Prisoners' Health Services (Finland)

Key Definitions

Community-equivalent healthcare: the health services available in the community to people who are not incarcerated. These health services vary across jurisdictions in Canada but generally refer to any health services not provided in hospitals, including visits to primary care teams, vaccinations provided by public health, medications from a pharmacy, programs such as screening, health promotion, and health prevention, and other services like rehabilitation, physiotherapy, and community mental health.

Unité de Soins en Milieu Pénitentiaire: a correctional health unit or care unit which is present within French correctional institutions. They are set up by the nearest hospital to deliver care onsite.

Unité Hospitalière Sécurisée Interregionale: a specialized hospital in France for incarcerated people requiring more than 48 hours of hospitalization.

Unités Hospitalières Spécialement Aménagées: a hospital unit focused on treating those requiring psychiatric care.

A Note on Terminology: The following report includes recommendations from sources that may not reflect current shifts in language including, but not limited to the following:

- "Incarcerated people" vs "prisoners"
- "Mental health and addictions symptoms" vs "mental illness"
- "Correctional institutions" vs "prisons"

EXECUTIVE SUMMARY

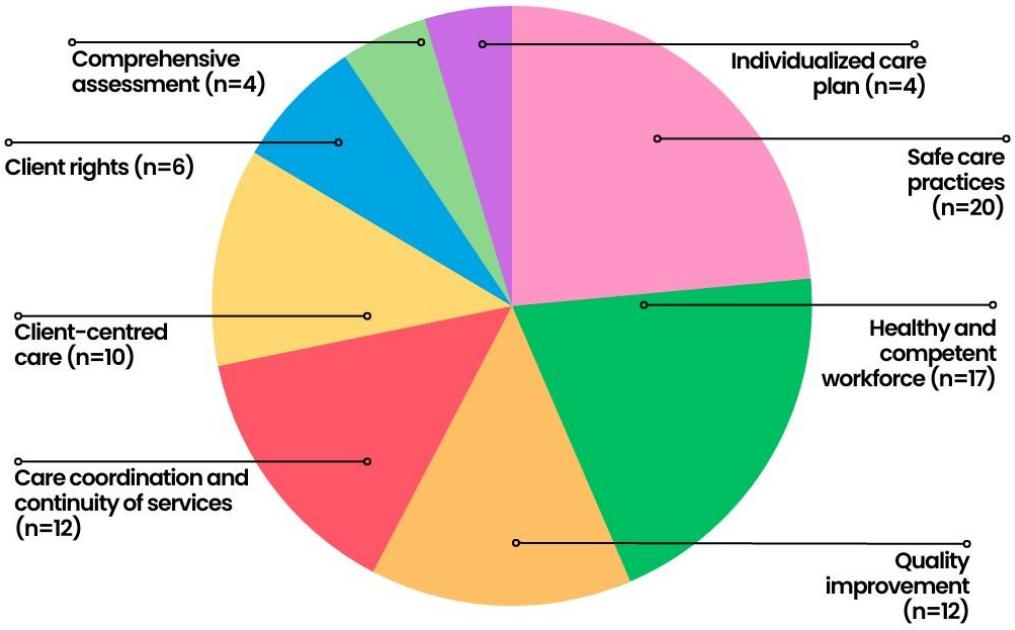
Objectives: To identify completed reviews of health services in Canadian federal correctional facilities, extract health services related recommendations, and identify models of healthcare in correctional institutions in other countries.

Design: Environmental scan

Method: Grey literature searches of government and correctional institution websites

Results: Twenty documents related to the evaluation of healthcare services in correctional institutions were identified and 85 recommendations related to health were extracted and categorized using the main topic areas of the CAN/HSO 34008:2024 *Correctional Service Canada Health Services* standard. Twelve healthcare models were identified from other countries. Current models of healthcare lack integration across health, institutions, justice, and social and community services. Correctional institutions are challenged to meet the needs of incarcerated people experiencing mental health and addictions symptoms, aging, and the terminally ill. System partnership models hold promise in relation to rehabilitation and reintegration into society.

Figure 1. Number of recommendations per proposed standard main topic area



Conclusion: Models of healthcare in Canadian correctional institutions are not structured to foster rehabilitation and reintegration into society. Examples of partnership models in the United Kingdom, Finland, Australia, and New Zealand are described and may offer a path forward for decision-makers.

Introduction

In Canada, corrections healthcare plays a vital role in the criminal justice system, aiming to promote the well-being and rehabilitation of individuals in federal and provincial correctional institutions. Correctional Service Canada (CSC) oversees primary, secondary and tertiary healthcare services for incarcerated people, addressing diverse needs such as mental health, substance use disorders, and chronic illness.[1] Despite federal guidance, the execution of healthcare policies involves collaboration with provincial and territorial healthcare authorities, creating a challenging operating environment. These challenges have led to several evaluations of healthcare delivery within corrections. Our aim is to conduct an environmental scan of evaluations related to health services delivery within Canadian correctional institutions conducted by CSC and other entities over the past decade. Additionally, we aim to explore models of healthcare in correctional institutions in various countries within the last five years. This project will provide background information to develop a new standard for CSC Health Services.

The concept of community-equivalent health services, as outlined in the United Nations Standard Minimum Rules for the Treatment of Prisoners[2] is an important aspect of rehabilitation within the correctional setting and following release. These rules emphasize the significance of offering incarcerated individuals healthcare services that mirror those available in the broader community. This ensures access to a comprehensive range of services, from primary care visits to rehabilitative, physiotherapy, and community mental health services.[2] Evaluating the services provided by CSC is crucial in understanding the existing healthcare infrastructure and identifying potential gaps that could be addressed to enhance the health of incarcerated people.

Several challenges persist within the corrections healthcare system. Notably, the high incidence of mental health and addictions symptoms among incarcerated people underlines the need for culturally sensitive interventions and comprehensive support systems within the criminal justice framework. Mental healthcare remains a significant concern, with high rates of mental disorders among inmates, emphasizing the imperative for thorough services within correctional institutions and upon release[3] Substance use disorders present a profound challenge, with federal incarcerated populations heavily reliant on pharmacological solutions.[4] As individuals transition from incarceration to the community, it becomes a deeply personal and sensitive journey, especially for those dealing with both mental health and substance use struggles. The hurdles faced during this transition highlight the importance of ensuring uninterrupted access to essential services and a seamless continuity of care, that would not only positively impact everyone, but would help establish continuity of care across systems. Ensuring a smooth transition reflects not just the practicalities but also the human stories behind individuals, making it imperative to offer holistic and compassionate support that extends seamlessly from incarceration to reintegration, ultimately fostering a sense of hope and belonging, thereby promoting successful reintegration into society.[3]

Other issues within the correctional system, such as prolonged isolation of youth and emergency response protocols, underline the necessity for more humane and ethical practices. Legislative measures like Bill C-83 demonstrate the government's commitment to addressing these challenges by emphasizing offender accountability and enhanced rehabilitation programs.[5] However, the effective implementation of these policies requires persistent efforts.[5] In addition, the overrepresentation of the Indigenous population within correctional institutions compared to the general population highlights the need for culturally safe and appropriate healthcare interventions and diversion strategies such as healing lodges. In 2020-2021, the Indigenous incarceration rate was 8.9 times that of the non-Indigenous incarceration rate.[6] Correctional Service Canada also found that in addition to being overrepresented, incarcerated Indigenous women have higher rates of mental disorders and alcohol and substance use disorders than non-Indigenous incarcerated women[7], which points to a need for mental healthcare assessment and treatment services that are both gender and culturally safe and appropriate.

The aim of this environmental scan is to identify completed reviews of health services in Canadian federal correctional institutions, extract health services related recommendations, and to identify models of healthcare in correctional institutions in other countries.

Questions:

1. What formal reviews have been completed on health services provided in Canadian correctional Institutions in the last 10 years?
2. What healthcare models are used in correctional institutions in other countries (United Kingdom, Australia, New Zealand, Germany, Switzerland, France, Denmark, Sweden, Norway, and Finland) implemented in the last five years that CSC could learn from to improve its health services, including policies, outcome measures, and the role of virtual care?

Methods

Searches

Question 1: Searches of academic databases MEDLINE (Ovid) and CINAHL (EBSCO) undertaken by a health sciences librarian did not produce any reports that met the inclusion criteria, therefore an environmental scan focused on relevant grey literature was conducted.

Question 2: A search of MEDLINE (Ovid) was undertaken by a health sciences librarian to identify articles on the topic. The search strategy, including all identified keywords and index terms, was adapted for PsycInfo (EBSCO). Searches of academic databases produced few reports that met the inclusion criteria, therefore an environmental scan focused on relevant grey literature was also conducted.

For both research questions, an iterative approach to document discovery was employed, consisting of the following steps:

1. Consultation with HSO to identify relevant reports, as well as entities and government bodies/departments as potential sources.
2. Search for identified reports and browse/search websites of identified entities and government bodies for relevant documents.

3. Consultation with Dr. Crystal Dieleman, content expert, who provided oversight and comments on the search process and direction to resources to consider in this report.
4. Scan reference lists of included reports for additional sources.
5. Second consultation with HSO to identify any gaps in sources, consideration of list of reports from the Technical Committee, and finalize list of reports.

Inclusion criteria

Question 1:

1. Reviews of health services within Canadian federal correctional institutions
2. Reviews with health services recommendations
3. Published within the last 10 years
4. English language

Question 2:

1. Healthcare models in correctional institutions Internationally in the following countries: United Kingdom, Australia, New Zealand, Germany, Switzerland, France, Denmark, Sweden, Norway, and Finland
2. Published within the last 5 years
3. English language

Sources of data

Question 1: Websites searched and/or browsed included the Canadian Human Rights Commission, the Office of the Correctional Investigator, the Office of the Auditor General of Canada, Reports to Parliament by Federal Institution: Correctional Service Canada, and Correctional Service of Canada. Google searches were also conducted.

Question 2: Websites searched and/or browsed included, where possible, governmental, parliament, office or ministry of justice, correctional services, and health services, for all included countries. Google searches were also conducted for models in general for each country and for specific models identified in the literature.

For a full reporting of websites used and searches for both research questions see Appendix 3.

Data collection

Citation information for the reports that met inclusion criteria was retrieved from the database searches and the environmental scan was entered into an Excel document for review.

Framework

Question 1: The CAN/HSO 34008:2024 *Correctional Service Canada Health Services* standard (Appendix 4) was used to guide data extraction. The majority of the extracted health services recommendations were categorized using the eight main topic areas of the standard. The main topic areas are as follows: 1. Client-centred care; 2. Client rights; 3. Comprehensive assessments; 4. Individualized care plan; 5. Safety practices; 6. Care coordination and continuity of services; 7. Healthy and competent workforce; and 8. Quality improvement. The recommendations that did not fit in the above categories were grouped and assigned to one of the following categories: 1. Alternatives to

traditional forms of incarceration; 2. Areas for research; 3. Separation/secession from traditional corrections structures.

Data extraction

Data extraction took place in Excel, and included the following, along with the citation information:

Question 1: Evaluating entity, document description, evaluation method or study design (where appropriate), and health services recommendations. We extracted data according to the main topic areas of the CAN/HSO 34008:2024 *Correctional Service Canada Health Services* standard.

Question 2: Country, objective and evaluation method or study design (where appropriate), model name, model type, and an overview of the model.

Data presentation and analysis

Question 1: The data extracted is presented in graphical, narrative, and tabular summaries. We provide a table of included documents indicating author(s), source, year of publication, review/study approach where appropriate, and extracted recommendations (Appendix 1, Table 1), and narratively outline the number of included documents, the number of included recommendations, and an overview of the recommendations for each main topic area (Appendix 1, Table 2). The healthcare-related recommendations extracted from the dataset were examined and categorized according to the most relevant main topic area of the CAN/HSO 34008:2024 *Correctional Service Canada Health Services* standard. Summaries of the recommendations by main topic areas are provided in relation to their respective dataset and extant literature. The recommendations appear in both the narrative and appendices of the report.

Question 2: The data extracted is presented in graphical, narrative, and tabular summaries. We provide a table of included documents indicating author(s), source, year of publication, review/study approach where appropriate (Appendix 1, Tables 5 & 6), and model and narratively outline the number of included documents, the number of included recommendations, and a descriptive overview of the models.

Results/Findings

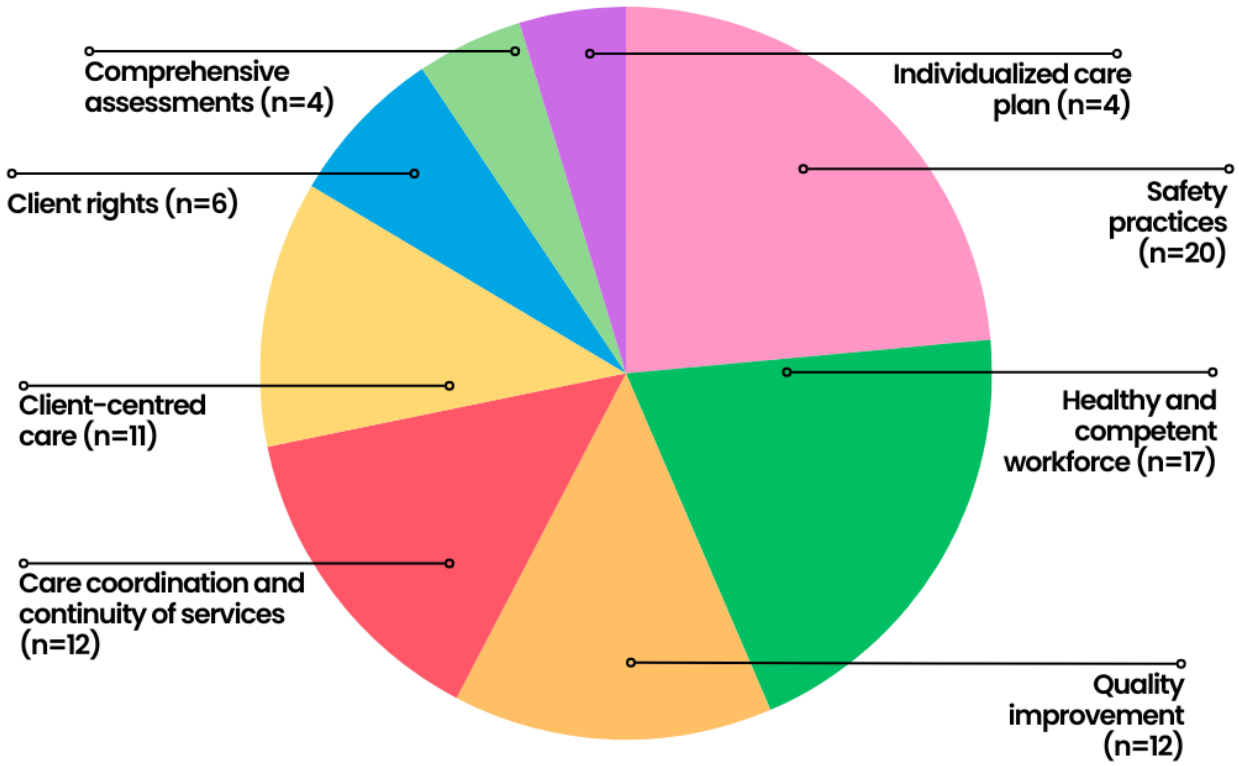
Question 1: What formal reviews have been completed on health services provided in Canadian correctional facilities in the last 10 years?

Twenty (20) documents were identified in the environmental scan. Of these, six documents were authored by the Office of the Correctional Investigator and three documents were authored or published by Correctional Service Canada.[8-10] Of the ten remaining, one each was produced by: the Canadian Royal Society[11] (n=1), the West Coast Prison Justice Society[12] (n=1), the Mental Health Commission of Canada[13] (n=1), the Standing Senate on Human Rights[14] (n=1), the Centre for Addiction and Mental Health[15] (n=1), the College of Family Physicians of Canada[16] (n=1), the Office of the Auditor General of Canada[17] (n=1), the Provincial Court of Alberta[18] (n=1), the Canadian Human Rights Commission[19] (n=1), the Structured Intervention Unit Implementation Advisory Panel[20] (n=1), and (n=1) was co-authored by the Correctional Investigator of Canada and the Canadian Human Rights Commission.[21]

Within the twenty documents, a variety of review methods or approaches were used with 12 documenting more than one approach.[9, 12-14, 20-26] Review methods or approaches included analyzing collected CSC data (n=12) [9, 10, 17, 20-27], interviews (n=10) [9, 12, 20-26], literature reviews (n=7) [9, 13, 21-24, 26], consultations with key informants (n=6) [8, 12, 14, 20, 25], site visit observation (n=3) [14, 20, 26] focus group (n=1) [13], intake questionnaire (n=1) [9], expert opinion[25] (n=1), public hearings[14] (n=1), and written submissions from the public (n=1).[14] Four did not document a particular approach or method.[11, 15, 16, 19] See Table 1 in Appendix 1 for the document number (referred to in the narrative below), reference, a breakdown of recommendations, along with method/approach for each.

In total, 101 recommendations are included in this report. For each proposed main topic area of the CAN/HSO 34008:2024 *Correctional Service Canada Health Services* standard, the following number of recommendations were extracted: Safety practices (n=20); Healthy and competent workforce (n=17); Quality improvement (n=12); Care coordination and continuity of services (n=12); Client-centred care (n=11); Client rights (n=6); Individualized care plan (n=4); and Comprehensive assessments (n=4). See Appendix 1, Table 2 for a breakdown of recommendations organized by proposed standard main topic areas.

Figure 1. Number of recommendations per proposed main topic area



The remaining 15 recommendations were categorized as follows: Alternatives to traditional forms of incarceration (n=6); Areas for research (n=4); and Separation/secession from traditional corrections structures (n=5). See Appendix 1, Table 3 for a breakdown of additional recommendations (Addendum of recommendations).

This section of the report is framed using the CAN/HSO 34008:2024 *Correctional Service Canada Health Services* standard (see Appendix 4) main topic areas as headings. The main topic areas are client-centred care, client rights, comprehensive assessments, individualized care plan, safety practices, care coordination and continuity of services (suggest case management), healthy and competent workforce, and quality improvement. We also extracted data (recommendations) that we deemed of importance to this scan and that can inform the main topic areas of the standard. We categorized these recommendations under the headings of "alternatives to traditional forms of incarceration," "areas for research," and "separation/succession from traditional corrections structures."

In the original version of the proposed the CAN/HSO 34008:2024 *Correctional Service Canada Health Services* standard the category of "Indigenous Health and Wellness" was included. After a discussion with HSO around their planned integration of Indigenous health and wellness into the existing main topic areas of the standard, the category was removed, but associated recommendations can be found in Appendix 1, Table 4.

Client-centred care

Eleven recommendations addressed under the standard main topic area of client-centred care and were extracted from nine documents as follows: *Evaluation of CSC's Health Services*[9] and the Mental Health Commission of Canada's *COVID-19, Mental Health, and Substance Use in Correctional Settings: Considerations for Addressing Systemic Vulnerabilities*[13] (2 each); and *Human Rights of Federally Sentenced Persons* by the Standing Senate on Human Rights[14], *45 Calls for Inclusion: Celebrating 45 Years of the Canadian Human Rights Act* by the Canadian Human Rights Commission[19], *Aging and Dying in Prison* by the Correctional Investigator Canada and Canadian Human Rights Commission[21], *Structured Intervention Unit Implementation Advisory Panel: 2021/22 Annual Report*[20], *Centre for Addiction and Mental Health's Mental Health and Criminal Justice Policy Framework*[15] *Damage/Control: Use of Force and the Cycle of Violence and Trauma in BC's Federal and Provincial Prisons* by the West Coast Prison Justice Society[12], and the Office of the Auditor General of Canada's *Preparing Women Offenders for Release*[17] (1 each). According to the Centre for Addiction and Mental Health, client-centred care is "an approach that fosters respectful, compassionate, culturally safe and appropriate and competent care that is responsive to the needs, values, beliefs and preferences of clients, patients and their family members." [28 para. 2]

Among recommendations grouped under client-centred care, there was little overlap. Recommendations called for a holistic approach to mental health, [14] ending the use of solitary confinement for incarcerated people with mental and health disabilities, [19] the use of evidence-informed mental healthcare and supports, [15] and for integrating substance use services into health and medical services, [13] among others. Correctional Service Canda states that "one of our priorities is ensuring that individuals incarcerated in Canada's federal institutions have access to quality, safe, patient-centred care." [29 para. 1]

Box 1 Client-Centred Care Recommendations

Mental Health and Addictions

That the Correctional Service of Canada implement a holistic approach to mental health by:

- evaluating the Peer Offender Prevention Service program at Stony Mountain Institution with a view to expanding it nationally to federal penitentiaries of all security levels.[14]

End the use of solitary confinement for prisoners with mental health disabilities. The CSC must ensure that it has appropriate therapeutic alternatives to solitary confinement when it is required to separate prisoners with mental health disabilities from the general population.[19]

People with mental illness in the corrections system should receive evidence-informed mental health care and supports. Examples of action that results from this principle:

- Health care practices in federal and provincial corrections comply with the UN's Mandela Rules.
- Health care in correctional institutions is provided by a separate health care entity. Mental health care is part of this entity and under the direction of forensic mental health care experts.
- Correctional institutions use the STAIR model to identify mental health needs and guide mental health care provision.
- Mental health care is equitable and meets the diverse needs of women, Indigenous peoples, Black people, and members of other racialized and/or historically marginalized populations. Offenders on remand receive the same evidence informed mental health care and supports as the sentenced population.
- The full range of evidence-based interventions for substance use, including harm reduction programs and supplies, are made available to all offenders who need them.[15]

Prioritize the integration of substance use services, including harm reduction, into the broader continuum of correctional health and medical services to improve patient experiences and population health.[13]

Correctional Service Canada should ensure that it appropriately identifies women offenders who need mental health services and assigns them to the appropriate level of care.[17]

Alternatives to Traditional Forms of Incarceration

That where the death of an offender is reasonably foreseen, CSC and the Parole Board be required to use proactive and coordinated case management to facilitate the offender's safe and compassionate release to the community as early as possible.[21]

Intake Assessment

That CSC Health Services endeavour to increase the efficiency of health-related intake assessment processes by considering the following:

- Eliminating the requirement for repeated administration of health assessments
- Optimizing and eliminating unnecessary repetition of health information between assessment tools
- Ensuring health referrals are appropriately recorded and monitored.[9]

Secondary Healthcare

That CSC Health Services collect data on wait times to access selected specialists' services for non-urgent care; and implement strategies (for example increased use of telemedicine where appropriate) if wait times exceed available Canadian benchmarks.[9]

Infection Prevention and Control

Involve incarcerated persons in the process and ensure ongoing communication about the situation to increase adherence to PPE use and public health measures.[13]

Use of Force

The healthcare professional should complete a written report that includes the prisoner's account of the incident and their assessment of any physical injuries and psychological impact. This report should be included in the use of force review if the prisoner consents, and a copy should be provided to the prisoner.[12]

Staffing

When implementing the enhanced staffing model for SIUs, CSC should reconsider its policy on the allocation of health human resources and dedicate clinical staff to the units.[20]

Summary

Client-centred is so easy to say, the doing is another matter. The associated recommendations call for correctional personnel to consider incarcerated people as individuals with their own respective strengths and vulnerabilities and that each person be approached with this in mind. The recommendations call for the exercise of informed clinical reasoning in the care and use of all interventions in persons experiencing mental health and addictions symptoms. There is not a single document in this review that does not address mental health and addictions symptoms in the correctional system, a testimony to its prevalence and the care and attention required.

Client rights

Under the standard main topic areas of client rights, six (6) healthcare-related recommendations were extracted from three documents as follows: *Human Rights of Federally Sentenced Persons* by the Standing Senate on Human Rights[14] (3); the Canadian Human Rights Commission's *45 Calls for Inclusion: Celebrating 45 Years of the Canadian Human Rights Act*[19] (2); and the Centre for Addiction and Mental Health's *Mental Health and Criminal Justice Policy Framework*[15] (1).

Human Rights of Federally Sentenced Persons prepared by the Standing Senate Committee on Human Rights (2021)[14] is a comprehensive, balanced treatise on what constitutes human rights, in particular chapter one. The document also provides testimony to the CSC gaps in respecting human rights as well as the multiple interpretations of human rights used across CSC and provincial and territorial corrections systems. The Canadian Human Rights Commission's *45 Calls for Inclusion: Celebrating 45 Years of the Canadian Human Rights Act*[19] includes a list of calls with specific reference to the *Aging and Dying in Prison* report.[21]

Box 2: Client right recommendations

Dental Care

That the Correctional Service of Canada increase the provision of dental care in federal penitentiaries to reflect the needs of federally sentenced persons, with an emphasis on preventative dental care.[14]

Alternatives to Traditional Forms of Incarceration

That the Correctional Service of Canada expand the application of section 84 releases to other vulnerable and marginalized groups, including federally sentenced Black persons, LGBTQI2S and the ill and aging populations.[14]

Structured Intervention Units

That the Correctional Service of Canada ensure that Structured Intervention Units adhere to the most recent court decisions and respect Canada's human rights obligations and international commitments, by:

- eliminating the use of solitary confinement for all federally sentenced persons.
- taking into account the different needs and experiences of particular groups, including LGBTQI2-S persons and women.
- eliminating solitary confinement of more than 15 days (a Mandela rule).
- providing meaningful human contact and continued access to programming as well as 24-hour access to health and mental health services.
- establishing judicial oversight to review all Structure Intervention Unit placements and decisions[14].

Rights of Marginalized Populations

That the Correctional Service of Canada protect the human rights of trans and gender diverse prisoners and ensure that its policies and practices fully respect the rights and meet the needs of trans, non-binary and gender-diverse prisoners, including transfer requests.[19]

Aging Populations

That the Correctional Service of Canada protect the rights of aging and dying prisoners as outlined in the CHRC and the OCI in their joint investigative report, "Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody" [19] .

Mental Health and Addictions

That the Correctional Service of Canada and provincial corrections systems ensure people with mental illness in the corrections system receive evidence-informed mental health care and supports, balancing the need to manage institutional safety and security with an individual's right to access mental health care.[15]

Canadians who can afford dental insurance or who cost-share insurance with their employer have access to this care. Recent federal legislation addresses this gap for the socially disadvantaged, but not incarcerated persons and as such seems discriminatory.

Failure to include dental care as part of the *Canada Health Act* was an unfortunate oversight, yet telling because the message in this oversight is that it is not of sufficient importance. In the intervening years, we have learned that poor oral health contributes to the development of several health conditions including endocarditis, cardiovascular disease, and pneumonia among others.[30]

Structured Intervention Units have a controversial history with CSC believing that they are protecting the person placed in the unit from harm or protecting the general population from harm. Incarcerated people largely see this intervention as harmful and there is evidence to support this claim. A systematic review and meta-analysis of the adverse psychological effects was completed in 2020 and found that incarcerated people experienced psychological deterioration beyond that of being in a correctional institution.[31]

Section 84 releases refer to the planning of an incarcerated Indigenous person's release and reintegration into their Indigenous community. Marginalized groups in general are overrepresented in correctional populations and the plans for the release of Black persons, LGBTQI2S persons and the ill and aging populations would benefit from the spirit of this legislation as well.

The 2019 report by the Canadian Human Rights Commission and the Office of the Correctional Investigator are clear in their report on *Aging and Dying in Prison*[21] that correctional institutions are not equipped to accommodate physically aging incarcerated people, manage complex chronic illness, provide palliative care, and do not have adequate release options. This represents a perfect storm that results in the impingement of human rights.[6]

The Canadian Association in Mental Health (CAMH) framework[15] is an excellent guide to the provision of mental healthcare no matter the setting. Using this framework will facilitate the provision of evidence-informed mental healthcare for the incarcerated people in Canada's correctional institutions.

The Standing Senate Committee on Human Rights in their 2021 report *Human Rights of Federally Sentenced Persons*[14] acknowledge the rights of incarcerated persons to medical assistance in dying (MAiD). CSC health services must provide palliative care, and that that includes end of life care. End of life care can include MAiD.

Summary

CSC has considerable depth and breadth of discretionary authority that certain situations demand. The Achilles heel of such authority is the temptation toward infringement of human rights by mistreatment, overuse of SIUs and the use of force. The *Canadian Charter of Rights and Freedoms* along with expert interpretation must be foundational to the preparation of corrections staff including healthcare professionals and may well need to be part of health professional curricula. Incarcerated persons should not incur deteriorating health and wellbeing due to incarceration but rather receive the corrections and rehabilitation programs to ready them for facing life upon release.

Comprehensive assessment

Under the standard main topic area of Comprehensive Assessments, four healthcare-related recommendations were extracted from three documents as follows: *Human Rights of Federally Sentenced Persons* by the Standing Senate on Human Rights[14] (2); and the Office of the Auditor General of Canada's *Preparing Women Offenders for Release*[17] (1) and *Damage/Control: Use of Force and the Cycle of Violence and Trauma in BC's Federal and Provincial Prisons* by the West Coast Prison Justice Society[22] (1 each).

Once again, the Standing Senate on Human Rights[14] makes explicit the importance of early identification of any form of mental health and addictions symptoms through comprehensive assessments to facilitate the provision of appropriate interventions and support. *Preparing Women Offenders for Release*[17], an assessment of mental health and addictions symptoms in incarcerated women, and the Office of the Correctional Investigator's *Annual Report 2020-2021*[22] reiterate the importance of attention to the mental health of incarcerated people. Recommendations also underline the importance of the skill set required for the management and support of incarcerated people with mental health and addictions symptoms.

Box 3: Comprehensive Assessments Recommendations

Mental Health and Addictions

That CSC implement the following measure to ensure federally sentenced persons with mental health issues receive appropriate support:

- conduct a culturally appropriate mental health assessment of all federally sentenced persons entering the federal correctional system within 30 days of admission.[14]

That CSC ensure that federally sentenced persons with mental health issues, or who exhibit behaviours that may indicate a mental health issue, who are placed in structured intervention units are evaluated within 24 hours of their placement by a recognized mental health care professional.[14]

CSC should determine the capacity of mental health services needed to treat women offenders identified with mental illness, according to professionally accepted standards, and address any service-level gaps in a timely manner.[17]

That CSC discontinue the practice of labeling non-suicidal self-injurious behaviour in prison settings as "instrumental," "willful," or "deliberate" in nature or intent. A comprehensive mental health assessment of self-injurious and suicidal persons should be completed, and clear guidance provided to front line staff in how to manage and de-escalate incidents of self-injurious and suicidal behaviour.[22]

Summary

Across the documents included in this scan of reviews of healthcare services in correctional institutions in Canada without exception, the mental health of incarcerated people is ubiquitous confirming its prevalence. The reason for this prevalence must not be located within the individual, this is a social construction and points to how communities, healthcare systems, correctional systems, and society are failing in attending to mental health and the need at community and society levels for policies that drive

prevention, early diagnosis, and culturally competent care as needed for people with mental health and addictions symptoms no matter the setting or context.

Individualized care plan

Under the standard main topic area of Individualized Care Plan, four healthcare-related recommendations were extracted from three documents as follows: *Correctional Services During and Beyond COVID-19* by the Royal Society of Canada[11] (2); and *Human Rights of Federally Sentenced Persons* by the Standing Senate on Human Rights[14] and the Office of the Auditor General of Canada's *Preparing Women Offenders for Release*[17] (1 each).

The Standing Senate on Human Rights is clear on the human rights of incarcerated people on individualized care plans, and it is no different for incarcerated people and those not incarcerated, it is a right of all persons who need healthcare.[14] The Royal Society of Canada addresses correctional services in relation to the COVID-19 pandemic and beyond.[11] This document highlights not only the importance of the care in prevention and treatment of COVID-19 but also uses it as a case example of the health promotion and treatment attention needed by incarcerated people in relation to all forms of illness. The Office of the Auditor General of Canada focused specifically on the preparation of women incarcerated people for release and the importance of the individualized plan of care to support women while in a correctional institution and upon release.[17]

Box 4: Individualized Care Plan Recommendations

Accessibility

That the CSC ensure that all federally sentenced deaf and hard of hearing persons can access correctional programming through appropriate access to relevant medical devices and reliable interpretation services.[14]

Mental Health and Addictions

That CSC provide trauma counselling and trauma-informed programming for imprisoned persons to address the root causes for their struggles, recognizing the imposed strain caused by COVID-19. Trauma counselling, however, should continue beyond the pandemic, recognizing that the great majority of people housed in prison have been victimized and had traumatic life experiences throughout their life-course.[11]

Provide sustained addiction counselling during and beyond the pandemic.[11]

That CSC should complete mental health treatment plans on time for the women offenders who need one and should include the information required by Correctional Service Canada guidelines.[17]

Summary

Every person in need of healthcare wants to know what to expect and how their care will unfold. This knowledge serves to empower them to be an active participant in their care. Building a care plan necessitates getting to know the person and what works best for them. It also brings to light important

information about a person they may not ordinarily disclose but that is important to their care. Unfortunately, it is rare that if asked a person can confirm they have a plan of care and that they know what it is and have participated in its construction.

Safety practices

Under the standard main topic area of safety practices 20 recommendations were extracted from 10 documents as follows: West Coast Prison Justice Society's *Damage/Control: Use of Force and The Cycle of Violence and Trauma in BC's Federal and Provincial Prisons*[12] (6); *Aging and Dying in Prison* by the Correctional Investigator Canada and Canadian Human Rights Commission[21] (3); Mental Health Commission of Canada's *COVID-19, Mental Health, and Substance Use in Correctional Settings*[13], the Office of the Correctional Investigator's *National Drug Formulary Investigation Summary of Findings and Recommendations*[25] and *Missed Opportunities: The Experience of Young Adults Incarcerated in Federal Penitentiaries*[24] (2 each); and Correctional Service Canada's *2022-2025 Accessibility Plan*[8] and *Evaluation of CSC's Health Services*[9], the Provincial Court of Alberta's *Report to the Minister of Justice and Solicitor General Public Fatality Inquiry*[18], the Office of the Auditor General of Canada's *Preparing Women Offenders for Release*[17], and the *Annual Report 2021-2022* from the Office of the Correctional Investigator[23] (1 each).

The recommendations surrounding safety practices are generally self-explanatory. Those emanating from two documents[12, 21] will receive separate mention here because safety practices in relation to the health of incarcerated people take more prominence in these documents. *Aging and Dying in Prison*[21] was discussed above and is an excellent treatise on the vulnerability of aging incarcerated people and the unsuitability of correctional institutions for older people. *Damage/Control: Use of Force and The Cycle of Violence and Trauma in BC's Federal and Provincial Prisons*[12] provided a set of recommendations of high importance to the safety of incarcerated people, drawing attention to the unintended harm associated with emergency response teams, restraints, professional healthcare provider presence, and their assessments. Also noteworthy is the emphasis on connecting youth offenders with staff specialized with the care of this population, attention to health promotion education and prevention programs.

Box 5: Safety Practices Recommendations

Aging Populations

That the Minister of Public Safety review and assess release options (e.g. medical and/or geriatric parole) for older and long-serving offenders who do not pose undue risk to public safety, and propose amendments to the Corrections and Conditional Release Act (CCRA) as appropriate.[21]

That CSC re-examine its use of force training and policy to incorporate best practices and lessons-learned regarding use of force on older individuals (including those using mobility devices).[21]

Accessibility

Enhance the accessibility of the built environment by:

- Reviewing accessibility standards in consultation with persons with disabilities.
- Developing an accessibility assessment strategy and facility assessments.
- Providing the necessary resources to address gaps identified by facility accessibility assessments.

- Reviewing the accessibility of emergency evacuation plans.
- Identifying and removing accessibility barriers for offenders.[8]

Health Education and Harm Reduction

That CSC Health Services ensure that offenders have timely access to health education programs and harm reduction products by:

- Providing clear direction and accountability for delivery and tracking of health education programs; and
- Monitoring the distribution of harm reduction products (bleach, condoms, dental dams, and lubricants) and addressing any identified accessibility issues.[9]

Mental Health and Addictions

Readily available, effective and adequately funded mental health and substance abuse programs, to include methadone and suboxone programs, would not only aid in rehabilitation but reduce demand and the incentive to participate in the smuggling of dangerous drugs.[18]

That CSC should ensure that women offenders with serious mental illness with significant impairment are not placed in segregation. It should improve its oversight of offenders being monitored for self-injury or suicide under enhanced observation, as well as its oversight of offenders identified with serious mental illness with significant impairment. The use of cells on the segregation range to monitor women offenders at risk of self-injury or suicide should be discontinued.[17]

Eliminate the use of Emergency Response Teams in regional treatment centres and on mental health units. Ensure decisions to deploy the ERT consider the potential traumatic impact of the team on the prisoner and weigh the potential for psychological harm against the potential benefit of using this high level of force. Amend policy to reflect this.[12]

Amend policy so that only healthcare staff can authorize and manage interventions to address self-harm and suicidality, including suicide smocks, observation cells and Pinel restraints based on clinical need. Pinel restraints should only be used in psychiatric facilities.[12]

[12]With respect to CSC's drug strategy:

- The Prison Needle Exchange Program (PNEP) criteria be significantly revamped to encourage participation consistent with actionable recommendations of this Office and the external interim evaluation, with a view to full national implementation within the next 12 months.
- The Overdose Prevention Service (OPS) be rolled out nationally, in tandem with PNEP implementation.
- Commissioner's Directive 585 – National Drug Strategy be immediately updated to incorporate evidence-based harm reduction, treatment and prevention principles and practices.
- CSC's zero tolerance policy to drug use and possession is recalibrated to focus on corrective measures for drug diversion and trafficking, rather than stigmatizing, targeting or disciplining persons struggling with addictions or substance abuse disorders.[23]

Infection Prevention and Control

Ensure sufficient resources to procure and safely store PPE.[13]

Ramp up substance use services with known public health advantages related to COVID-19, overdoses, and blood-borne infection risks, including harm reduction policies, safe consumption sites, access to clean needles and OAT [opioid-agonist therapies]. These activities are critical to supporting decarceration efforts.[13]

Youth Populations

The Correctional Investigator recommends that some institutional and community Parole Officers, with a special aptitude and interest for working with young adults, be specially trained as youth care counsellors. The role of the youth care counsellor includes:

- Provide consistent guidance and support
- Provide basic counselling
- Develop a correctional/community plan tailored to the needs of the young adult[24]

The Correctional Investigator recommends that those with the designated youth counsellor training be assigned to all cases involving young adults.[24]

Staffing

Provide 24-hour nursing care at all maximum and medium security and multi-level institutions. This will ensure medical staff are always available to respond to mental and physical health crises. It also ensures post-use of force medical assessments can happen at any time of day or night.[12]

Involve healthcare leadership in selecting and training officers for all treatment centres and mental health units.[12]

That vulnerable populations (older offenders and those with mental and/or physical health issues) be monitored daily during lockdowns by professional health care staff.[21]

Use of Force

Ensure that medical assessments after acts of force are used solely to support the wellbeing of the patient and document signs of ill-treatment. Any signs of ill-treatment must be reported to senior CSC operational and medical staff and the Office of the Correctional Investigator.[12]

Ensure post-use of force medical assessments include an assessment of the prisoner's mental state and any potential impact on the prisoner's mental health. When indicated, monitor and treat prisoners for Post-Traumatic Stress Disorder.[12]

Continuity of Care

New admissions to federal custody with a valid prescription or who require medical treatment should be seen by an attending institutional physician within 72 hours of being admitted. This practice will ensure that prescribed medications are appropriately and efficiently reconciled and continuity of care between the community or provincial and federal custody is maintained.[25]

CSC should immediately amend policy to ensure that the medication regime for inmates being transferred is not changed unless or until the attending physician at the receiving institution has conducted either an in-patient assessment or consultation with the transferring institution.[25]

Summary

This set of recommendations speaks to the risk of harm that incarcerated people live with day to day. Undoubtedly exposure to harm is not new, however, if Corrections Canada is correcting and showing their population a way forward attending to these risks is essential. The uptake of the programming offered in a context of risk will fall short of its objective and impact the likelihood of eventual recidivism.

Care coordination and continuity of services

Under the standard main topic areas of Care Coordination and Continuity of Services, 12 health related recommendations were extracted from seven documents as follows: *Correctional Services During and Beyond COVID-19* by the Royal Society of Canada[11] and *COVID-19, Mental Health, and Substance Use in Correctional Settings: Considerations for Addressing Systemic Vulnerabilities* by the Mental Health Commission of Canada[13] (3 each); *Human Rights of Federally Sentenced Persons* by the Standing Senate on Human Rights[14] (2); and the Centre for Addiction and Mental Health's *Mental Health and Criminal Justice Policy Framework*[15], *Aging and Dying In Prison: An Investigation into the Experiences of Older Individuals in Federal Custody* by the Correctional Investigator Canada and Canadian Human Rights Commission[21], the Office of the Correctional Investigator's *Overcoming Barriers to Reintegration: An Investigation of Federal Community Correctional Centres*[26], and *Damage/Control: Use of Force and the Cycle Of Violence and Trauma in BC's Federal and Provincial Prisons* by the West Coast Prison Justice Society[12] (1 each).

Continuity of care is a challenge across all healthcare settings reflecting the siloed functioning across all sectors and the delayed information technology benefits of one person one record. Care coordination and continuity challenges will be more pronounced for a population that experiences discrimination, stigmatism, racism, and general inequity. The first two recommendations were extracted from document one on the Human Rights of Prisoners and call for their transfer to facilities with expertise in care of the individuals with mental health and addictions symptoms.[14] The next three recommendations are contained in a policy brief outlining system weaknesses exacerbated in the context of the pandemic, and highlighting the need for an item as basic as the provision of valid identification needed to access healthcare on release.[11] The remaining recommendations overlap with points already made in relation to the need for collaboration across systems, processes, and services in place in the community for continuity.

Box 6: Care Coordination and Continuity of Services Recommendations

Mental Health and Addictions

That CSC implement the following measure to ensure federally sentenced persons with mental health issues receive appropriate support:

- ensure that mental health beds are contracted in psychiatric facilities pursuant to section 29 of the Corrections and Conditional Release Act.[14]

That CSC expand its use of section 29 agreements and contract the development/provision of mental health services and beds in provincial psychiatric hospitals to provide adequate mental health services for federally sentenced persons.[14]

There should be collaboration and coordination between the criminal justice system and the mental health system. Examples of action that results from this principle:

- People with mental illness experience a continuity of their mental health care, including substance use treatment, as they transition through the criminal justice system and particularly as they move from the community to the corrections system and vice versa.
- People with mental illness in correctional institutions receive comprehensive discharge planning that includes connections to mental health care, medications, social services, and other community resources before discharge.
- Correctional institutions have partnerships with forensic mental health inpatient programs to temporarily transfer care of offenders with mental illness in need of acute mental health care.
- Forensic mental health programs have partnerships with supportive housing programs and community mental health services.
- Government policy supports and enhances connections between the criminal justice system and the mental health system.[15]

Transfer prisoners with acute mental health needs or histories of serious and chronic self harm to community psychiatric facilities.[12]

Reintegration

Make it possible for incarcerated persons to be able to apply, at least six months prior to release, for a health card in order for correctional services organizations to assist with effective discharge planning.[11]

Make health cards available to individuals housed in community correctional centres—they are not incarcerated and thus are not excluded from the Canada Health Act.[11]

Make identification from prison and/or a letter/photo attesting to the person's identity sufficient to acquire a health card post incarceration.[11]

That CSC significantly reallocate existing institutional resources to community corrections in order to better support the reintegration needs of aging offenders.[21]

Address ongoing systemic health-service shortcomings through:

- policy changes that focus on achieving health access parity and providing continued access to services across the continuum of criminal justice involvement (including release/discharge).[13]

Ensure continued access to medications (e.g., buprenorphine, methadone), treatment, and supports for those being discharged from prisons, including alternative housing arrangements for those at risk of homelessness, already homeless, or precariously housed.[13]

Strengthen corrections' communications, collaborations, partnerships, and integration with public health authorities, as well as with mental health and substance use services and other community services needed to adequately support decarcerated individuals.[13]

That every CCC [Community Correctional Centre] have consistent access to the necessary resources, including nurses, social workers and psychologists, to ensure access to appropriate services and care.[26]

Summary

The recommendations are all relevant to care coordination and continuity and as stated in the introduction to this main topic areas represent a challenge no matter the setting. This main topic area deserves special mention because of the vulnerability of the population and their added risk of experiencing discrimination, stigmatism, and racism within and across systems.

Healthy and competent workforce

Under the standard main topic area of a Healthy and Competent Workforce 17 recommendations were extracted from seven documents as follows: the Mental Health Commission of Canada's *COVID-19, Mental Health, and Substance Use in Correctional Settings: Considerations for Addressing Systemic Vulnerabilities*[13] (5); *Fatal Response: An Investigation into the Preventable Death of Matthew Ryan Hines* by the Office of the Correctional Investigator[27] (4); *Human Rights of Federally Sentenced Persons* from the Standing Senate on Human Rights[14] (3); West Coast Prison Justice Society's *Damage/Control: Use of Force and the Cycle of Violence and Trauma in BC's Federal and Provincial Prisons*[12] (2); and *45 Calls for Inclusion: Celebrating 45 years of the Canadian Human Rights Act* by the Canadian Human Rights Commission[19], *Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody* by the Correctional Investigator Canada and Canadian Human Rights Commission[21], and the Office of the Correctional Investigator's *Annual Report 2021-2022*[23] (1 each).

The recommendations in relation to a healthy and competent workforce are germane no matter the workplace, however, in correctional institutions they take on particular significance for incarcerated people who need not be re-traumatized and for healthcare professionals and staff wellbeing and workplace satisfaction. In instances where an individual does not feel competent to carry out their duties and responsibilities, they risk actions that may harm others as well as themselves. The recommendations are more generally distributed across the seven documents. *Human Rights of Federally Sentenced Persons* was summarized under client rights and not surprisingly here the link is made to workforce competency and the protection of the human rights of incarcerated people.[14] Five recommendations were extracted from the document by the Mental Health Commission of Canada[13] demonstrating the level of importance of the competency of the workforce to meet the needs of incarcerated people living with mental health and addictions symptoms, associated substance use, stigma, discrimination, and racism. A workforce that understands and practices equity, diversity, and inclusion in executing their duties and responsibilities is less likely to impinge on the human rights of those persons in their field of duty. *Fatal Response: An Investigation into the Preventable Death of Matthew Ryan Hines* is the report of a preventable death and produced four recommendations for frontline healthcare personnel which are all directly related to competency and preparedness in the care of persons with mental health and addictions symptoms.[27] Twelve of these 17 recommendations refer to mental health and all documents included in this scan do as well, leaving no doubt of the prevalence of mental health and addictions symptoms in the correctional population and the care competency limitations of healthcare professionals in correctional institutions.

Box 7: Healthy and Competent Workforce Recommendations

Rights of Marginalized Populations

That CSC provide additional rights-based training to correctional staff to ensure they are sensitive to the complex needs of aging, as well as physically and mentally ill federally sentenced population. The Correctional Service of Canada should also make federal correctional institutions more accessible for federally sentenced persons with mobility issues.[14]

That the CSC improve its training for correctional personnel regarding human rights standards and principles of equality and non-discrimination, including in relation to race, sex, sexual orientation, gender identity and expression, and mental health.[14]

That the CSC ensure that its staff and facilities are equipped to meet the varied and complex needs of prisoners with mental health disabilities.[19]

Aging Populations

That CSC provide staff with training in age-related needs — physical, social and psychological — as well as training on how to identify, respond to and appropriately manage behaviour related to dementia.[21]

Mental Health and Addictions

That CSC implement a holistic approach to mental health by:

- providing all employees, as a condition of employment, with appropriate mental health and mental health crisis intervention training that is consistent with their vocational role. Further, the Correctional Service of Canada shall establish appropriate standards for training, ensure that all trainees demonstrate that they have met the standard and that ongoing evaluations of the quality, quantity and outcomes of the training be conducted and used to inform annual improvement of the training.[14]

To counter the stigma associated with problematic substance use, mental illness, and COVID-19 (infection, risk, complications), ramp up campaigns specific to correctional institutions and training for health, mental health, and substance use service providers, as well as the general public.[13]

That CSC require advanced training in working with people with mental health disabilities for all staff working on mental health units, in treatment centres, in segregation/SIUs, and as members of Emergency Response Teams as a prerequisite for performing these roles. Require regular refresher courses.[12]

Infection Prevention and Control

That CSC train all correctional staff in hygiene, infection prevention and control, and sanitation practices and principles (including the use of and adherence to PPE).[13]

Front-Line Staff

Incentivize health and correctional staff workforce development and training, as well as recruitment and retention (e.g., through ongoing professional development, adequate and consistent compensation packages, emergency pay, sick leave benefits, and guaranteed resourcing of PPE).[13]

That CSC should immediately develop a separate and distinct intervention and management model to assist front-line staff in recognizing, responding and addressing situations of medical emergency and/or acute mental health distress.[27]

That CSC should review and revise the channels, methods and flow of information between clinical and front-line staff to ensure first-response staff members are adequately prepared to safely manage medical and mental health needs.[27]

That CSC front-line staff members should receive regular refresher and upgraded training in conflict de-escalation. Training should emphasize how to manage oppositional/defiant behaviours in situations where underlying mental health issues are present or previously identified.[27]

Healthcare Professionals

Address ongoing systemic health-service shortcomings through:

- workforce development and training (e.g., management of comorbid mental illness, substance use disorders, and infectious diseases and the adoption of best practices for staff recruitment and retention).[13]

Train correctional health-service providers in mental health, substance use, and infectious-disease knowledge, skills, and competencies. Ensure adequate mental health supports for service providers and corrections staff, including trauma therapy, counselling, and continued access to family and social supports (particularly for those self-isolating).[13]

That a scope of practice review be undertaken to ensure Registered Nursing staff are adequately trained, supported and prepared to work in a correctional environment and include specific instruction in use of force, inflammatory agents and provision of emergency trauma care.[27]

That CSC develop a training program for front-line health professionals. This program should draw on the most recent research on racial bias and its impact on medical decisions and procedures.[23]

Develop policy and training on dual loyalty and the domestic and international ethical obligations of medical professionals working in prisons.[12]

Summary

Workplace culture and safe environment are of high importance. All main topic areas of the CAN/HSO 34008:2024 *Correctional Service Canada Health Services* standard are interlinked. There are linkages that predominate namely client rights and workforce competency. The leadership and quality improvement literature emphasize the importance of a culture of measure that addresses structural process and outcome indicators.[32] This means that organizations may have structures, processes, policies, and guidelines that employees are required to follow but that may be non-person-centered. The importance of continuing education for employees cannot be understated, however, if they find

themselves working amid structures and processes without flexibility of adaptation to allow for person-centeredness both employees and incarcerated people will experience a lack of satisfaction.

Quality improvement

Under the standard main topic area of Quality Improvement 12 healthcare-related recommendations were extracted from six documents as follows: *Human Rights of Federally Sentenced Persons* from the Standing Senate on Human Rights[14] (2); Correctional Service Canada's *Evaluation of CSC's Health Services*[9] (3); the Mental Health Commission of Canada's *COVID-19, Mental Health, and Substance Use In Correctional Settings: Considerations For Addressing Systemic Vulnerabilities*[13], *Correctional services during and beyond COVID-19* by the Royal Society of Canada[11], and West Coast Prison Justice Society's Damage/Control: Use *of Force and the Cycle of Violence and Trauma in* BC's *Federal and Provincial Prisons*[12] (2 each); and Office of the Correctional Investigator's *Annual Report 2020-2021*[22] (1).

All organizations have programs related to quality improvement, it is by intent that this main topic area of the standard is inserted in the report adjacent to that of a Healthy Workforce. The two are closely connected and if the workforce is not feeling healthy, competent, and engaged quality improvement efforts will languish.

Box 8: Quality Improvement Recommendations

Staffing

That the CSC work with the provinces, territories, medical associations and professional governing and licensing bodies to ensure professional standards are adhered to and doctors are available in federal penitentiaries on a full-time basis and registered nurses on a 24-hour basis.[14]

That the CSC establish a policy to ensure that only medical professionals have the authority to determine whether a federally sentenced person requires medical attention.[14]

Create specialized officer-nurse teams at treatment centres and maximum and medium institutions to respond to situations involving emotional or medical distress using joint decision-making. This could follow models in the community that pair specially trained police with psychiatric nurses to respond to emergencies involving people with mental health issues.[12]

Medical Records

That CSC Health Services improve the understanding of information sharing requirements and limitations, as elaborated in their guidelines, in accordance with privacy laws and other relevant legislation. That CSC Health Services improve timely access to relevant and accurate medical records for Health Care staff. These will be accomplished by:

- Finalizing the implementation of electronic medical records to improve accessibility and consistency of health information
- Enhancing awareness of information sharing procedures and "need-to-know" principle among CSC personnel, including concrete examples of where and how the principle should be applied; and
- Conducting a review of information sharing issues identified in board of investigation incidents to contribute to existing lessons learned and to inform procedural/policy changes if necessary.[9]

Continuity of Care

That CSC:

- Review the model of community mental health service delivery to ensure that community mental health services are being provided to offenders with the greatest mental health needs.
- Ensure that clinical discharge planning activities are tracked in electronic information systems.[9]

Chronic Disease Management

That CSC Health Services continue to implement the Chronic Disease Management Strategy, with reference to any special needs/requirements for older, women, and Indigenous offenders, and methods for tracking impacts.[9]

Infection Prevention and Control

Create or update all infection control, pandemic response policies and strategic plans to integrate public health measures into correctional operations.[13]

Pandemic planning should pay attention to strategies to mitigate the mental health and substance use impact of infection prevention and control measures, including the risk of opioid overdose.[13]

Mental Health and Addictions

That CSC implement experimental psychosocial interventions, with long-term monitoring, to test whether such interventions can reduce the suicide rate among the subgroup of inmates at risk.[10]

That CSC incident investigations examine all four pillars of addressing problematic substance use to inform prevention, treatment, harm reduction and enforcement strategies.[10]

Have senior mental health practitioners review all uses of force against prisoners with mental health disabilities.[12]

That CSC develop a reliable method for administratively tracking individuals with mental health concerns in order to identify how policies and practices, such as use-of-force, impact this particularly vulnerable population.[22]

Summary

This set of recommendations is intended to improve the delivery of care within incarcerated people. *Human Rights of Federally Sentenced Persons* is clear about the need for CSC, the justice system, and the healthcare system to work in harmony for the protection of human rights and for the wellbeing of all involved.[14] Document eight evaluating CSC's health services reveals the broken links across health services and settings suggesting this is a symptom of the absence of integration of CSC, justice, and health services[9]. Four documents represent reports at a granular level in relation to mental health and substance use, deaths in custody, and tracking effects of use of force.[10, 12, 13, 22] A cursory review makes the recommendations seem doable. A critical review begs the question are the structures and processes in place within CSC to work with the provinces, territories, medical associations, and

professional governing and licensing bodies so that the people are positioned to innovate and adapt to local culture and situations as needs arise and change?

Alternatives to traditional forms of incarceration

Six recommendations for alternatives to correctional institutions for people with mental health and addictions symptoms and aged incarcerated people were extracted from four documents as follows: *Aging and Dying in Prison* by the Correctional Investigator Canada and Canadian Human Rights Commission[21] (3); *Human Rights of Federally Sentenced Persons* by the Standing Senate on Human Rights[14], Centre for Addiction and Mental Health's *Mental Health and Criminal Justice Policy Framework*[15], and *Damage/Control: Use of Force and the Cycle of Violence and Trauma in BC's Federal and Provincial Prisons* by the West Coast Prison Justice Society[12] (1 each).

The recommendations call for alternatives in instances of mental health and addictions symptoms suggesting healing lodges as one alternative. The recommendations also suggest consideration be given to physically accessible community placement or accommodation in long-term care facilities.

Box 9: Alternatives to Traditional Forms of Incarceration Recommendations

Mental Health and Addictions

People with mental illness who become involved in the criminal justice system should have access to range of diversion and release options. Examples of action that results from this principle:

- People with mental illness in the corrections system have access to culturally appropriate custody (e.g. Healing Lodges) and community-based sentences.[15]

Develop an alternative model for identifying and responding to prisoners with mental health disabilities in crisis in partnership with mental health experts (including experts in forensic psychiatry) and people with lived experience. This includes prisoners in emotional distress (such as prisoners who are self-harming) as well as prisoners who are experiencing behavioural emergencies connected with their disabilities. These responses should be supportive and trauma informed rather than punitive.[12]

Aging Populations

That the CSC increase efforts to develop more contracts with provinces and territories to establish alternatives to federal correctional institutions for aging federally sentenced persons and those with acute medical conditions as well as mental health issues pursuant to section 29 of the Corrections and Conditional Release Act.[14]

We recommend that an independent review of all older individuals in federal custody be conducted with the objective of determining whether a placement in the community, a long-term care facility or a hospice would be more appropriate.[21]

That CSC designate facilities for older individuals who want to live in such areas—and that such facilities are designed or retrofitted to ensure physical accessibility.[21]

That CSC enhance partnerships with outside service providers and reallocate funds to create additional bed space in the community and secure designated spots in long-term care facilities and hospices for older individuals who pose no undue risk to public safety.[21]

This data was extracted from the included documents because it invited conceptualization and consideration of alternatives to correctional institutions for people with mental health and addictions symptoms and those in advanced age. Fifteen years ago, Hatton and Fisher conducted studies with incarcerated women in California because the rates of women being incarcerated had surpassed those of men, and that rates of mental health and addictions symptoms in these women were 70% versus 55% in men.[33] At the same time the US Public Broadcasting Service in their news coverage questioned if correctional institutions were the new asylums. This query points to the unintended consequences of deinstitutionalization without continuity of care for people with mental health and addictions symptoms on discharge and the need to reimagine care for people with mental health and addictions symptoms. The act of reimagining is what is called for to come up with alternatives. Criminalizing people with mental health and addictions symptoms followed by incarceration in the absence of expert mental healthcare defeats the possibility of rehabilitation and a stable mental state. The cycle must be interrupted, it is time to be brave and bold bringing people with mental health and addictions symptoms together with the systems of CSC, Justice, and Health and Social Services to dare to try. For example, what if a incarcerated person with mental health and addictions symptoms and reasonably stable is released to a furnished tiny home, an income, a health card, a rehabilitation program with supports in place, and a sponsor? This may not be perfect but perhaps enough to have hope and a chance to reintegrate. Many other options could be generated by the systems involved and incarcerated people or those who are formerly incarcerated.

Areas for research

Four recommendations fell under this heading extracted from two documents as follows: Correctional Service Canada's *Fourth Independent Review Committee on Non-Natural Deaths in Custody That Occurred Between April 1st, 2014 to March 31st, 2017*[10] (3) and the Mental Health Commission of Canada's *COVID-19, Mental Health, and Substance Use in Correctional Settings: Considerations for Addressing Systemic Vulnerabilities*[13] (1).

Box 10: Areas for Research Recommendations

Alternatives to Traditional Forms of Incarceration

Commit resources to study recently enacted legislation and policies that support decarceration to determine their potential impact on recidivism, cost savings, and social, economic, and health impacts (e.g., infectious disease, chronic disease, mental health, and substance use).[13]

Mental Health and Addictions

Establishing a study to develop predictive indicators on the use of opioids by inmates during incarceration.[10]

Developing a substance-related disorder assessment instrument that will link the level of dependency to specific substances.[10]

Continuing studies that will help provide a better understanding of the phenomenon of penitentiary overdoses and equip CSC to prevent them.[10]

The CSC has a research unit and although the studies suggested in these recommendations would generate knowledge it would be worthwhile considering studies that are upstream and targeted toward the prevention of incarceration. It is noteworthy that prevention is always the hardest to sell leaving us vulnerable to forever dealing with consequences that go far beyond an individual.

Separation/secession from traditional corrections structures

In the review of included documents, we found five recommendations for the complete separation of mental healthcare services from the Department of Justice from four documents as follows: *Aging and Dying in Prison* by the Correctional Investigator Canada and Canadian Human Rights Commission[21] (2), and the College of Family Physicians of Canada's *Position Statement on Health Care Delivery*[16], *Damage/Control: Use of Force and the Cycle of Violence and Trauma in BC's Federal and Provincial Prisons* by the West Coast Prison Justice Society, and the Mental Health Commission of Canada's *COVID-19, Mental Health, and Substance Use in Correctional Settings: Considerations for Addressing Systemic Vulnerabilities*[13] (1 each).

The College of Family Physicians of Canada[16] and the West Coast Prison Justice[12] maintain that healthcare be independent of correctional institutions. This same decoupling was recommended for older incarcerated people[21], and a national decarcerating strategy was also recommended.[13]

Box 11: Separation/Secession from Traditional Corrections Structures

Separation of Healthcare

Responsibility for delivery of medical and mental health care services in federal correctional facilities should be separated completely from the Department of Justice Canada.[16]

Provide healthcare independently of CSC through partnerships with provincial health ministries in order to ensure full clinical independence.[12]

Aging Populations

That CSC develop a separate and distinct Commissioner's Directive specific to older individuals, which ensures that their specific needs and interests are identified and met through the provision of effective and adapted programs, services and interventions.[21]

That CSC fund and implement an integrated and comprehensive National Older Offender Strategy immediately. The strategy should:

- go beyond an "aging in place" approach, including the mandatory and ongoing review of release options for older individuals who do not pose undue risk to public safety
- examine, respect, and respond to the intersectional characteristics and needs of older individuals in federal custody
- establish a timeframe for assessing, retrofitting and, where necessary, building facilities under CSC authority to ensure accessibility.[21]

Infection Prevention and Control

Create a national correctional decarcerating strategy that is linked with national emergency measures and public health responses.[13]

Summary

This set of recommendations was included in the event they may serve to catalyse conversations about possibility and the reimagining of how healthcare and correctional institutions, and Criminal Justice could co-design a path forward for all incarcerated people to have the opportunity to rehabilitate in a context that creates the circumstances in which they can thrive.

Question 2: What healthcare models are used in correctional facilities internationally?

Country-level models

Five documents describing five models were identified in the search and environmental scan outlining organizational models for healthcare delivery in correctional institutions.[34-38] All five documents are grey literature sources; none of the included documents were peer-reviewed research articles. Of these, three documents were authored by government organizations or departments, including HM Government and NHS (National Health Service) England[35], HM Prison and Probation Service[38], and Public Health Wales and the Welsch Government.[37] The remaining two were authored or published by non-governmental organizations, including the World Health Organization Regional Office for Europe[36] and KCE (Belgian Health Care Knowledge Centre).[34]

Organizational models found within the five included documents are from the United Kingdom (England and Scotland) [34-36, 38], France[34], Switzerland[34], and Finland.[36] Two documents covered organizational models from multiple countries.[34, 36]

See Table 5 in Appendix 1 for a reference for each document, the countries covered, and an overview of the models discussed.

The models are presented below outlined by country, name, purpose/aim, partnerships/main actors, and funding.

Purpose/aim

Of the four countries covered, a purpose/aim for the country-level model is only reported for the United Kingdom (England) and Finland.

United Kingdom: England
According to the *National Partnership Agreement for Prison Healthcare in England 2018-2021*, the objectives of the healthcare system in correctional institutions in England are:

- To improve the health and wellbeing of people in correctional institutions and reduce health inequalities.

- To reduce re-offending and support rehabilitation by addressing health-related drivers of offending behaviour.
- To support access to and continuity of care through the prison estate, pre-custody, and post-custody into the community.[35]

Finland
Unit for Prisoners' Health Services
To maintain and improve people's health, wellbeing and work and functional capacity, and to reduce health inequalities.[36]

Partnerships/main actors

United Kingdom: England
In England the oversight and management of healthcare is the responsibility of the National Prison Healthcare Board, which is made up of five organizations as of 2018: 1. The Department of Health and Social Care; 2. The Ministry of Justice; 3. Public Health England; 4. Her Majesty's Prison and Probation Service; 5. NHS England.[35, 36]

United Kingdom: Scotland
Within the United Kingdom, the Scottish healthcare and correctional systems operate separately from that of England. The Scottish Prison Service, an executive agency of the Scottish Government, is responsible for delivering custodial and rehabilitation services, while the regional health boards, under NHS Scotland, are responsible for delivering healthcare services in correctional settings that are equivalent to those in the community.[34]

France
In France, healthcare in correctional institutions is the responsibility of the Ministry of Health. Healthcare services are provided by nearby "associated hospitals" in the same way as the general public. Each hospital has a care unit, or Unité de Soins en Milieu Pénitentiaire (USMP), inside their assigned correctional institution(s) to deliver onsite care, while care requiring hospitalization or specific equipment would take place at the hospital itself. If hospitalization is required for more than 48 hours the patient could be discharged to the Unité Hospitalière Sécurisée Interregionale (UHSI). Psychological and psychiatric care is delivered by the Services Médico-Psychologiques Régionaux (SMPR), which is part of the associated hospital. Psychiatric hospitalization can be within a USHI or one of the Unités Hospitalières Spécialement Aménagées (UHSA).[34]

Switzerland
The Swiss government is responsible for overall strategy within areas of health and justice, while the 26 cantons are responsible for implementation. Collaboration between correctional institutions and healthcare across Switzerland varies due to differences among the cantons, but two main models exist: 1. Health services staff are partially or fully employed by the corrections authority or department of justice; 2. Health services staff are employed by the health authority.[34]

Finland
The Government of Finland is responsible for the organization of health services in correctional institutions, which is provided by the Unit for Prisoners' Health Services (VTH) and independent under the Finnish Institute for Health and Welfare (THL), which is part of the Ministry of Social Affairs and

Health. The Criminal Sanctions Agency, under the Ministry of Justice, manages and operates all Finnish correctional institutions. VTH's board, which acts as an advisory body, includes members from the Ministry of Social Affairs and Health and the Ministry of Justice, the Criminal Sanctions Agency, THL, public health and social welfare institutions, and nongovernmental organization sector.[36]

Funding

United Kingdom: England
In England, healthcare services in correctional institutions are funded by the Department of Health and Social Care within the United Kingdom government[36] while National Health Service (NHS) England is responsible for the commission of healthcare services for people in correctional institutions.[36, 38]

United Kingdom: Scotland
Healthcare in Scotland is nationally funded through taxes and National Insurance Contributions, and all residents are eligible for most services for free at the point of use. Funding for l healthcare in correctional institutions is part of the baseline for the NHS rather than divided based on an allocation formula like the rest of healthcare spending.[34]

France
Health coverage in correctional institutions is primarily funded through regional health insurers. Incarcerated people register through the Primary Fund Health Insurance (CPAM, Caisse Primaire d'Assurance Maladie) for their correctional facility, although contributions are paid by the state.[34]

Switzerland
Each of the 26 Swiss cantons are responsible for their own budget. Healthcare spending for incarcerated people is paid for out of the cantonal security budget. All persons living in Switzerland must have private health insurance, and most medical expenses are covered by health insurance. Some expenses, such as care within a psychiatric clinic, are classified as within the realm of justice and security and would be paid for by the canton. Hospital care is charged first to private health insurance, next to the residency canton of the incarcerated person, and finally to the correctional facility canton.[34]

Finland
Healthcare services in Finland are the responsibility of the Criminal Sanctions Agency, under the Ministry of Justice, which provides the VTH with an annual budget. The cost of healthcare in correctional institutions is covered entirely by the national government.[36]

Program models

In addition to models at the country level, the search and environmental scan also uncovered program models for the care of people with mental health and addictions symptoms. Six documents in total reported on seven program models[39-44], two from Australia[41, 43], two from the United Kingdom (Ireland[39] and Scotland[42]), and two from New Zealand.[40, 44] Of these, four are grey literature sources[39-42], one is a peer-reviewed journal article[43], and one is a book chapter.[44] Within the documents seven different program models are described, with one document describing two models.[40] These program models have the potential to be implemented at the country, regional, or institutional level, however, it is unclear how widely the models are used. In the results/findings section below we differentiate between different levels of program models where possible.

See Table 6 in Appendix 1 for a reference for each model, its corresponding document, the country covered, the level of implementation and integration, and an overview of the model.

Implementation and integration

Of the seven program models, three have been implemented nationally in the United Kingdom (Ireland[39] and Scotland[42]) and New Zealand, [44] three regionally in New Zealand[40] and Australia[41, 43], and one at the correctional facility level in New Zealand.[40] Most of the models are integrated into the correctional institutions via healthcare services personnel only meaning the model is not integrated by the remainder of the correctional staff in carrying out their duties and responsibilities. The two exceptions are the Prison Model of Care (PMOC) in Australia[43] and the Clinical Governance Model in New Zealand[44]. The document discussing the PMOC states "there were no new resources for this change in service model, requiring clearer role definition within multi-disciplinary teams and collaboration with correctional staff that collaboration with correctional staff is needed." [43 p. 286] The Clinical Governance Model at its core requires collaboration among all levels, including government, managers, clinicians and staff to "share responsibility and accountability for the quality of care, continuously improving, minimizing risks, and fostering an environment of excellence in care." [44 p. 120]

Client-centred care

Four program models specifically identified person-centred care as an essential component, with three of those models coming out of New Zealand. Regionally, the Model of Care for Stanford House in the Central region of New Zealand states that person or "whānau-centred care" is one of their models' key principles, along with "individualized care, planning transitions along the recovery care journey, integration with non-governmental/community/justice organizations, adapting care to individual needs/strengths, evidence-based care and stewardship of resources." [40 p. 81] Within Auckland's Model of Care from the Auckland region of New Zealand, one of the five key principles guiding the service is the importance of cultural and personal identity.[40] Nationally, the tripartite/clinical governance model has been recommended by the New Zealand Health and Safety and Quality Commission as being aligned with the Ministry of Health strategy quality goals, which include people-centredness.[44] Finally, one of the four dimensions of recovery in Forensicare's Journey of Recovery and Care from Australia is personal recovery, which is based on everyone's social, cultural, and familial situation or experiences.[41]

Discussion

This project had two overall aims, identifying reviews of healthcare services provided in Correctional Services Canada Institutions over the past decade with associated healthcare-related recommendations, and the identification of models of health services in operation in correctional institutions over the past five years in 10 countries. To address these aims a rapid review was conducted by searching databases for peer-reviewed literature. Searches of MEDLINE, CINAHL, and PsycInfo were empty. Grey literature searches were executed to obtain the documents included. The absence of publications evaluating healthcare services in correctional institutions calls for reflection and a strategy for incarcerated people to be included as mainstream organizations in which ethically

approved research is considered mainstream and incarcerated people can choose to participate in research intended to contribute to their wellbeing.

The Senate Committee report on human rights in corrections institutions[14] is a comprehensive assessment of the state of the human rights of incarcerated people and provides insights into how rehabilitation is impeded in the absence of respect for human rights. Across the more than 100 recommendations extracted, almost all have some link to human rights, many of which have appeared across consecutive evaluations.

The recommendations speak to the presence of discrimination, stigmatism, racism, and lack of respect afforded incarcerated people. Rehabilitation cannot be achieved in such a climate. A systems approach among Corrections Services, Healthcare Services, Criminal Justice, and Social Services is essential to create the conditions for rehabilitation in correctional institutions and eventual reintegration.

It is noteworthy that most recommendations clustered around workforce training and competency, safety practices, quality improvement, and comprehensive assessments. Considerable emphasis has been placed on the upskilling and continuing education of the healthcare workforce in correctional institutions. Consideration needs to be given to healthcare professional entry to practice programs to include competency in respecting the Charter of Human Rights and Freedoms. In addition, correctional systems need to consider if their structures and processes create the conditions for staff to deliver high-quality, person-centred care.

Anecdotally, correctional institutions are considered dangerous places. People are raised to avoid danger, yet we sentence people, many of whom (≥ 50%) have mental health and addictions symptoms to incarceration in a correctional facility that may or may not offer treatment of their symptoms. In the absence of a comprehensive assessment and an individualized plan of care and treatment, those with mental health and addictions symptoms become a danger to themselves and others so we create a plethora of safety practices. The information emanating from the various recommendations represents an opportunity for critical appraisal to understand how the way we compartmentalize people and decide their disposition may be directly proportional to a rising correctional institution population.

The 1978 Alma Ata Declaration advanced the need for primary care based on principles of social justice and the importance of its availability for all. A European Union position paper on the health of detainees described the complex health needs of incarcerated people underlining the central role of primary care in corrections institutions and in the community to improve health and reduce mortality of this marginalized population.[45] Ample evidence of the benefits of primary care in the general population and specifically in the previously incarcerated populations exists. These benefits include individualized case management following release resulting in increased use of health as well as mental health services[46-48], reduced reincarceration, and criminal justice costs[49, 50], lower rates of hospitalization, and fewer deaths from common chronic illnesses and reduced socio-economic inequity[51] and production of positive effects in relation to mental health and substance abuse, and infectious diseases.[47] Although challenges to access adequate primary care exist upon release[52, 53] every endeavor possible is needed to make access to primary care inclusive.

Equivalent care for incarcerated persons has its origins in the Mandela Rules (24.1).[2] Given the evidence of the benefits of primary care upon release it is reasonable to assume the health status of the correctional population will improve with access to primary care. Community equivalent primary

care needs to be seamless and for this to happen the systems of health, justice, and corrections must collaborate with one another and operate on the principles of equity, diversity, inclusion, and ability. The discussion continues with some reflections on models of healthcare in correctional institutions.

The models of healthcare extracted from the literature for the most part report a partnership model whereby all entities involved with corrections and healthcare come together to work toward optimal health services delivery. There are nuances in the operationalization of models. For example, although the Ministry of Health is responsible for correctional health services in several countries Scotland uses a primary care approach while France is closely aligned with hospital care delivery thereby side-stepping health promotion and illness prevention. In the Netherlands, the Justice Ministry is responsible and is operationalized via multidisciplinary teams in which system managers and nurses are employed by correctional institutions, nurses are required to have an additional year of study to practice in correctional facilities, and physician care is contracted.

Strengths and Limitations

This environmental scan identified 20 documents with information about evaluations of healthcare services in corrections institutions in Canada over the past 10 years. The Senate Committee report on human rights in correctional institutions[14] is comprehensive and an excellent resource for all involved with correctional institutions and incarcerated people.

Most documents contained recommendations related to the mental health needs of incarcerated people, almost to the exclusion of other healthcare-related needs. This confirms what is known about the prevalence of mental health and addictions symptoms in the correctional institutional population.

The original aim was to conduct a rapid review of databases of published literature on the topic and this was not done because information on the topic was not found in the peer-reviewed literature but rather in grey literature, and this source is difficult to search because it is not database specific except for theses. The project was time limited and therefore search limits and country limits were imposed.

Conclusion

Evaluations of healthcare in correctional institutions reveal discrimination, stigmatism, racism, and a general lack of respect for human rights. Healthcare is not integrated with other services within corrections institutions or with community-related services. A comprehensive assessment and treatment of persons in corrections institutions experiencing mental health and addictions symptoms is lacking as is continuity of care upon release.

Models of healthcare in corrections institutions are not structured to foster rehabilitation and reintegration into society. Examples of partnership models in Australia, France, Finland, the Netherlands, New Zealand, and the United Kingdom are described and may offer a path forward for decision-makers.

The main topic areas of the CAN/HSO 34008:2024 *Correctional Service Canada Health Services* standard (in progress) are designed to drive integrated health-focused services whereby all corrections

institutions staff and services partners respect human rights, promote rehabilitation, and foster societal reintegration.

References

1. Correctional Service Canada. (2020). *Health services*. Government of Canada. https://www.csc-scc.gc.ca/health/index-eng.shtml

2. United Nations Office on Drugs and Crime. (2015). *The United Nations standard minimum rules for the treatment of prisoners (the Nelson Mandela rules)*. https://www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf

3. Reingle Gonzalez, J. M., & Connell, N. M. (2014). Mental health of prisoners: Identifying barriers to mental health treatment and medication continuity. *American Journal of Public Health*, *104*(12), 2328-33. https://doi.org/10.2105/AJPH.2014.302043

4. Government of Canada. (2018). *Strengthening Canada's approach to substance use issues*. https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/strengthening-canada-approach-substance-use-issue.html

5. Government of Canada (2019). *Bill C-83: An Act to amend the Corrections and Conditional Release Act and another Act*. https://www.justice.gc.ca/eng/csj-sjc/pl/charter-charte/c83.html

6. Robinson, P., Small, T., Chen, A., & Irving, M. (2023). *Over-representation of Indigenous persons in adult provincial custody, 2019/2020 and 2020/2021*. Statistics Canada. https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2023001/article/00004-eng.pdf

7. Brown, G. P., Barker, J., McMillan, K., & Norman, R. (2018). *Prevalence of mental disorder among federally sentenced women offenders: In-custody and intake samples*. Correctional Service Canada. https://publications.gc.ca/collections/collection_2018/scc-csc/PS83-3-420-eng.pdf

8. Correctional Service Canada. (2022). *2022-2025 accessibility plan*. https://www.csc-scc.gc.ca/publications/005007-1000-en.shtml

9. Delveaux, K., MacDonald, C., McConnell, A., Bradley, S., Adam Crawford, & Tse, F. (2017). *Evaluation of CSC's health services*. Correctional Service Canada. https://www.csc-scc.gc.ca/publications/092/005007-2017-eng.pdf

10. Nadeau, L., Brochu, S., & Cormier, R. (2018). *Fourth independent review committee on non-natural deaths in custody that occurred between April 1st, 2014 To March 31st, 2017*. Correctional Service Canada. https://www.csc-scc.gc.ca/publications/092/005007-2310-en.pdf

11. Bucerius, S., Crewe, B., Pyrooz, D., Ricciardelli, R., & Tetrault, J. (2021). *Correctional services during and beyond COVID-19.* Royal Society of Canada. https://rsc-src.ca/sites/default/files/images/Corrections%20PB_EN.pdf

12. West Coast Prison Justice Society. (2019). *Damage/control: Use of force and the cycle of violence and trauma in BC's federal and provincial prisons*. https://prisonjustice.org/wp-content/uploads/2021/05/use-of-force-report-Nov-21-2019-updated.pdf

13. Mental Health Commission of Canada. (2021). *COVID-19, mental health, and substance use in correctional settings: Considerations for addressing systemic vulnerabilities*. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-07/COVID_19_Corrections_Policy_Brief_Eng_0.pdf

14. Ataullahjan, S., Bernard, W. E. T., & Cordy, J. (2021). *Human rights of federally sentenced persons*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf

15. Centre for Addiction and Mental Health. (2020). *Mental health and criminal justice policy framework*. https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/camh-cj-framework-2020-pdf.pdf

16. The College of Family Physicians of Canada. (2016). *Position statement on health care delivery*. https://www.cfpc.ca/CFPC/media/Resources/Prison-Health/2022-12-Health-Care-Delivery-EN-FINAL.pdf

17. Office of the Auditor General of Canada. (2017). *Preparing women offenders for release* (Report No. 5). Reports of the Auditor General of Canada to the Parliament of Canada. https://www.oag-bvg.gc.ca/internet/English/parl_oag_201711_05_e_42670.html

18. Holmes, J. D. (2019). *Report to the minister of justice and solicitor general public fatality inquiry*. Provincial Court of Alberta. https://open.alberta.ca/dataset/7bb1cc06-8c4a-4b59-8523-37a9d6b2f4b8/resource/56aca31e-f0d9-4565-90dc-732e09e6a35a/download/01449.pdf

19. Canadian Human Rights Commission. (2022). *45 calls for inclusion: Celebrating 45 years of the Canadian Human Rights Act*. https://www.chrc-ccdp.gc.ca/en/resources/45-calls-inclusion-celebrating-45-years-the-canadian-human-rights-act#week6

20. Sapers, H. (2022). *Structured intervention unit implementation advisory panel: 2021-2022 annual report*. https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/2022-siu-iap-nnlrpt/2022-siu-iap-nnlrpt-en.pdf

21. The Correctional Investigator Canada, & Canadian Human Rights Commission. (2019). *Aging and dying in prison: An investigation into the experiences of older individuals in federal custody*. https://www.chrc-ccdp.gc.ca/sites/default/files/publication-pdfs/oth-aut20190228-eng.pdf

22. Zinger, I. (2021). *Annual report 2020-2021*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20202021-eng.pdf

23. Zinger, I. (2022). *Annual report 2021-2022*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20212022-eng.pdf

24. Office of the Correctional Investigator. (2017). *Missed opportunities: The experience of young adults incarcerated in federal penitentiaries*. https://oci-bec.gc.ca/en/content/missed-opportunities-experience-young-adults-incarcerated-federal-penitentiaries-final#_Toc491868918

25. Office of the Correctional Investigator. (2015). *National drug formulary investigation summary of findings and recommendations*. https://oci-bec.gc.ca/en/content/national-drug-formulary-investigation-summary-findings-and-recommendations

26. Office of the Correctional Investigator. (2014). *Overcoming barriers to reintegration: An investigation of federal community correctional centres* https://oci-bec.gc.ca/en/content/overcoming-barriers-reintegration-investigation-federal-community-correctional-centres

27. Office of the Correctional Investigator. (2017). *Fatal response: An investigation into the preventable death of Matthew Ryan Hines*. https://oci-bec.gc.ca/en/content/fatal-response-investigation-preventable-death-matthew-ryan-hines-final-report-february-15

28. Centre for Addiction and Mental Health. *Patient- and family-centred care*. https://www.camh.ca/en/professionals/treating-conditions-and-disorders/approaches-to-care/patient-centred-care

29. Correctional Service Canada. (2023). *CSC health services summary*.

30. Mayo Clinic. (2021). *Oral health: A window to your overall health*. https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475

31. Luigi, M., Dellazizzo, L., Giguere, C. E., Goulet, M. H., & Dumais, A. (2020). Shedding light on "the hole": A systematic review and meta-analysis on adverse psychological effects and mortality following solitary confinement in correctional settings. *Frontiers in Psychiatry*, *11*, 840. https://doi.org/10.3389/fpsyt.2020.00840

32. Bungay, S., & Merour, A. (2019). *How structure, process, and rules make people free*. https://www.infoq.com/articles/structure-process-rules-make-people-free/

33. Hatton, D. C., & Fisher, A. A. (2008). Incarceration and the new asylums: Consequences for the mental health of women prisoners. *Issues in Mental Health Nursing*, *29*(12), 1304-7. https://doi.org/10.1080/01612840802498599

34. Dubois, C., Linchet, S., Mahieu, C., Reynaert, J.-F., & Seron, P. (2017). *Organization models of health care services in prisons in four countries*. KCE (Belgian Health Care Knowledge Centre). https://kce.fgov.be/sites/default/files/2021-11/KCE_293_Prisons_health_care_Chapter_4.pdf

35. HM Government, & NHS England. (2018). *National partnership agreement for prison healthcare in England 2018-2021*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767832/6.4289_MoJ_National_health_partnership_A4-L_v10_web.pdf

36. World Health Organization Regional Office for Europe. (2020). *Organizational models of prison health: Considerations for better governance*. https://iris.who.int/bitstream/handle/10665/336214/WHO-EURO-2020-1268-41018-55685-eng.pdf

37. Public Health Wales and Welsh Government. (2022). *Substance misuse treatment framework clinical pathway for the management of substance misuse in prisons in Wales* [Draft]. https://www.gov.wales/sites/default/files/consultations/2022-07/clinical-pathway-for-the-management-of-substance-misuse-in-prisons-in-wales.pdf

38. HM Prison and Probation Service. (2019). *Model for operational delivery: New resettlement prisons supporting effective delivery in the adult male prison estate*. https://data.parliament.uk/DepositedPapers/Files/DEP2019-0487/New_Resettlement_Prisons_MOD.pdf

39. Irish Prison Service. (n.d.). *Psychology service*. https://www.irishprisons.ie/prisoner-services/psychology-service/

40. McKenna, B., & Sweetman, L. (2021). *Models of care in forensic mental health services: A review of the international and national literature*. Ministry of Health & New Zealand Government. https://www.health.govt.nz/system/files/documents/publications/models_of_care_in_forensic_mental_health_services_-_final_version_december_2021.pdf

41. Forensicare. (2021). *Model of care 2021-26*. https://www.forensicare.vic.gov.au/wp-content/uploads/2023/09/FC73-Model-of-Care-Act-Update-WEB-002.pdf

42. Forensic Network. (2022). *Review of the delivery of psychological therapies in forensic mental health services in Scotland*. https://forensicnetwork.scot.nhs.uk/wp-content/uploads/2022/09/Review-of-the-Delivery-of-Psychological-Therapies-in-Forensic-Mental-Health-Scotland-V.1.pdf

43. McKenna, B., Skipworth, J., Tapsell, R., Pillai, K., Madell, D., Simpson, A., Cavney, J., & Rouse, P. (2018). Impact of an assertive community treatment model of care on the treatment of prisoners with a serious mental illness. *Australasian Psychiatry*, *26*(3), 285-9. https://doi.org/10.1177/1039856217748247

44. Cavney, J. (2022). A tripartite model of cultural, clinical, and operational governance in the planning and delivery of culturally informed care for Indigenous Māori forensic mental health service users. In J. Tomlin & B. Völlm (Eds.), *Diversity and marginalisation in forensic mental health care*. Routledge. https://www.taylorfrancis.com/chapters/edit/10.4324/9781003184768-16/tripartite-model-cultural-clinical-operational-governance-planning-delivery-culturally-informed-care-indigenous-m%C4%81ori-forensic-mental-health-service-users-james-cavney

45. Groenewegen, P., Dirkzwager, A., Massalimova, D., Sirdifield, C., Smith, L., & van Dam, A. (2022). The health of detainees and the role of primary care: Position paper of the European forum for primary care. *Primary Health Care Research & Development*, *23*, e29, Article e29. https://doi.org/10.1017/S1463423622000184

46. Kinner, S. A., Alati, R., Longo, M., Spittal, M. J., Boyle, F. M., Williams, G. M., & Lennox, N. G. (2016). Low-intensity case management increases contact with primary care in recently released prisoners: A single-blinded, multisite, randomised controlled trial. *Journal of Epidemiology and Community Health*, *70*(7), 683-8. https://doi.org/10.1136/jech-2015-206565

47. Kouyoumdjian, F. G., McIsaac, K. E., Liauw, J., Green, S., Karachiwalla, F., Siu, W., Burkholder, K., Binswanger, I., Kiefer, L., Kinner, S. A., Korchinski, M., Matheson, F. I., Young, P., & Hwang, S. W. (2015). A systematic review of randomized controlled trials of interventions to improve the health of persons during imprisonment and in the year after release. *American Journal of Public Health*, *105*(4), e13-e33. https://doi.org/10.2105/ajph.2014.302498

48. Young, J. T., Arnold-Reed, D., Preen, D., Bulsara, M., Lennox, N., & Kinner, S. A. (2015). Early primary care physician contact and health service utilisation in a large sample of recently released ex-prisoners in Australia: Prospective cohort study. *BMJ Open*, *5*(6), e008021. https://doi.org/10.1136/bmjopen-2015-008021

49. Wang, E. A., Lin, H.-j., Aminawung, J. A., Busch, S. H., Gallagher, C., Maurer, K., Puglisi, L., Shavit, S., & Frisman, L. (2019). Propensity-matched study of enhanced primary care on contact with the criminal justice system among individuals recently released from prison to New Haven. *BMJ Open*, *9*(5), e028097. https://doi.org/10.1136/bmjopen-2018-028097

50. Harvey, T. D., Busch, S. H., Lin, H.-J., Aminawung, J. A., Puglisi, L., Shavit, S., & Wang, E. A. (2022). Cost savings of a primary care program for individuals recently released from prison: A propensity-matched study. *BMC Health Services Research*, *22*(1), 585. https://doi.org/10.1186/s12913-022-07985-5

51. Kringos, D. S., Boerma, W., Zee, J. v. d., & Groenewegen, P. (2013). Europe's strong primary care systems are linked to better population health but also to higher health spending. *Health Affairs*, *32*(4), 686-94. https://doi.org/10.1377/hlthaff.2012.1242

52. Calais-Ferreira, L., Butler, A., Dent, S., Preen, D. B., Young, J. T., & Kinner, S. A. (2022). Multimorbidity and quality of primary care after release from prison: A prospective data-linkage cohort study. *BMC Health Serv Res*, *22*(1), 876. https://doi.org/10.1186/s12913-022-08209-6

53. Fahmy, N., Kouyoumdjian, F. G., Berkowitz, J., Fahmy, S., Neves, C. M., Hwang, S. W., & Martin, R. E. (2018). Access to primary care for persons recently released from prison. *Annals of Family Medicine*, *16*(6), 549-51. https://doi.org/10.1370/afm.2314

Appendix 1: Tables

Table 1: Summary of reports reviewing health services in Canadian federal correctional institutions

Note: Some recommendations have multiple bullets that have been divided between more than one main topic area, and as such the total number of overall recommendations in Table 1 will be fewer than in Table 2 and the report narrative.

Reference	Method or approach	Recommendations (Healthcare related)
Ataullahjan, S., Bernard, W. E. T., & Cordy, J. (2021). *Human rights of federally sentenced persons*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf	Site visits; consultations; public hearings (witness testimony); written submissions	• That the Correctional Service of Canada work with the provinces, territories, medical associations and professional governing and licensing bodies to ensure professional standards are adhered to and doctors are available in federal penitentiaries on a full-time basis and registered nurses on a 24-hour basis. • That the Correctional Service of Canada establish a policy to ensure that only medical professionals have the authority to determine whether a federally-sentenced person requires medical attention. • That the Correctional Service of Canada increase the provision of dental care in federal penitentiaries to reflect the needs of federally-sentenced persons, with an emphasis on preventative dental care. • That the Correctional Service of Canada increase efforts to develop more contracts with provinces and territories to establish alternatives to federal correctional facilities for aging federally-sentenced persons and those with acute medical conditions as well as mental health issues pursuant to section 29 of the Corrections and Conditional Release Act. • That the Correctional Service of Canada provide additional rights-based training to correctional staff to ensure they are sensitive to the complex needs of aging, as well as physically and mentally ill federally-sentenced population. The Correctional Service of Canada should also make federal correctional facilities more accessible for federally-sentenced persons with mobility issues. • That the Correctional Service of Canada implement the following measures to ensure federally-sentenced persons with mental health issues receive appropriate support:

Reference	Method or approach	Recommendations (Healthcare related)
		○ conduct a culturally appropriate mental health assessment of all federally-sentenced persons entering the federal correctional system within 30 days of admission; ○ ensure that mental health beds are contracted in psychiatric facilities pursuant to section 29 of the Corrections and Conditional Release Act; • That the Correctional Service of Canada implement a holistic approach to mental health by: ○ providing all employees, as a condition of employment, with appropriate mental health and mental health crisis intervention training that is consistent with their vocational role. Further, the Correctional Service of Canada shall establish appropriate standards for training, ensure that all trainees demonstrate that they have met the standard and that ongoing evaluations of the quality, quantity and outcomes of the training be conducted and used to inform annual improvement of the training; and ○ evaluating the Peer Offender Prevention Service program at Stony Mountain Institution with a view to expanding it nationally to federal penitentiaries of all security levels. • That the Correctional Service of Canada ensure that federally-sentenced persons with mental health issues, or whom exhibit behaviours that may indicate a mental health issue, who are placed in structured intervention units are evaluated within 24 hours of their placement by a recognized mental health care professional. • That the Correctional Service of Canada expand its use of section 29 agreements and contract the development/provision of mental health services and beds in provincial psychiatric hospitals to provide adequate mental health services for federally-sentenced persons. • That the Correctional Service of Canada ensure that Structured Intervention Units adhere to the most recent court decisions and respect Canada's human rights obligations and international commitments, including by: ○ eliminating the use of solitary confinement for all federally-sentenced persons.

Reference	Method or approach	Recommendations (Healthcare related)
		○ taking into account the different needs and experiences of particular groups, including LGBTQI2-S persons and women. ○ eliminating solitary confinement in excess of 15 days. ○ providing meaningful human contact and continued access to programming as well as 24-hour access to health and mental health services. ○ establishing judicial oversight to review all Structured Intervention Unit placements and decisions. • That the Correctional Service of Canada immediately end the use of separation by any name with youth, women and those with disabling mental health issues, and implement mental health assessments and judicial oversight to eliminate the overrepresentation of federally-sentenced Indigenous Peoples, Black persons, other racialized persons and persons with mental health issues in Structured Intervention Units. • That the Correctional Service of Canada improve its training for correctional personnel regarding human rights standards and principles of equality and non-discrimination, including in relation to race, sex, sexual orientation, gender identity and expression, and mental health. • That the Correctional Service of Canada ensure that all federally-sentenced deaf and hard of hearing persons are able to access correctional programming through appropriate access to relevant medical devices and reliable interpretation services. • That the Correctional Service of Canada expand the application of section 84 releases to other vulnerable and marginalized groups, including federally-sentenced Black persons, LGBTQI2S and the ill and aging population.
Bucerius, S., Crewe, B., Pyrooz, D., Ricciardelli, R., & Tetrault, J. (2021). *Correctional services during and beyond COVID-19.* Royal Society of Canada.	Not reported	• Provide trauma counselling and trauma-informed programming for imprisoned persons to address the root causes for their struggles, recognizing the imposed strain caused by COVID-19. Trauma counselling, however, should continue beyond the pandemic, recognizing that the great majority of people housed in prison have been victimized and had traumatic life experiences throughout their life-course. • Provide sustained addiction counselling during and beyond the pandemic.

Reference	Method or approach	Recommendations (Healthcare related)
https://rsc-src.ca/sites/default/files/images/Corrections%20PB_EN.pdf		• Make it possible for incarcerated persons to be able to apply, at least six months prior to release, for a health card in order for correctional services organizations to assist with effective discharge planning. • Make health cards available to individuals housed in community correctional centres—they are not incarcerated and thus are not excluded from the Canada Health Act. • Make identification from prison and/or a letter/photo attesting to the person's identity sufficient to acquire a health card post incarceration.
Canadian Human Rights Commission. (2022). *45 calls for inclusion: Celebrating 45 years of the Canadian Human Rights Act*. https://www.chrc-ccdp.gc.ca/en/resources/45-calls-inclusion-celebrating-45-years-the-canadian-human-rights-act#week6	Not reported	• Improve mental health care for federal prisoners. The CSC must ensure that its staff and facilities are equipped to meet the varied and complex needs of prisoners with mental health disabilities. • End the use of solitary confinement for prisoners with mental health disabilities. The CSC must ensure that it has appropriate therapeutic alternatives to solitary confinement when it is required to separate prisoners with mental health disabilities from the general population. • Protect the human rights of trans and gender diverse prisoners. The CSC must ensure that its policies and its practices fully respect the rights and meet the needs of trans, non-binary and gender-diverse prisoners, including with respect to transfer requests. • Protect the rights of aging and dying prisoners. Canada must review and implement the joint recommendations put forward by the CHRC and the OCI in their joint investigative report, "Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody."
Centre for Addiction and Mental Health. (2020). *Mental health and criminal justice policy framework*. https://www.camh.ca/-/media/files/pdfs---public-policy-	Not reported	• People with mental illness who become involved in the criminal justice system should have access to range of diversion and release options. Examples of action that results from this principle: ○ People with mental illness in the corrections system have access to culturally appropriate custody (e.g. Healing Lodges) and community-based sentences.

Reference	Method or approach	Recommendations (Healthcare related)
submissions/camh-cj-framework-2020-pdf.pdf		• People with mental illness in the corrections system should receive evidence-informed mental health care and supports. Examples of action that results from this principle: ○ Health care practices in federal and provincial corrections comply with the UN's Mandela Rules. ○ Health care in correctional facilities is provided by a separate health care entity. Mental health care is part of this entity and under the direction of forensic mental health care experts. ○ Correctional facilities use the STAIR model to identify mental health needs and guide mental health care provision. ○ Mental health care is equitable and meets the diverse needs of women, Indigenous peoples, Black people and members of other racialized and/or historically marginalized populations. Offenders on remand receive the same evidence informed mental health care and supports as the sentenced population. ○ The full range of evidence-based interventions for substance use, including harm reduction programs and supplies, are made available to all offenders who need them. ○ The federal and provincial corrections systems balance the need to manage institutional safety and security with an individual's right to access mental health care. • There should be collaboration and coordination between the criminal justice system and the mental health system. Examples of action that results from this principle: ○ People with mental illness experience a continuity of their mental health care, including substance use treatment, as they transition through the criminal justice system and particularly as they move from the community to the corrections system and vice versa. ○ People with mental illness in correctional facilities receive comprehensive discharge planning that includes connections to mental health care,

Reference	Method or approach	Recommendations (Healthcare related)
		medications, social services, and other community resources before discharge. ○ Correctional facilities have partnerships with forensic mental health inpatient programs to temporarily transfer care of offenders with mental illness in need of acute mental health care. ○ Forensic mental health programs have partnerships with supportive housing programs and community mental health services. ○ Government policy supports and enhances connections between the criminal justice system and the mental health system.
The College of Family Physicians of Canada. (2016). *Position statement on health care delivery*. https://www.cfpc.ca/CFPC/media/Resources/Prison-Health/2022-12-Health-Care-Delivery-EN-FINAL.pdf	Not reported	• The pharmaceutical formulary in corrections should be harmonized to ensure any medication can be easily accessed while detained. • Responsibility for delivery of medical and mental health care services in federal correctional facilities should be separated completely from the Department of Justice Canada.
The Correctional Investigator Canada, & Canadian Human Rights Commission. (2019). *Aging and dying in prison: An investigation into the experiences of older individuals in federal custody*. https://www.chrc-ccdp.gc.ca/sites/defaul	Lit review; CSC data; interviews	• That an independent review of all older individuals in federal custody be conducted with the objective of determining whether a placement in the community, a long-term care facility or a hospice would be more appropriate. • That CSC develop a separate and distinct Commissioner's Directive specific to older individuals, which ensures that their specific needs and interests are identified and met through the provision of effective and adapted programs, services and interventions. • That CSC provide staff with training in age-related needs — physical, social and psychological — as well as training on how to identify, respond to and appropriately manage behaviour related to dementia.

Reference	Method or approach	Recommendations (Healthcare related)

t/files/publication-pdfs/oth-aut20190228-eng.pdf		• That CSC re-examine its use of force training and policy to incorporate best practices and lessons-learned regarding use of force on older individuals (including those using mobility devices).
		• That vulnerable populations (older offenders and those with mental and/or physical health issues) be monitored daily during lockdowns by professional health care staff.
		• That CSC designate facilities for older individuals who want to live in such areas—and that such facilities are designed or retrofitted to ensure physical accessibility.
		• That where the death of an offender is reasonably foreseen, CSC and the Parole Board be required to use proactive and coordinated case management to facilitate the offender's safe and compassionate release to the community as early as possible.
		• That the Minister of Public Safety review and assess release options (e.g. medical and/or geriatric parole) for older and long-serving offenders who do not pose undue risk to public safety, and propose amendments to the Corrections and Conditional Release Act (CCRA) as appropriate.
		• That CSC enhance partnerships with outside service providers and reallocate funds to create additional bed space in the community and secure designated spots in long-term care facilities and hospices for older individuals who pose no undue risk to public safety.
		• That CSC fund and implement an integrated and comprehensive National Older Offender Strategy immediately. The strategy should:
		  ○ go beyond an "aging in place" approach, including the mandatory and ongoing review of release options for older individuals who do not pose undue risk to public safety.
		  ○ examine, respect and respond to the intersectional characteristics and needs of older individuals in federal custody.
		  ○ establish a timeframe for assessing, retrofitting and, where necessary, building facilities under CSC authority to ensure accessibility.
		• That CSC significantly reallocate existing institutional resources to community corrections in order to better support the reintegration needs of aging offenders.

Reference	Method or approach	Recommendations (Healthcare related)
Correctional Service Canada. (2022). *2022-2025 accessibility plan*. https://www.csc-scc.gc.ca/publications/005007-1000-en.shtml	Consultations	• Enhance the accessibility of the built environment by: ○ Reviewing accessibility standards in consultation with persons with disabilities; ○ Developing an accessibility assessment strategy and facility assessments; ○ Providing the necessary resources to address gaps identified by facility accessibility assessments; and, ○ Reviewing the accessibility of emergency evacuation plans. ○ Identifying and removing accessibility barriers for offenders
Delveaux, K., MacDonald, C., McConnell, A., Bradley, S., Adam Crawford, & Tse, F. (2017). *Evaluation of CSC's health services*. Correctional Service Canada. https://www.csc-scc.gc.ca/publications/092/005007-2017-eng.pdf	Lit review; Interviews; CSC data; questionnaires	• That CSC Health Services endeavour to increase the efficiency of health-related intake assessment processes by considering the following: ○ Eliminating the requirement for repeated administration of health assessments; ○ Optimizing and eliminating unnecessary repetition of health information between assessment tools; and, ○ Ensuring health referrals are appropriately recorded and monitored. • That CSC Health Services collect data on wait times to access selected specialists services for non-urgent care; and implement strategies (for example increased use of telemedicine where appropriate) if wait times exceed available Canadian benchmarks. • That CSC Health Services improve the understanding of information sharing requirements and limitations, as elaborated in their guidelines, in accordance with privacy laws and other relevant legislation. That CSC Health Services improve timely access to relevant and accurate medical records for Health Care staff. These will be accomplished by: ○ Finalizing the implementation of electronic medical records to improve accessibility and consistency of health information; ○ Enhancing awareness of information sharing procedures and "need-to-know" principle among CSC personnel, including concrete examples of where and how the principle should be applied; and

Reference	Method or approach	Recommendations (Healthcare related)
		○ Conducting a review of information sharing issues identified in board of investigation incidents to contribute to existing lessons learned and to inform procedural/policy changes if necessary. • That CSC Health Services ensure that offenders have timely access to health education programs and harm reduction products by: ○ Providing clear direction and accountability for delivery and tracking of health education programs; and ○ Monitoring the distribution of harm reduction products (bleach, condoms, dental dams, and lubricants) and addressing any identified accessibility issues. • That CSC: ○ Review the model of community mental health service delivery to ensure that community mental health services are being provided to offenders with the greatest mental health needs. ○ Ensure that clinical discharge planning activities are tracked in electronic information systems. • That CSC Health Services continue to implement the Chronic Disease Management Strategy, with reference to any special needs/requirements for older, women, and Indigenous offenders, and methods for tracking impacts.
Holmes, J. D. (2019). *Report to the minister of justice and solicitor general public fatality inquiry*. Provincial Court of Alberta. https://open.alberta.ca/dataset/7bb1cc06-8c4a-4b59-8523-37a9d6b2f4b8/resource/56aca31e-f0d9-4565-90dc-	Public inquiry	• The inmate population disproportionately suffers from addiction and other mental health concerns. Readily available, effective and adequately funded mental health and substance abuse programs, to include methadone and suboxone programs, would not only aid in rehabilitation but reduce demand and the incentive to participate in the smuggling of dangerous drugs.

Reference	Method or approach	Recommendations (Healthcare related)
732e09e6a35a/download/01449.pdf .		

Mental Health Commission of Canada. (2021). *COVID-19, mental health, and substance use in correctional settings: Considerations for addressing systemic vulnerabilities*. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-07/COVID_19_Corrections_Policy_Brief_Eng_0.pdf	Literature review; focus group	• Involve incarcerated persons in the process and ensure ongoing communication about the situation to increase adherence to PPE use and public health measures.
		• Train all correctional staff in hygiene, infection prevention and control, and sanitation practices and principles (including the use of and adherence to PPE).
		• Ensure sufficient resources to procure and safely store PPE.
		• Create or update all infection control, pandemic response policies and strategic plans to integrate public health measures into correctional operations.
		• Pandemic planning should pay attention to strategies to mitigate the mental health and substance use impact of infection prevention and control measures, including the risk of opioid overdose.
		• To counter the stigma associated with problematic substance use, mental illness, and COVID-19 (infection, risk, complications), ramp up campaigns specific to correctional facilities and training for health, mental health, and substance use service providers, as well as the general public.
		• Prioritize the integration of substance use services, including harm reduction, into the broader continuum of correctional health and medical services to improve patient experiences and population health.
		• Address ongoing systemic health-service shortcomings through:
		  ○ policy changes that focus on achieving health access parity and providing continued access to services across the continuum of criminal justice involvement (including release/discharge).
		  ○ workforce development and training (e.g., management of comorbid mental illness, substance use disorders, and infectious diseases and the adoption of best practices for staff recruitment and retention).
		• Incentivize health and correctional staff workforce development and training, as well as recruitment and retention (e.g., through ongoing professional development, adequate and consistent compensation packages, emergency pay, sick leave benefits, and guaranteed resourcing of PPE).

Reference	Method or approach	Recommendations (Healthcare related)
		• Train correctional health-service providers in mental health, substance use, and infectious-disease knowledge, skills, and competencies. Ensure adequate mental health supports for service providers and corrections staff, including trauma therapy, counselling, and continued access to family and social supports (particularly for those self-isolating). • Ramp up substance use services with known public health advantages related to COVID-19, overdoses, and blood-borne infection risks, including harm reduction policies, safe consumption sites, access to clean needles and OAT. These activities are critical to supporting decarceration efforts. • Create a national correctional decarceration strategy that is linked with national emergency measures and public health responses. • Strengthen corrections' communications, collaborations, partnerships, and integration with public health authorities, as well as with mental health and substance use services and other community services needed to adequately support decarcerated individuals. • Commit resources to study recently enacted legislation and policies that support decarceration to determine their potential impact on recidivism, cost savings, and social, economic, and health impacts (e.g., infectious disease, chronic disease, mental health, and substance use).
Nadeau, L., Brochu, S., & Cormier, R. (2018). *Fourth Independent Review Committee on non-natural deaths in custody that occurred between April 1st, 2014 to March 31st, 2017*. Correctional Service Canada. https://www.csc-	CSC data	• CSC implement experimental psychosocial interventions, with long-term monitoring, to test whether such interventions can reduce the suicide rate among the subgroup of inmates at risk. • CSC incident investigations examine all four pillars of addressing problematic substance use to inform prevention, treatment, harm reduction and enforcement strategies. • Establishing a study to develop predictive indicators on the use of opioids by inmates during incarceration; • Developing a substance-related disorder assessment instrument that will link the level of dependency to specific substances;

Reference	Method or approach	Recommendations (Healthcare related)
scc.gc.ca/publications/092/005007-2310-en.pdf		• Continuing studies that will help provide a better understanding of the phenomenon of penitentiary overdoses and equip CSC to prevent them.
Office of the Auditor General of Canada. (2017). *Preparing women offenders for release* (Report No. 5). Reports of the Auditor General of Canada to the Parliament of Canada. https://www.oag-bvg.gc.ca/internet/English/parl_oag_201711_05_e_42670.html	CSC data	• Correctional Service Canada should ensure that it appropriately identifies women offenders who need mental health services and assigns them to the appropriate level of care. • Correctional Service Canada should complete mental health treatment plans on time for the women offenders who need one and should include the information required by Correctional Service Canada guidelines. • Correctional Service Canada should determine the capacity of mental health services needed to treat women offenders identified with mental illness, according to professionally accepted standards, and address any service-level gaps in a timely manner. • Correctional Service Canada should ensure that women offenders with serious mental illness with significant impairment are not placed in segregation. It should improve its oversight of offenders being monitored for self-injury or suicide under enhanced observation, as well as its oversight of offenders identified with serious mental illness with significant impairment. The use of cells on the segregation range to monitor women offenders at risk of self-injury or suicide should be discontinued.
Office of the Correctional Investigator. (2014). *Overcoming barriers to reintegration: An investigation of federal community correctional centres* https://oci-bec.gc.ca/en/content/overcoming-barriers-reintegration-investigation-federal-	Lit review; CSC data; interviews; site visits;	• That every CCC have consistent access to the necessary resources, including nurses, social workers and psychologists, to ensure access to appropriate services and care.

Reference	Method or approach	Recommendations (Healthcare related)
community-correctional-centres		
Office of the Correctional Investigator. (2015). *National drug formulary investigation summary of findings and recommendations*. https://oci-bec.gc.ca/en/content/national-drug-formulary-investigation-summary-findings-and-recommendations .	CSC data; interviews; consultations; expert opinion	• New admissions to federal custody with a valid prescription or who require medical treatment should be seen by an attending institutional physician within 72 hours of being admitted. This practice will ensure that prescribed medications are appropriately and efficiently reconciled and continuity of care between the community or provincial and federal custody is maintained. • CSC should immediately amend policy to ensure that the medication regime for inmates being transferred is not changed unless or until the attending physician at the receiving institution has conducted either an in-patient assessment or consultation with the transferring institution.
Office of the Correctional Investigator. (2017). *Fatal response: An investigation into the preventable death of Matthew Ryan Hines*. https://oci-bec.gc.ca/en/content/fatal-response-investigation-preventable-death-matthew-ryan-hines-final-report-february-15	CSC data	• CSC should immediately develop a separate and distinct intervention and management model to assist front-line staff in recognizing, responding and addressing situations of medical emergency and/or acute mental health distress. • CSC should review and revise the channels, methods and flow of information between clinical and front-line staff to ensure first-response staff members are adequately prepared to safely manage medical and mental health needs. • A scope of practice review should be undertaken to ensure Registered Nursing staff are adequately trained, supported and prepared to work in a correctional environment and include specific instruction in use of force, inflammatory agents and provision of emergency trauma care. • CSC front-line staff members should receive regular refresher and upgraded training in conflict de-escalation. Training should emphasize how to manage oppositional/defiant behaviours in situations where underlying mental health issues are present or previously identified.

Reference	Method or approach	Recommendations (Healthcare related)

Office of the Correctional Investigator. (2017). *Missed opportunities: The experience of young adults incarcerated in federal penitentiaries*. https://oci-bec.gc.ca/en/content/missed-opportunities-experience-young-adults-incarcerated-federal-penitentiaries-final#_Toc491868918	Lit review; CSC data; interviews	• The Correctional Investigator recommends that some institutional and community Parole Officers, with a special aptitude and interest for working with young adults, be specially trained as youth care counsellors. The role of the youth care counsellor includes:
		  ○ Provide consistent guidance and support
		  ○ Provide basic counselling
		  ○ Develop a correctional/community plan tailored to the needs of the young adult
		• The Correctional Investigator recommends that those with the designated youth counsellor training be assigned to all cases involving young adults.

Sapers, H. (2022). *Structured intervention unit implementation advisory panel: 2021/22 annual report.* https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/2022-siu-iap-nnlrpt/2022-siu-iap-nnlrpt-en.pdf	CSC data; site visits; interviews; consultations	• When implementing the enhanced staffing model for SIUs, CSC should reconsider its policy on the allocation of health human resources and dedicate clinical staff to the units
West Coast Prison Justice Society. (2019). *Damage/control: Use*	Interviews; consultations	• Require advanced training in working with people with mental health disabilities for all staff working on mental health units, in treatment centres, in segregation/SIUs, and as members of Emergency Response Teams as a prerequisite for performing these roles. Require regular refresher courses.

Reference	Method or approach	Recommendations (Healthcare related)
of force and the cycle of violence and trauma in BC's federal and provincial prisons. https://prisonjustice.org/wp-content/uploads/2021/05/use-of-force-report-Nov-21-2019-updated.pdf		• Create specialized officer-nurse teams at treatment centres and maximum and medium institutions to respond to situations involving emotional or medical distress using joint decision-making. This could follow models in the community that pair specially trained police with psychiatric nurses to respond to emergencies involving people with mental health issues. • Develop an alternative model for identifying and responding to prisoners with mental health disabilities in crisis in partnership with mental health experts (including experts in forensic psychiatry) and people with lived experience. This includes prisoners in emotional distress (such as prisoners who are self-harming) as well as prisoners who are experiencing behavioural emergencies connected with their disabilities. These responses should be supportive and trauma informed rather than punitive. • Eliminate the use of Emergency Response Teams in regional treatment centres and on mental health units. Ensure decisions to deploy the ERT consider the potential traumatic impact of the team on the prisoner and weigh the potential for psychological harm against the potential benefit of using this high level of force. Amend policy to reflect this. • Have senior mental health practitioners review all uses of force against prisoners with mental health disabilities. • Amend policy so that only healthcare staff can authorize and manage interventions to address self-harm and suicidality, including suicide smocks, observation cells and Pinel restraints based on clinical need. Pinel restraints should only be used in psychiatric facilities. • Involve healthcare leadership in selecting and training officers for all treatment centres and mental health units. • Transfer prisoners with acute mental health needs or histories of serious and chronic self harm to community psychiatric facilities. • Develop policy and training on dual loyalty and the domestic and international ethical obligations of medical professionals working in prisons. • Provide 24-hour nursing care at all maximum and medium security and multi-level institutions. This will ensure medical staff are always available to respond to mental

Reference	Method or approach	Recommendations (Healthcare related)
		and physical health crises. It also ensures post-use of force medical assessments can happen at any time of day or night. • Provide healthcare independently of CSC through partnerships with provincial health ministries in order to ensure full clinical independence. • Ensure that medical assessments after acts of force are used solely to support the wellbeing of the patient and document signs of ill-treatment. Any signs of ill-treatment must be reported to senior CSC operational and medical staff and the Office of the Correctional Investigator. • Ensure post-use of force medical assessments include an assessment of the prisoner's mental state and any potential impact on the prisoner's mental health. When indicated, monitor and treat prisoners for Post-Traumatic Stress Disorder. • The healthcare professional should complete a written report that includes the prisoner's account of the incident and their assessment of any physical injuries and psychological impact. This report should be included in the use of force review if the prisoner consents, and a copy should be provided to the prisoner.
Zinger, I. (2021). *Annual report 2020-2021*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20202021-eng.pdf	CSC Data; literature review; interviews	• That CSC develop a reliable method for administratively tracking individuals with mental health concerns in order to identify how policies and practices, such as use-of-force, impact this particularly vulnerable population. • That CSC discontinue the practice of labeling non-suicidal self-injurious behaviour in prison settings as "instrumental," "willful," or "deliberate" in nature or intent. A comprehensive mental health assessment of self-injurious and suicidal persons should be completed, and clear guidance provided to front line staff in how to manage and de-escalate incidents of self-injurious and suicidal behaviour.
Zinger, I. (2022). *Annual report 2021-2022*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/	CSC data; literature review; interviews	• With respect to CSC's drug strategy, I recommend the following set of measures: ○ The Prison Needle Exchange Program (PNEP) criteria be significantly revamped to encourage participation consistent with actionable recommendations of this Office and the external interim evaluation, with a view to full national implementation within the next 12 months.

Reference	Method or approach	Recommendations (Healthcare related)
files/2023-06/annrpt20212022-eng.pdf		○ The Overdose Prevention Service (OPS) be rolled out nationally, in tandem with PNEP implementation. ○ Commissioner's Directive 585 – National Drug Strategy be immediately updated to incorporate evidence-based harm reduction, treatment and prevention principles and practices. ○ CSC's zero tolerance policy to drug use and possession is recalibrated to focus on corrective measures for drug diversion and trafficking, rather than stigmatizing, targeting or disciplining persons struggling with addictions or substance abuse disorders. • That CSC: ○ Conduct a review of the program requirements and eligibility criteria for the Mother-Child Program, with a view to increasing access and participation in the program and removing barriers, particularly for Indigenous mothers; and, ○ Collect, track, and publicly report on participation in the Mother-Child Program to better understand who it is serving and how the program is functioning. • That CSC develop a training program for front-line health professionals. This program should draw on the most recent research on racial bias and its impact on medical decisions and procedures.

Table 2: Recommendations by CAN/HSO 34008:2024 *Correctional Service Canada Health Services* standard main topic area

Main topic area	Sources	Recommendations (healthcare related)

Client-centred care (n=11)	Ataullahjan, S., Bernard, W. E. T., & Cordy, J. (2021). *Human rights of federally sentenced persons*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf
	
	Canadian Human Rights Commission. (2022). *45 calls for inclusion: Celebrating 45 years of the Canadian Human Rights Act*. https://www.chrc-ccdp.gc.ca/en/resources/45-calls-inclusion-celebrating-45-years-the-canadian-human-rights-act#week6
	
	Centre for Addiction and Mental Health. (2020). *Mental health and criminal justice policy framework*. https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/camh-cj-framework-2020-pdf.pdf
	
	The Correctional Investigator Canada, & Canadian Human Rights Commission. (2019). *Aging and dying in prison: An investigation into the experiences of older individuals in federal custody*. https://www.chrc-
		• That the Correctional Service of Canada implement a holistic approach to mental health by:
		  ○ evaluating the Peer Offender Prevention Service program at Stony Mountain Institution with a view to expanding it nationally to federal penitentiaries of all security levels.[14]
		• End the use of solitary confinement for prisoners with mental health disabilities. The CSC must ensure that it has appropriate therapeutic alternatives to solitary confinement when it is required to separate prisoners with mental health disabilities from the general population.[19]
		• People with mental illness in the corrections system should receive evidence-informed mental health care and supports. Examples of action that results from this principle:
		  ○ Health care practices in federal and provincial corrections comply with the UN's Mandela Rules.
		  ○ Health care in correctional facilities is provided by a separate health care entity. Mental health care is part of this entity and under the direction of forensic mental health care experts.
		  ○ Correctional facilities use the STAIR model to identify mental health needs and guide mental health care provision.
		  ○ Mental health care is equitable and meets the diverse needs of women, Indigenous peoples, Black people, and members of other racialized and/or historically marginalized populations. Offenders on remand receive the same evidence informed mental health care and supports as the sentenced population.

Main topic area	Sources	Recommendations (healthcare related)
	ccdp.gc.ca/sites/default/files/publication-pdfs/oth-aut20190228-eng.pdf Delveaux, K., MacDonald, C., McConnell, A., Bradley, S., Adam Crawford, & Tse, F. (2017). *Evaluation of CSC's health services*. Correctional Service Canada. https://www.csc-scc.gc.ca/publications/092/005007-2017-eng.pdf Mental Health Commission of Canada. COVID-19, mental health, and substance use in correctional settings: Considerations for addressing systemic vulnerabilities. 2021. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-07/COVID_19_Corrections_Policy_Brief_Eng_0.pdf Office of the Auditor General of Canada. (2017). *Preparing women offenders for release* (Report No. 5). Reports of the Auditor General of Canada to the Parliament of Canada. https://www.oag-bvg.gc.ca/internet/English/parl_oag_201711_05_e_42670.html West Coast Prison Justice Society. (2019). *Damage/control: Use of force and the cycle of violence and trauma in*	○ The full range of evidence-based interventions for substance use, including harm reduction programs and supplies, are made available to all offenders who need them.[15] • That where the death of an offender is reasonably foreseen, CSC and the Parole Board be required to use proactive and coordinated case management to facilitate the offender's safe and compassionate release to the community as early as possible.[21] • That CSC Health Services endeavour to increase the efficiency of health-related intake assessment processes by considering the following: ○ Eliminating the requirement for repeated administration of health assessments; ○ Optimizing and eliminating unnecessary repetition of health information between assessment tools; and, ○ Ensuring health referrals are appropriately recorded and monitored.[9] • That CSC Health Services collect data on wait times to access selected specialists services for non-urgent care; and implement strategies (for example increased use of telemedicine where appropriate) if wait times exceed available Canadian benchmarks.[9] • Involve incarcerated persons in the process and ensure ongoing communication about the situation to increase adherence to PPE use and public health measures.[13] • Prioritize the integration of substance use services, including harm reduction, into the broader continuum of correctional health and medical services to improve patient experiences and population health.[13] • The healthcare professional should complete a written report that includes the prisoner's account of the incident and their

Main topic area	Sources	Recommendations (healthcare related)
	BC's federal and provincial prisons. https://prisonjustice.org/wp-content/uploads/2021/05/use-of-force-report-Nov-21-2019-updated.pdf	assessment of any physical injuries and psychological impact. This report should be included in the use of force review if the prisoner consents, and a copy should be provided to the prisoner.[12] • Correctional Service Canada should ensure that it appropriately identifies women offenders who need mental health services and assigns them to the appropriate level of care.[17] • When implementing the enhanced staffing model for SIUs, CSC should reconsider its policy on the allocation of health human resources and dedicate clinical staff to the units.[20]
Client rights (n=6)	Ataullahjan, S., Bernard, W. E. T., & Cordy, J. (2021). *Human rights of federally sentenced persons*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf Canadian Human Rights Commission. (2022). *45 calls for inclusion: Celebrating 45 years of the Canadian Human Rights Act*. https://www.chrc-ccdp.gc.ca/en/resources/45-calls-inclusion-celebrating-45-years-the-canadian-human-rights-act#week6 Centre for Addiction and Mental Health. (2020). *Mental health and criminal justice policy framework*. https://www.camh.ca/-/media/files/pdfs---	• That the Correctional Service of Canada increase the provision of dental care in federal penitentiaries to reflect the needs of federally-sentenced persons, with an emphasis on preventative dental care.[14] • That the Correctional Service of Canada ensure that Structured Intervention Units adhere to the most recent court decisions and respect Canada's human rights obligations and international commitments, by: ○ eliminating the use of solitary confinement for all federally-sentenced persons. ○ taking into account the different needs and experiences of particular groups, including LGBTQI2-S persons and women. ○ eliminating solitary confinement in excess of 15 days (a Mandela rule). ○ providing meaningful human contact and continued access to programming as well as 24-hour access to health and mental health services.[14] ○ establishing judicial oversight to review all Structure Intervention Unit placements and decisions[14]

Main topic area	Sources	Recommendations (healthcare related)
	public-policy-submissions/camh-cj-framework-2020-pdf.pdf	• That the Correctional Service of Canada expand the application of section 84 releases to other vulnerable and marginalized groups, including federally sentenced Black persons, LGBTQI2S and the ill and aging populations.[14] • That the Correctional Service of Canada protect the human rights of trans and gender diverse prisoners, and ensure that its policies and practices fully respect the rights and meet the needs of trans, non-binary and gender-diverse prisoners, including transfer requests.[19] • That the Correctional Service of Canada protect the rights of aging and dying prisoners as outlined in the CHRC and the OCI in their joint investigative report, "Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody." [19] • People with mental illness in the corrections system should receive evidence-informed mental health care and supports. Examples of action that results from this principle: ○ The federal and provincial corrections systems balance the need to manage institutional safety and security with an individual's right to access mental health care.[15]
Comprehensive assessments (n=4)	Ataullahjan, S., Bernard, W. E. T., & Cordy, J. (2021). *Human rights of federally sentenced persons*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf Office of the Auditor General of Canada. (2017). *Preparing women offenders for release* (Report No. 5). Reports of the Auditor General of Canada to the	• That the Correctional Service of Canada implement the following measures to ensure federally-sentenced persons with mental health issues receive appropriate support: ○ conduct a culturally appropriate mental health assessment of all federally-sentenced persons entering the federal correctional system within 30 days of admission.[14] • That CSC ensure that federally sentenced persons with mental health issues, or who exhibit behaviours that may indicate a mental health issue, who are placed in structured intervention units are evaluated within 24 hours of their placement by a recognized mental health care professional.[14]

Main topic area	Sources	Recommendations (healthcare related)
	Parliament of Canada. https://www.oag-bvg.gc.ca/internet/English/parl_oag_201711_05_e_42670.html Zinger, I. (2021). *Annual report 2020-2021*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20202021-eng.pdf	• CSC should determine the capacity of mental health services needed to treat women offenders identified with mental illness, according to professionally accepted standards, and address any service-level gaps in a timely manner.[17] • That CSC discontinue the practice of labeling non-suicidal self-injurious behaviour in prison settings as "instrumental," "willful," or "deliberate" in nature or intent. A comprehensive mental health assessment of self-injurious and suicidal persons should be completed, and clear guidance provided to front line staff in how to manage and de-escalate incidents of self-injurious and suicidal behaviour.[22]
Individualized care plan (n=4)	Ataullahjan, S., Bernard, W. E. T., & Cordy, J. (2021). *Human rights of federally sentenced persons*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf Bucerius, S., Crewe, B., Pyrooz, D., Ricciardelli, R., & Tetrault, J. (2021). *Correctional services during and beyond COVID-19.* Royal Society of Canada. https://rsc-src.ca/sites/default/files/images/Corrections%20PB_EN.pdf Office of the Auditor General of Canada. (2017). *Preparing women offenders for release* (Report No. 5). Reports of the Auditor General of Canada to the Parliament of Canada. https://www.oag-	• That the CSC ensure that all federally-sentenced deaf and hard of hearing persons are able to access correctional programming through appropriate access to relevant medical devices and reliable interpretation services.[14] • That CSC provide trauma counselling and trauma-informed programming for imprisoned persons to address the root causes for their struggles, recognizing the imposed strain caused by COVID-19. Trauma counselling, however, should continue beyond the pandemic, recognizing that the great majority of people housed in prison have been victimized and had traumatic life experiences throughout their life-course.[11] • Provide sustained addiction counselling during and beyond the pandemic.[11] • That CSC should complete mental health treatment plans on time for the women offenders who need one and should include the information required by Correctional Service Canada guidelines.[17]

Main topic area	Sources	Recommendations (healthcare related)
	bvg.gc.ca/internet/English/parl_oag_201711_05_e_42670.html	

Safety practices (n=20)	The Correctional Investigator Canada, & Canadian Human Rights Commission. (2019). *Aging and dying in prison: An investigation into the experiences of older individuals in federal custody*. https://www.chrc-ccdp.gc.ca/sites/default/files/publication-pdfs/oth-aut20190228-eng.pdf
	
	Correctional Service Canada. (2022). *2022-2025 accessibility plan*. https://www.csc-scc.gc.ca/publications/005007-1000-en.shtml
	
	Delveaux, K., MacDonald, C., McConnell, A., Bradley, S., Adam Crawford, & Tse, F. (2017). *Evaluation of CSC's health services*. Correctional Service Canada. https://www.csc-scc.gc.ca/publications/092/005007-2017-eng.pdf
	
	Holmes, J. D. (2019). *Report to the minister of justice and solicitor general public fatality inquiry*. Provincial Court of Alberta. https://open.alberta.ca/dataset/7bb1cc06-8c4a-4b59-8523-37a9d6b2f4b8/resource/56aca31e-f0d9-
		• That CSC re-examine its use of force training and policy to incorporate best practices and lessons-learned regarding use of force on older individuals (including those using mobility devices).[21]
		• That vulnerable populations (older offenders and those with mental and/or physical health issues) be monitored daily during lockdowns by professional health care staff.[21]
		• That the Minister of Public Safety review and assess release options (e.g. medical and/or geriatric parole) for older and long-serving offenders who do not pose undue risk to public safety, and propose amendments to the Corrections and Conditional Release Act (CCRA) as appropriate.[21]
		• Enhance the accessibility of the built environment by:
		  ○ Reviewing accessibility standards in consultation with persons with disabilities.
		  ○ Developing an accessibility assessment strategy and facility assessments.
		  ○ Providing the necessary resources to address gaps identified by facility accessibility assessments.
		  ○ Reviewing the accessibility of emergency evacuation plans. [8]
		  ○ Identifying and removing accessibility barriers for offenders.[8]
		• That CSC Health Services ensure that offenders have timely access to health education programs and harm reduction products by:
		  ○ Providing clear direction and accountability for delivery and tracking of health education programs; and

Main topic area	Sources	Recommendations (healthcare related)
	4565-90dc-732e09e6a35a/download/01449.pdf Mental Health Commission of Canada. COVID-19, mental health, and substance use in correctional settings: Considerations for addressing systemic vulnerabilities. 2021. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-07/COVID_19_Corrections_Policy_Brief_Eng_0.pdf Office of the Auditor General of Canada. (2017). *Preparing women offenders for release* (Report No. 5). Reports of the Auditor General of Canada to the Parliament of Canada. https://www.oag-bvg.gc.ca/internet/English/parl_oag_201711_05_e_42670.html Office of the Correctional Investigator. (2015). *National drug formulary investigation summary of findings and recommendations*. https://oci-bec.gc.ca/en/content/national-drug-formulary-investigation-summary-findings-and-recommendations Office of the Correctional Investigator. (2017). *Missed opportunities: The experience of young adults incarcerated*	○ Monitoring the distribution of harm reduction products (bleach, condoms, dental dams, and lubricants) and addressing any identified accessibility issues.[9] • Readily available, effective and adequately funded mental health and substance abuse programs, to include methadone and suboxone programs, would not only aid in rehabilitation but reduce demand and the incentive to participate in the smuggling of dangerous drugs.[18] • Ensure sufficient resources to procure and safely store PPE.[13] • Ramp up substance use services with known public health advantages related to COVID-19, overdoses, and blood-borne infection risks, including harm reduction policies, safe consumption sites, access to clean needles and OAT [opioid-agonist therapies]. These activities are critical to supporting decarceration efforts.[13] • That CSC should ensure that women offenders with serious mental illness with significant impairment are not placed in segregation. It should improve its oversight of offenders being monitored for self-injury or suicide under enhanced observation, as well as its oversight of offenders identified with serious mental illness with significant impairment. The use of cells on the segregation range to monitor women offenders at risk of self-injury or suicide should be discontinued.[17] • The Correctional Investigator recommends that some institutional and community Parole Officers, with a special aptitude and interest for working with young adults, be specially trained as youth care counsellors. The role of the youth care counsellor includes: ○ Provide consistent guidance and support ○ Provide basic counselling ○ Develop a correctional/community plan tailored to the needs of the young adult[24]

Main topic area	Sources	Recommendations (healthcare related)
	in federal penitentiaries. https://oci-bec.gc.ca/en/content/missed-opportunities-experience-young-adults-incarcerated-federal-penitentiaries-final#_Toc491868918 West Coast Prison Justice Society. (2019). *Damage/control: Use of force and the cycle of violence and trauma in BC's federal and provincial prisons*. https://prisonjustice.org/wp-content/uploads/2021/05/use-of-force-report-Nov-21-2019-updated.pdf Zinger, I. (2022). *Annual report 2021-2022*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20212022-eng.pdf	• The Correctional Investigator recommends that those with the designated youth counsellor training be assigned to all cases involving young adults.[24] • Eliminate the use of Emergency Response Teams in regional treatment centres and on mental health units. Ensure decisions to deploy the ERT consider the potential traumatic impact of the team on the prisoner and weigh the potential for psychological harm against the potential benefit of using this high level of force. Amend policy to reflect this.[12] • Amend policy so that only healthcare staff can authorize and manage interventions to address self-harm and suicidality, including suicide smocks, observation cells and Pinel restraints based on clinical need. Pinel restraints should only be used in psychiatric facilities.[12] • Involve healthcare leadership in selecting and training officers for all treatment centres and mental health units.[12] • Provide 24-hour nursing care at all maximum and medium security and multi-level institutions. This will ensure medical staff are always available to respond to mental and physical health crises. It also ensures post-use of force medical assessments can happen at any time of day or night.[12] • Ensure that medical assessments after acts of force are used solely to support the wellbeing of the patient and document signs of ill-treatment. Any signs of ill-treatment must be reported to senior CSC operational and medical staff and the Office of the Correctional Investigator.[12] • Ensure post-use of force medical assessments include an assessment of the prisoner's mental state and any potential impact on the prisoner's mental health. When indicated, monitor and treat prisoners for Post-Traumatic Stress Disorder.[12] • With respect to CSC's drug strategy:

Main topic area	Sources	Recommendations (healthcare related)
		○ The Prison Needle Exchange Program (PNEP) criteria be significantly revamped to encourage participation consistent with actionable recommendations of this Office and the external interim evaluation, with a view to full national implementation within the next 12 months. ○ The Overdose Prevention Service (OPS) be rolled out nationally, in tandem with PNEP implementation. ○ Commissioner's Directive 585 – National Drug Strategy be immediately updated to incorporate evidence-based harm reduction, treatment and prevention principles and practices. ○ CSC's zero tolerance policy to drug use and possession is recalibrated to focus on corrective measures for drug diversion and trafficking, rather than stigmatizing, targeting or disciplining persons struggling with addictions or substance abuse disorders.[23] • New admissions to federal custody with a valid prescription or who require medical treatment should be seen by an attending institutional physician within 72 hours of being admitted. This practice will ensure that prescribed medications are appropriately and efficiently reconciled and continuity of care between the community or provincial and federal custody is maintained.[25] • CSC should immediately amend policy to ensure that the medication regime for inmates being transferred is not changed unless or until the attending physician at the receiving institution has conducted either an in-patient assessment or consultation with the transferring institution.[25]

Main topic area	Sources	Recommendations (healthcare related)

Care coordination and continuity of services (n=12)	Ataullahjan, S., Bernard, W. E. T., & Cordy, J. (2021). *Human rights of federally sentenced persons*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf .
	
	Bucerius, S., Crewe, B., Pyrooz, D., Ricciardelli, R., & Tetrault, J. (2021). *Correctional services during and beyond COVID-19.* Royal Society of Canada. https://rsc-src.ca/sites/default/files/images/Corrections%20PB_EN.pdf
	
	Centre for Addiction and Mental Health. (2020). *Mental health and criminal justice policy framework*. https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/camh-cj-framework-2020-pdf.pdf
	
	The Correctional Investigator Canada, & Canadian Human Rights Commission. (2019). *Aging and dying in prison: An investigation into the experiences of older individuals in federal custody*. https://www.chrc-ccdp.gc.ca/sites/default/files/publication-pdfs/oth-aut20190228-eng.pdf
		• That CSC implement the following measure to ensure federally sentenced persons with mental health issues receive appropriate support:
		  ○ ensure that mental health beds are contracted in psychiatric facilities pursuant to section 29 of the Corrections and Conditional Release Act.[14]
		• That CSC expand its use of section 29 agreements and contract the development/provision of mental health services and beds in provincial psychiatric hospitals to provide adequate mental health services for federally-sentenced persons.[14]
		• Make it possible for incarcerated persons to be able to apply, at least six months prior to release, for a health card in order for correctional services organizations to assist with effective discharge planning.[11]
		• Make health cards available to individuals housed in community correctional centres—they are not incarcerated and thus are not excluded from the Canada Health Act.[11]
		• Make identification from prison and/or a letter/photo attesting to the person's identity sufficient to acquire a health card post incarceration.[11]
		• There should be collaboration and coordination between the criminal justice system and the mental health system. Examples of action that results from this principle:
		  ○ People with mental illness experience a continuity of their mental health care, including substance use treatment, as they transition through the criminal justice system and particularly as they move from the community to the corrections system and vice versa.
		  ○ People with mental illness in correctional facilities receive comprehensive discharge planning that includes connections to mental health care,

Main topic area	Sources	Recommendations (healthcare related)
	Mental Health Commission of Canada. COVID-19, mental health, and substance use in correctional settings: Considerations for addressing systemic vulnerabilities. 2021. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-07/COVID_19_Corrections_Policy_Brief_Eng_0.pdf Office of the Correctional Investigator. (2014). *Overcoming barriers to reintegration: An investigation of federal community correctional centres* https://oci-bec.gc.ca/en/content/overcoming-barriers-reintegration-investigation-federal-community-correctional-centres West Coast Prison Justice Society. (2019). *Damage/control: Use of force and the cycle of violence and trauma in BC's federal and provincial prisons*. https://prisonjustice.org/wp-content/uploads/2021/05/use-of-force-report-Nov-21-2019-updated.pdf	medications, social services, and other community resources before discharge. ○ Correctional facilities have partnerships with forensic mental health inpatient programs to temporarily transfer care of offenders with mental illness in need of acute mental health care. ○ Forensic mental health programs have partnerships with supportive housing programs and community mental health services. ○ Government policy supports and enhances connections between the criminal justice system and the mental health system. • That CSC significantly reallocate existing institutional resources to community corrections in order to better support the reintegration needs of aging offenders.[21] • Address ongoing systemic health-service shortcomings through: ○ policy changes that focus on achieving health access parity and providing continued access to services across the continuum of criminal justice involvement (including release/discharge).[13] • Ensure continued access to medications (e.g., buprenorphine, methadone), treatment, and supports for those being discharged from prisons, including alternative housing arrangements for those at risk of homelessness, already homeless, or precariously housed.[13] • Strengthen corrections' communications, collaborations, partnerships, and integration with public health authorities, as well as with mental health and substance use services and other community services needed to adequately support decarcerated individuals.[13]

Main topic area	Sources	Recommendations (healthcare related)
		• That every CCC [Community Correctional Centre] have consistent access to the necessary resources, including nurses, social workers and psychologists, to ensure access to appropriate services and care.[26] • Transfer prisoners with acute mental health needs or histories of serious and chronic self harm to community psychiatric facilities.[12]
Healthy and competent workforce (n=17)	Ataullahjan, S., Bernard, W. E. T., & Cordy, J. (2021). *Human rights of federally sentenced persons*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf Canadian Human Rights Commission. (2022). *45 calls for inclusion: Celebrating 45 years of the Canadian Human Rights Act*. https://www.chrc-ccdp.gc.ca/en/resources/45-calls-inclusion-celebrating-45-years-the-canadian-human-rights-act#week6 The Correctional Investigator Canada, & Canadian Human Rights Commission. (2019). *Aging and dying in prison: An investigation into the experiences of older individuals in federal custody*. https://www.chrc-ccdp.gc.ca/sites/default/files/publication-pdfs/oth-aut20190228-eng.pdf	• That CSC provide additional rights-based training to correctional staff to ensure they are sensitive to the complex needs of aging, as well as physically and mentally ill federally-sentenced population. The Correctional Service of Canada should also make federal correctional facilities more accessible for federally-sentenced persons with mobility issues.[14] • That CSC implement a holistic approach to mental health by: ○ providing all employees, as a condition of employment, with appropriate mental health and mental health crisis intervention training that is consistent with their vocational role. Further, the Correctional Service of Canada shall establish appropriate standards for training, ensure that all trainees demonstrate that they have met the standard and that ongoing evaluations of the quality, quantity and outcomes of the training be conducted and used to inform annual improvement of the training.[14] • That the CSC improve its training for correctional personnel regarding human rights standards and principles of equality and non-discrimination, including in relation to race, sex, sexual orientation, gender identity and expression, and mental health.[14]

Main topic area	Sources	Recommendations (healthcare related)
	Mental Health Commission of Canada. COVID-19, mental health, and substance use in correctional settings: Considerations for addressing systemic vulnerabilities. 2021. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-07/COVID_19_Corrections_Policy_Brief_Eng_0.pdf Office of the Correctional Investigator. (2017). *Fatal response: An investigation into the preventable death of Matthew Ryan Hines*. https://oci-bec.gc.ca/en/content/fatal-response-investigation-preventable-death-matthew-ryan-hines-final-report-february-15 West Coast Prison Justice Society. (2019). *Damage/control: Use of force and the cycle of violence and trauma in BC's federal and provincial prisons*. https://prisonjustice.org/wp-content/uploads/2021/05/use-of-force-report-Nov-21-2019-updated.pdf Zinger, I. (2022). *Annual report 2021-2022*. Office of the Correctional Investigator. https://oci-	• That the CSC ensure that its staff and facilities are equipped to meet the varied and complex needs of prisoners with mental health disabilities.[19] • That CSC provide staff with training in age-related needs — physical, social and psychological — as well as training on how to identify, respond to and appropriately manage behaviour related to dementia.[21] • That CSC train all correctional staff in hygiene, infection prevention and control, and sanitation practices and principles (including the use of and adherence to PPE).[13] • To counter the stigma associated with problematic substance use, mental illness, and COVID-19 (infection, risk, complications), ramp up campaigns specific to correctional facilities and training for health, mental health, and substance use service providers, as well as the general public.[13] • Address ongoing systemic health-service shortcomings through: ○ workforce development and training (e.g., management of comorbid mental illness, substance use disorders, and infectious diseases and the adoption of best practices for staff recruitment and retention).[13] • Incentivize health and correctional staff workforce development and training, as well as recruitment and retention (e.g., through ongoing professional development, adequate and consistent compensation packages, emergency pay, sick leave benefits, and guaranteed resourcing of PPE).[13] • Train correctional health-service providers in mental health, substance use, and infectious-disease knowledge, skills, and competencies. Ensure adequate mental health supports for service providers and corrections staff, including trauma therapy, counselling, and continued access to family and social supports (particularly for those self-isolating).[13]

Main topic area	Sources	Recommendations (healthcare related)
	bec.gc.ca/sites/default/files/2023-06/annrpt20212022-eng.pdf	• That CSC should immediately develop a separate and distinct intervention and management model to assist front-line staff in recognizing, responding and addressing situations of medical emergency and/or acute mental health distress.[27] • That CSC should review and revise the channels, methods and flow of information between clinical and front-line staff to ensure first-response staff members are adequately prepared to safely manage medical and mental health needs.[27] • That a scope of practice review be undertaken to ensure Registered Nursing staff are adequately trained, supported and prepared to work in a correctional environment and include specific instruction in use of force, inflammatory agents and provision of emergency trauma care.[27] • That CSC front-line staff members should receive regular refresher and upgraded training in conflict de-escalation. Training should emphasize how to manage oppositional/defiant behaviours in situations where underlying mental health issues are present or previously identified.[27] • That CSC require advanced training in working with people with mental health disabilities for all staff working on mental health units, in treatment centres, in segregation/SIUs, and as members of Emergency Response Teams as a prerequisite for performing these roles. Require regular refresher courses.[12] • Develop policy and training on dual loyalty and the domestic and international ethical obligations of medical professionals working in prisons.[12] • That CSC develop a training program for front-line health professionals. This program should draw on the most recent research on racial bias and its impact on medical decisions and procedures.[23]

Main topic area	Sources	Recommendations (healthcare related)

Quality improvement (n=12)	Ataullahjan, S., Bernard, W. E. T., & Cordy, J. (2021). *Human rights of federally sentenced persons*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf
	
	Delveaux, K., MacDonald, C., McConnell, A., Bradley, S., Adam Crawford, & Tse, F. (2017). *Evaluation of CSC's health services*. Correctional Service Canada. https://www.csc-scc.gc.ca/publications/092/005007-2017-eng.pdf
	
	Mental Health Commission of Canada. COVID-19, mental health, and substance use in correctional settings: Considerations for addressing systemic vulnerabilities. 2021. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-07/COVID_19_Corrections_Policy_Brief_Eng_0.pdf
	
	Nadeau, L., Brochu, S., & Cormier, R. (2018). *Fourth Independent Review Committee on non-natural deaths in custody that occurred between April 1st, 2014 to March 31st, 2017*. Correctional Service Canada. https://www.csc-
		• That the CSC work with the provinces, territories, medical associations and professional governing and licensing bodies to ensure professional standards are adhered to and doctors are available in federal penitentiaries on a full-time basis and registered nurses on a 24-hour basis.[14]
		• That the CSC establish a policy to ensure that only medical professionals have the authority to determine whether a federally-sentenced person requires medical attention.[14]
		• That CSC Health Services improve the understanding of information sharing requirements and limitations, as elaborated in their guidelines, in accordance with privacy laws and other relevant legislation. That CSC Health Services improve timely access to relevant and accurate medical records for Health Care staff. These will be accomplished by:
		  ○ Finalizing the implementation of electronic medical records to improve accessibility and consistency of health information
		  ○ Enhancing awareness of information sharing procedures and "need-to-know" principle among CSC personnel, including concrete examples of where and how the principle should be applied; and
		  ○ Conducting a review of information sharing issues identified in board of investigation incidents to contribute to existing lessons learned and to inform procedural/policy changes if necessary.[9]
		• That CSC:
		  ○ Review the model of community mental health service delivery to ensure that community mental health services are being provided to offenders with the greatest mental health needs.[9]
		  ○ Ensure that clinical discharge planning activities are tracked in electronic information systems.[9]

Main topic area	Sources	Recommendations (healthcare related)
	scc.gc.ca/publications/092/005007-2310-en.pdf West Coast Prison Justice Society. (2019). *Damage/control: Use of force and the cycle of violence and trauma in BC's federal and provincial prisons*. https://prisonjustice.org/wp-content/uploads/2021/05/use-of-force-report-Nov-21-2019-updated.pdf Zinger, I. (2021). *Annual report 2020-2021*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20202021-eng.pdf	• That CSC Health Services continue to implement the Chronic Disease Management Strategy, with reference to any special needs/requirements for older, women, and Indigenous offenders, and methods for tracking impacts.[9] • Create or update all infection control, pandemic response policies and strategic plans to integrate public health measures into correctional operations.[13] • Pandemic planning should pay attention to strategies to mitigate the mental health and substance use impact of infection prevention and control measures, including the risk of opioid overdose.[13] • That CSC implement experimental psychosocial interventions, with long-term monitoring, to test whether such interventions can reduce the suicide rate among the subgroup of inmates at risk.[10] • That CSC incident investigations examine all four pillars of addressing problematic substance use to inform prevention, treatment, harm reduction and enforcement strategies.[10] • Create specialized officer-nurse teams at treatment centres and maximum and medium institutions to respond to situations involving emotional or medical distress using joint decision-making. This could follow models in the community that pair specially trained police with psychiatric nurses to respond to emergencies involving people with mental health issues.[12] • Have senior mental health practitioners review all uses of force against prisoners with mental health disabilities.[12] • That CSC develop a reliable method for administratively tracking individuals with mental health concerns in order to identify how policies and practices, such as use-of-force, impact this particularly vulnerable population.[22]

Table 3: Addendum of recommendations

Category	Sources	Recommendations (Healthcare related)
Alternatives to traditional forms of incarceration (n=6)	Ataullahjan, S., Bernard, W. E. T., & Cordy, J. (2021). *Human rights of federally sentenced persons*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf Centre for Addiction and Mental Health. (2020). *Mental health and criminal justice policy framework*. https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/camh-cj-framework-2020-pdf.pdf The Correctional Investigator Canada, & Canadian Human Rights Commission. (2019). *Aging and dying in prison: An investigation into the experiences of older individuals in federal custody*. https://www.chrc-ccdp.gc.ca/sites/default/files/publication-pdfs/oth-aut20190228-eng.pdf West Coast Prison Justice Society. (2019). *Damage/control: Use of force and the cycle of violence and trauma in BC's federal and provincial prisons*. https://prisonjustice.org/wp-content/uploads/2021/05/use-of-force-report-Nov-21-2019-updated.pdf	• That the CSC increase efforts to develop more contracts with provinces and territories to establish alternatives to federal correctional facilities for aging federally-sentenced persons and those with acute medical conditions as well as mental health issues pursuant to section 29 of the Corrections and Conditional Release Act.[14] • People with mental illness who become involved in the criminal justice system should have access to range of diversion and release options. Examples of action that results from this principle: ○ People with mental illness in the corrections system have access to culturally appropriate custody (e.g. Healing Lodges) and community-based sentences.[15] • We recommend that an independent review of all older individuals in federal custody be conducted with the objective of determining whether a placement in the community, a long-term care facility or a hospice would be more appropriate.[21] • That CSC designate facilities for older individuals who want to live in such areas—and that such facilities are designed or retrofitted to ensure physical accessibility.[21] • That CSC enhance partnerships with outside service providers and reallocate funds to create additional bed space in the community and secure designated spots in long-term care facilities and hospices for older individuals who pose no undue risk to public safety.[21] • Develop an alternative model for identifying and responding to prisoners with mental health disabilities in crisis in partnership with mental health experts (including experts in forensic psychiatry) and people with lived experience. This includes prisoners in emotional distress (such as prisoners who are self-harming) as well as prisoners who are experiencing behavioural

Category	Sources	Recommendations (Healthcare related)
		emergencies connected with their disabilities. These responses should be supportive and trauma informed rather than punitive.[12]
Areas for research (n=4)	Mental Health Commission of Canada. COVID-19, mental health, and substance use in correctional settings: Considerations for addressing systemic vulnerabilities. 2021. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-07/COVID_19_Corrections_Policy_Brief_Eng_0.pdf Nadeau, L., Brochu, S., & Cormier, R. (2018). *Fourth Independent Review Committee on non-natural deaths in custody that occurred between April 1st, 2014 to March 31st, 2017*. Correctional Service Canada. https://www.csc-scc.gc.ca/publications/092/005007-2310-en.pdf	• Commit resources to study recently enacted legislation and policies that support decarceration to determine their potential impact on recidivism, cost savings, and social, economic, and health impacts (e.g., infectious disease, chronic disease, mental health, and substance use).[13] • Establishing a study to develop predictive indicators on the use of opioids by inmates during incarceration.[10] • Developing a substance-related disorder assessment instrument that will link the level of dependency to specific substances.[10] • Continuing studies that will help provide a better understanding of the phenomenon of penitentiary overdoses and equip CSC to prevent them.[10]
Separation/secession from traditional corrections structures (n=5)	The College of Family Physicians of Canada. (2016). *Position statement on health care delivery*. https://www.cfpc.ca/CFPC/media/Resources/Prison-Health/2022-12-Health-Care-Delivery-EN-FINAL.pdf The Correctional Investigator Canada, & Canadian Human Rights Commission. (2019). *Aging and dying in prison: An investigation into the*	• Responsibility for delivery of medical and mental health care services in federal correctional facilities should be separated completely from the Department of Justice Canada.[16] • That CSC develop a separate and distinct Commissioner's Directive specific to older individuals, which ensures that their specific needs and interests are identified and met through the provision of effective and adapted programs, services and interventions.[21] • That CSC fund and implement an integrated and comprehensive National Older Offender Strategy immediately. The strategy should:

Category	Sources	Recommendations (Healthcare related)
	experiences of older individuals in federal custody. https://www.chrc-ccdp.gc.ca/sites/default/files/publication-pdfs/oth-aut20190228-eng.pdf Mental Health Commission of Canada. COVID-19, mental health, and substance use in correctional settings: Considerations for addressing systemic vulnerabilities. 2021. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-07/COVID_19_Corrections_Policy_Brief_Eng_0.pdf West Coast Prison Justice Society. (2019). *Damage/control: Use of force and the cycle of violence and trauma in BC's federal and provincial prisons*. https://prisonjustice.org/wp-content/uploads/2021/05/use-of-force-report-Nov-21-2019-updated.pdf	○ go beyond an "aging in place" approach, including the mandatory and ongoing review of release options for older individuals who do not pose undue risk to public safety. ○ examine, respect and respond to the intersectional characteristics and needs of older individuals in federal custody. ○ establish a timeframe for assessing, retrofitting and, where necessary, building facilities under CSC authority to ensure accessibility.[21] • Create a national correctional decarceration strategy that is linked with national emergency measures and public health responses.[13] • Provide healthcare independently of CSC through partnerships with provincial health ministries in order to ensure full clinical independence.[12]

Table 4: Indigenous health and wellness recommendations

Sources	Recommendations (Healthcare related)

Ataullahjan, S., Bernard, W. E. T., & Cordy, J. (2021). *Human rights of federally sentenced persons*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/432/RIDR/reports/2021-06-16_FederallySentenced_e.pdf
 	
Canadian Centre on Substance Use and Addiction (2017). *Supporting reintegration in corrections by addressing problematic substance use: An environmental scan*. https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Reintegration-Corrections-Problematic-Substance-Use-Environmental-Scan-2017-en.pdf
 	
Centre for Addiction and Mental Health. (2020). *Mental health and criminal justice policy framework*. https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/camh-cj-framework-2020-pdf.pdf
 	
Zinger, I. (2022). *Annual report 2021-2022*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20212022-eng.pdf
	• That the Correctional Service of Canada immediately end the use of separation by any name with youth, women and those with disabling mental health issues, and implement mental health assessments and judicial oversight to eliminate the overrepresentation of federally-sentenced Indigenous Peoples, Black persons, other racialized persons and persons with mental health issues in Structured Intervention Units.[14]
	• People with mental illness who become involved in the criminal justice system should have access to range of diversion and release options. Examples of action that results from this principle: People with mental illness in the corrections system have access to culturally appropriate custody (e.g. Healing Lodges) and community-based sentences.[15]
	• That CSC:
	  ○ Conduct a review of the program requirements and eligibility criteria for the Mother-Child Program, with a view to increasing access and participation in the program and removing barriers, particularly for Indigenous mothers.
	  ○ Collect, track, and publicly report on participation in the Mother-Child Program to better understand who it is serving and how the program is functioning.[23]
	• Adapt treatment practices to incorporate Indigenous culture. Indigenous culture sees PSU [problematic substance use] as stemming from illness of the spirit. Treatment should also aim to restore Indigenous culture and identity through reconnecting with nature, family, community and ancestors. Services should be holistic and take into consideration many factors related to well-being, such as physical, spiritual, mental, cultural and emotional health.
	• Treatment should reflect the specific Indigenous tribes that reside in an area (e.g., Blackfoot, Cree). Programs should be implemented in areas with a high population of Indigenous people so that they can stay close to their community and families.
	• Trauma experienced by the Indigenous population as a whole and abuse suffered by individuals in childhood and adulthood should be recognized in treatment.

	• Those working with Indigenous offenders should be trained in Indigenous cultural practices (e.g., ceremonies) and cultural humility. Providers should have a clear understanding of the culture and its etiquette, the issues faced by this population and its self-identify as Indigenous. It might be important to consider recruiting Indigenous staff differently than traditional correctional staff (e.g., online applications might be too invasive). • PSU [problematic substance use] treatment should also be provided in a culturally safe manner, which means consideration of the cultural and structural differences and power relationships that might exist due to the history of First Nations people.

Table 5: Summary of reports of international country-level models of prison healthcare

Reference	Country	Model Overview
Dubois, C., Linchet, S., Mahieu, C., Reynaert, J.-F., & Seron, P. (2017). *Organization models of health care services in prisons in four countries*. KCE (Belgian Health Care Knowledge Centre). https://kce.fgov.be/sites/default/files/2021-11/KCE_293_Prisons_health_care_Chapter_4.pdf	France; Switzerland; United Kingdom (Scotland)	**France** The law of 18th January 1994 on health and social protection makes prisoners part of the ordinary health system. Prisoners must be registered at the Primary Fund Health Insurance (CPAM, Caisse Primaire d'Assurance Maladie) relevant to their prison. Moreover, prisoners should access the same standard of care as any other citizen (law of March 2002). General primary care within every prison is organized within the USMP (179 Unités de Soins en Milieu Pénitentiaire), and psychiatric care in the USMP or the SMPR (26 Services Médico-Psychologiques Régionaux). USMP and SMPR are managed by a neighbouring hospital. Hospitalization are organized either in the neighbouring hospital (for hospitalisation<48h), or in the UHSI (8 Unités Hospitalières Sécurisées Interrégionales, 182 beds) (hospitalisation>48h) or, for forced psychiatric hospitalization in the UHSA (7 Unités Hospitalières Spécialement Aménagées, 340 beds). **Scotland** The responsibility of healthcare in prison was transferred from the Scottish Prison Service (SPS) to the National Health Service (NHS) in November 2011, in line with the principle of equivalence of care and the will to tackle health inequalities, two priorities of the Scottish Government. Regional Health Boards are responsible for the planning and delivery of health services to the population in their respective territories, including

Reference	Country	Model Overview
		prisons' population. Health and social care are integrated through partnerships between Health Boards, Local Authorities, health and social care professionals, the third sector, users and other stakeholders. Prison health system is based on primary care. There should be a multidisciplinary care plan for each prisoner, which will include the involvement of prison officers (as carers) where relevant, and should include details such as the condition/s to be addressed, agreed management including review and expected outcome. Any care plan should (as far as reasonably possible) (a) be agreed with the prisoner concerned, and (b) take account of the prisoner`s family/social circumstances. **Switzerland** Switzerland is a Federal State composed of 26 cantons. Therefore, prison as well as healthcare system are framed by national, cantonal and inter-cantonal administrations and actors. This situation has led to the development of local health systems with different characteristics across the country, which includes the management of prison healthcare. Collaboration between prison and healthcare authorities differs from canton to canton. Although the principles of equivalence of care and independence of medical services are general, there are two different main organizational models in Switzerland: • Medical and nursing staff are in whole (German speaking Canton of Zurich) or in part (German speaking Cantons Solothurn, Bern and St. Gallen) employed by prison authority or by justice.

Reference	Country	Model Overview
		• The whole medical staff is employed by the health authority (like in the Vaudois and Geneva Cantons where University hospitals play a great role in healthcare organisation). Medical and nursing costs are covered by the LAmal insurance system.
HM Government, & NHS England. (2018). *National Partnership Agreement for Prison Healthcare in England 2018-2021*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767832/6.4289_MoJ_National_health_partnership_A4-L_v10_web.pdf	United Kingdom (England)	We recognise our respective statutory responsibilities and independence, but we must work together to ensure safe, legal, decent and effective care that improves health outcomes for prisoners, reduces health inequalities (particularly for those with protected characteristics), protects the public and reduces reoffending. We commit to collaborate and co-operate at all levels within our organisations to achieve our shared priorities and deliver our joint workplan. Appropriate governance structures support delivery of what we are jointly committing to. The National Prison Healthcare Board has responsibility for the oversight and on-going management of this agreement and delivery of our shared objectives. It oversees partnership risks and their mitigation, and enables dispute resolution. From 2018, each of the five members of the partnership will equally share responsibility for the function of the NPHB. • Governance at establishment level is provided through the development and operation of Local Delivery Boards (LDBs), led by the Prison Governor/Director for Private Prisons and including providers of custody, healthcare, substance misuse and Local Authority leads for social care services. The work of LDBs should be underpinned by a Local Delivery Agreement to set out how partnership work is taken forward at a local level to support delivery. • Organisational governance structures exist in each individual organisation, which will be used to ensure decisions that impact on organisational spending and delivery

Reference	Country	Model Overview
		are signed off appropriately. Each member is responsible for ensuring decisions are signed off and information is disseminated through the proper channels.
World Health Organization Regional Office for Europe. (2020). *Organizational models of prison health: considerations for better governance*. https://iris.who.int/bitstream/handle/10665/336214/WHO-EURO-2020-1268-41018-55685-eng.pdf	Finland; United Kingdom (England)	In Finland, prison health services are organized and funded by the Government of Finland and provided by the Unit for Prisoners' Health Services (VTH). VTH is an independent entity under the Finnish Institute for Health and Welfare (THL), which in turn is under the Ministry of Social Affairs and Health. All VTH's outpatient clinics and hospitals operate in prison premises. The prison system is managed and operated by the Criminal Sanctions Agency, which operates under the Ministry of Justice. Prison health services in England are funded by DHSC (Department of Health and Social Care), a department of the United Kingdom government. Health services are commissioned by National Health Service (NHS) England/NHS Improvement from health-care providers such as NHS community health-care providers (such as hospital trusts) and private health-care provider companies. Primary care services and some specialist health services are provided in prisons; people in prison visit local hospitals in the community for secondary care appointments or emergency/tertiary care.
HM Prison and Probation Service. (2019). *Model for Operational Delivery: New Resettlement Prisons Supporting effective delivery in the adult male prison estate*.	United Kingdom (England)	NHS England is responsible for the commissioning of all health services (except for emergency care, ambulance services and out-of-hours services) for people in prisons in England. The range of services which are directly commissioned for prisons includes secondary care services (hospital care) and substance misuse

Reference	Country	Model Overview
https://data.parliament.uk/DepositedPapers/Files/DEP2019-0487/New_Resettlement_Prisons_MOD.pdf		services in addition to the continued commissioning of medical, mental health, dental and ophthalmic services. The National Partnership Agreement for Prison Healthcare in England 2018 – 2021 sets out the partnership agreement for prison healthcare between the Ministry of Justice, Her Majesty's Prison and Probation Service, Public Health England, the Department of Health & Social Care, and NHS England. A partnership agreement has been in place to support the commissioning and delivery of healthcare in English prisons since the introduction of the Health and Social Care Act (2012). The Prison Health Partnership (of NHS England, Public Health England and Her Majesty's Prison and Probation Service) has, for five years, driven improvements to the commissioning and delivery of healthcare in prisons in England.

Table 6: Summary of reports of international program-level models

Model Name	Country	Implementation Level	Integration	Model Overview
IPS Psychology Service Integrated, Layered Care Model[39]	United Kingdom (Ireland)	National	Healthcare services personnel only	The model is built upon a five-tier framework including 'whole population approaches – primary care – secondary care – tertiary care – consultation'. It acknowledges that clients commonly move between different tiers of service provision in their recovery journey and may often benefit from services at different levels of intensity. Comprehensive, collaborative assessment is required which leads to a clear intervention pathway for service users.
Auckland's Model of Care[40] Model of Care for Stanford House (Central Region) [40]	New Zealand	Regional (Aukland)/Prison (Central)	Healthcare services personnel only	Auckland region: Auckland's model of care is 'recovery- and strengths focused' and seeks to provide culturally appropriate, evidence-based care. Five key principles guide the service: (a) 'recovery as a philosophy and a journey', (b) 'the importance of cultural and personal identity', (c) 'the importance of understanding risk', (d) 'recovery in the forensic setting' and (e) 'excellence'. Service delivery aims to embody a 'whole-of-life concept'. Central region: The model of care for Stanford House is recovery focused and strength based, 'guided by recovery competencies which provide an evidence-based framework within a forensic service'. Key principles of the model of care include person/whānau-centred care, individualised care, planning transitions along the recovery care journey, integration with non-governmental/community/justice organisations, adapting care to individual needs/strengths, evidence-based care and stewardship of resources. The model of care also details further key elements, including trauma-informed care, peer support, accountability to key

Model Name	Country	Implementation Level	Integration	Model Overview
				performance indicator measures and implementation of Te Whare Tapa Whā [Māori health model].
The Forensicare Journey of Recovery and Care ('The Journey') [41]	Australia	Regional	Healthcare services personnel only	Forensicare's Journey of Recovery and Care fosters rediscovery through four dimensions of recovery: personal, clinical, wellbeing, and offence specific. Personal recovery is built on an understanding of the specific familial, social, cultural and belief systems and trauma experiences of each person living with a mental illness. Clinical recovery is the process of lessening or ending symptoms associated with mental illness. Wellbeing recovery involves the rebuilding of everyday living skills to support empowerment and decision-making and ultimately, independence in day-to-day living. Offence specific: Aligned with the Risk-Need-Responsivity model used across correctional services to guide treatment of offending populations.
The Forensic Matrix[42]	United Kingdom (Scotland)	National	Healthcare services personnel only	A model of stepped care for forensic patients built on the premise that although forensic patients may present with complex problems, often patients will present with common underlying psychological needs which can be, or may require to be, addressed prior to embarking on more intensive offence-specific work. Thorough evaluation of a patient's risk and needs by highly specialist practitioners will identify which interventions are appropriate and how these should best be sequenced, recognising that needs may be met at differing levels of intensity intervention and

Model Name	Country	Implementation Level	Integration	Model Overview
				treatment. For example, it may be appropriate for patients to engage in 'low intensity' (LI) interventions that are less resource-intensive, prior to engaging in highly resource intensive, specialist therapies.
Prison model of care (PMOC) [43]	Australia	Regional	Healthcare services personnel with prison personnel collaboration	A multi-disciplinary 'modified' assertive community treatment model with after-hours on-call emergency support. The principles of this model are assertive engagement, continuity of care, multi-disciplinary service delivery and a small case load. The PMOC divides healthcare delivery into five steps – screening, referral, assessment, treatment and release planning. There were no new resources for this change in service model, requiring clearer role definition within multi-disciplinary teams and collaboration with correctional staff. In the treatment phase, the PMOC requires needs to be identified, interventions provided and efficacy to be monitored.
Clinical governance model[44]	New Zealand	National	Institution-wide	Can be defined in many ways, but there are common elements that relate to seven primary 'pillars': clinical effectiveness, risk management, patient experience and involvement, communication, resource effectiveness, strategic effectiveness, and learning effectiveness. Clinical governance in New Zealand is thus a system by which the 'governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for [service users]'. The New Zealand Health Safety and Quality Commission also recommended developing clinical leadership at all levels of health organisations as a way of effecting change and enhancing quality and that clinical

Model Name	Country	Implementation Level	Integration	Model Overview
				governance aligns to strategic quality goals defined by Ministry of Health to include people-centredness; access and equity; safety; effectiveness; and efficiency that rested on the Treaty of Waitangi principles: partnership, participation, and protection.

Appendix 2: Excluded Reports

Question 1

Reports marked with an asterisk (*) are likely to be of interest to HSO

Wrong population

Office of the Auditor General of Canada. (2019). *Report 1—Respect in the workplace*. Reports of the Auditor General of Canada to the Parliament of Canada. https://www.oag-bvg.gc.ca/internet/English/parl_oag_201911_01_e_43530.html

Scott, T. (2017). *Child victims of federally sentenced offenders: A profile of victims and perpetrators* (Report No. PS83-3-381). Correctional Service Canada. https://publications.gc.ca/collections/collection_2017/scc-csc/PS83-3-381-eng.pdf

Wrong setting

Ali, F., Hill, C., & Fischer, B. (2017). *Synthetic cannabinoid use in correctional populations – An emerging challenge for offender health and safety? A brief review* (Report No. R-397). Research Branch, Correctional Service Canada. https://publications.gc.ca/collections/collection_2017/scc-csc/PS83-3-397-eng.pdf

Auditor General of New Brunswick. (2018). *Departments of Health and Justice and Public Safety*: *Addiction and mental health services in provincial adult correctional institution*s. In Report of the Auditor General of New Brunswick. https://www.agnb-vgnb.ca/content/dam/agnb-vgnb/pdf/Reports-Rapports/2018V1/Chap3e.pdf

Brown, G., Hoffman, R., Neufeld, E., & Mrozewski, T. (2017). *Suicide risk assessment instruments: A review of current literature (Report No. R-392). Correctional Service Canada. https://publications.gc.ca/collections/collection_2017/scc-csc/PS83-3-392-eng.pdf*

Expert Advisory Committee on Health Care Transformation in Corrections. (n.d.). *Transforming health care in our provincial prisons: Final report of Ontario's Expert Advisory Committee on Health Care Transformation in Corrections*. https://johnhoward.on.ca/wp-content/uploads/2019/05/Transforming-Health-Care-in-Our-Provincial-Prisons-External-Advisory-Report-2.pdf

Martin, M. S., Viau-Deschênes, C., & Yogarajah, T. (2017). *Trauma-informed care for offenders who engage in chronic self-injurious behaviour: A rapid evidence assessment* (Report No. R-388). Correctional Service Canada. https://publications.gc.ca/collections/collection_2018/scc-csc/PS83-3-388-eng.pdf

Nolan, A. & Stewart, L.A. (2015). Correctional health promotion and health education initiatives: A review of the literature. Correctional Service Canada. https://publications.gc.ca/collections/collection_2017/scc-csc/PS83-3-355-eng.pdf

Office of the Auditor General of Canada. (2018). *Report 6—Community Supervision—Correctional Service Canada*. Reports of the Auditor General of Canada to the Parliament of Canada. https://www.oag-bvg.gc.ca/internet/English/parl_oag_201811_06_e_43204.html

Ombudsperson British Columbia. (2021). *ALONE: The prolonged and repeated isolation of youth in custody* (Special Report No. 48). https://bcombudsperson.ca/assets/media/OMB-Alone_Youth-in-Custody-06-11-2021.pdf

Optimus SBR. (2015). *Facility and service delivery options, analysis and recommendations report*. Prepared for the Ministry of Community Safety and Correctional Services. https://www.correctionsdivision.ca/wp-content/uploads/2019/03/MCSCS-Facilities-Report-2015-for-Ministry.pdf

No health services recommendations

Beauchamp, T., Cram, S., Smeth, A., & MacDonald F. (2023). *Inflammatory agents and use of force: Prevalence amongst self-injurious behaviour incidents* (Report No. R-459). Correctional Service Canada. https://publications.gc.ca/collections/collection_2023/scc-csc/PS83-5-R459-eng.pdf

Beaudette, J. (2014). *Prevalence of mental health disorders among incoming federal offenders: Prairie region*. Research Branch. Correctional Service Canada. https://publications.gc.ca/collections/collection_2015/scc-csc/PS82-1-14-3-eng.pdf

Beaudette, J.N., Nolan, A., Power, J., Varis, D.D., & Ritchie, M.B. (2014). *A culturally-informed and culturally-safe exploration of self-injury desistance in Aboriginal offenders* (Report No. R-319). Correctional Service Canada. https://www.csc-scc.gc.ca/005/008/092/r319-eng.pdf

Bernard, W. E., Ataullahjan, S., Cordy, J. (2019). *Interim report of the standing senate committee on human rights*. The Standing Senate on Human Rights. https://sencanada.ca/content/sen/committee/421/RIDR/Reports/RIDR_Report_Prisioners_e.pdf

Brown, G. P., Greco, C., Barker, J., McMillan, K., Tiersma, G., Wardrop, K., & Wilton, G. (2023). *Health and well-being of older offenders on conditional release in the community* (Report No. R-453). Correctional Service Canada. https://publications.gc.ca/collections/collection_2023/scc-csc/PS83-5-R453-eng.pdf

Brown, G., Rabinowitz, T., Boudreau, H., & Wright, A. (2017). *Approved and off-label use of prescribed psychotropic medications among federal offenders* (Report No. R-387). Correctional Service Canada. https://publications.gc.ca/collections/collection_2017/scc-csc/PS83-3-387-eng.pdf

Brown, G.P., Barker, J., McMillan, K., Norman, R., Derkzen, D., Stewart, L.A., & Wardrop, K. (2018). *Prevalence of mental disorder among federal women offenders: Intake and in-custody* (Report No. R-420). Correctional Service Canada. https://publications.gc.ca/collections/collection_2018/scc-csc/PS83-3-420-eng.pdf

Canadian Human Rights Commission (2023). *Submission to the United Nations Human Rights Council on the occasion of its review of Canada during the 4th cycle of the Universal Periodic Review*. http://www.chrc-ccdp.gc.ca/sites/default/files/2023-07/chrc_-_upr_submission_-_april_2023.pdf

Canadian Human Rights Commission. (2022). *Improved health services for people with opioid use disorder in federal Institutions*. https://www.chrc-ccdp.gc.ca/en/resources/improved-health-services-people-opioid-use-disorder-federal-institutions

Cormier, R., Jones, G., & Leonardi, L. (2019). *Fifth independent review committee on non-natural deaths in custody that occurred between April 1st, 2017 to March 31st, 2019*. Correctional Service Canada. https://www.csc-scc.gc.ca/publications/092/005007-2312-en.pdf

Correctional Service Canada, Research Branch. (2014). *Infectious disease surveillance 2014: Human immunodeficiency virus (HIV)*. https://publications.gc.ca/collections/collection_2021/scc-csc/PS84-156-2-2016-eng.pdf

Correctional Service Canada. (2021). *Medical practitioner by-laws.* https://buyandsell.gc.ca/cds/public/2021/10/28/f223b66c5b959c50c50187bbc0b7f87a/annex_g_-_csc_-_medical_by-law.pdf

Correctional Service Canada. (2022). *SIU audit readiness engagement*. https://www.csc-scc.gc.ca/publications/092/005007-2561-en.pdf

Derkzen, D., Barker, J., McMillan, K., & Stewart, L. (2017). *Rates of current mental disorders among women offenders in custody in CSC*. Research Branch, Correctional Service Canada. https://publications.gc.ca/collections/collection_2018/scc-csc/PS82-1-16-23-eng.pdf

Doob, A. N., & Sprott, J. B. (2020). *Understanding the operation of correctional service Canada's structured intervention units: Some preliminary findings*. https://johnhoward.ca/wp-content/uploads/2020/10/UnderstandingCSC_SIUDoobSprott26-10-2020-1.pdf

Farrell MacDonald, S., Stewart, L. A., & Feeley, S. (2014). *The impact of the community mental health initiative (CMHI)* (Report No. R-337). Research Branch, Correctional Service Canada. Research Branch. https://publications.gc.ca/collections/collection_2016/scc-csc/PS83-5-R337-eng.pdf

Kelly, L., & MacDonald, S. F. (2015*). Comparing lifetime substance use patterns of men and women offenders* (Report No. 14-44). Research Branch, Correctional Service Canada. https://www.csc-scc.gc.ca/005/008/092/005008-rb14-44-eng.pdf

MacDonald, S. F., Keown, L.-A., Boudreau, H., Gobeil, R., & Wardrop, K. (2015). *Prevalence of psychotropic medication prescription among federal offenders* (Report No. R-373). Correctional Service Canada. https://www.publicsafety.gc.ca/lbrr/archives/cn97242721-eng.pdf

*McKendy, L., Biro, S., Stanley, D., Miron, M., Taylor, J., & Keown, L. A. (2018). *Overdose incidents in federal custody, 2018/2019*. Research Branch, Correctional Service Canada. https://publications.gc.ca/site/archivee-archived.html?url=https://publications.gc.ca/collections/collection

Murphy, Y., Ali, F., Fischer, B. (2018). *Health and service access challenges for correctional offenders with mental health and substance use problems in transition from incarceration to community: A literature review* (Report No. R-398). Correctional Service Canada. https://publications.gc.ca/collections/collection_2018/scc-csc/PS83-3-398-eng.pdf

Neufeld, J. (n.d.). *Corrections and correctional facilities as a public health setting in Canada*. National Collaborating Centre for Infectious Diseases. https://nccid.ca/wp-content/uploads/sites/2/2020/09/Corrections_2020_Final.pdf

Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders* (Report No. R-332). Correctional Service Canada. https://publications.gc.ca/collections/collection_2017/scc-csc/PS83-3-332-eng.pdf

Nolan, A., & Stewart, L. (2014). *Self-reported physical health status of incoming federally-sentenced women offenders: Comparison to men offenders* (Report No. ERR-14-5, Emerging Research Results). Correctional Service Canada. https://www.csc-scc.gc.ca/005/008/092/err14-5-eng.pdf

Office of the Auditor General of Canada. (2016). *Report 3: Preparing Indigenous offenders for release—Correctional Service Canada*. Reports of the Auditor General of Canada to the Parliament of Canada. https://www.oag-bvg.gc.ca/internet/English/parl_oag_201611_03_e_41832.html

Office of the Auditor General of Canada. (2022). *Report 4: Systemic Barriers—Correctional Service Canada*. Reports of the Auditor General of Canada to the Parliament of Canada. https://www.oag-bvg.gc.ca/internet/docs/parl_oag_202205_04_e.pdf

Power, J., & Beaudette, J. (2014). *Self-Injurious behaviour in treatment centres: Correlates, trajectories, and descriptive analysis* (Report No. R-303). Correctional Service Canada. https://publications.gc.ca/collections/collection_2015/scc-csc/PS83-3-303-eng.pdf

Power, J., Beaudette, J., & Varis, D. (2014). *Staff perspectives on working with Aboriginal offenders who self-injure: What works, what doesn't, and the role of culture* (Report No. R-317). Correctional Service Canada. https://publications.gc.ca/collections/collection_2015/scc-csc/PS83-3-317-eng.pdf

Scallan, E., Lancaster, K., Kouyoumdjian, F. (2021). *The "problem" of health: An analysis of health care provision in Canada's federal prisons*. https://doi.org/10.1177/1363459319846940

Sheahan, C., Tanga, M., Wardrop, K., & Bah, R. (2023). *Qualitative examination of specific responsivity factors of correctional program participants with mental health symptoms, cognitive impairment, or learning disabilities* (Report No. R-441). Correctional Service Canada. https://publications.gc.ca/collections/collection_2023/scc-csc/PS83-5-R441-eng.pdf

Stewart, L., Brine, K., Wilton, G., Power, J., & Hnain, C. (2015). *Resilience factors related to success on release for offenders with mental disorders*. Correctional Service Canada. https://publications.gc.ca/collections/collection_2017/scc-csc/PS83-5-R336-eng.pdf

Stewart, L., Nolan, A., Thompson, J. & Sapers, J. (2015). *Social determinants of physical health conditions among incoming Canadian federal inmates* (Report No. B-59). Correctional Service Canada. https://www.publicsafety.gc.ca/lbrr/archives/cn38760-eng.pdf

Stewart, L., Sapers, J., Nolan, A., & Power, J. (2014). *Self-reported physical health status of newly admitted federally-sentenced men offenders* (Report No. R-314). Correctional Service Canada. https://publications.gc.ca/collections/collection_2015/scc-csc/PS83-3-314-eng.pdf

Stewart, L.A, Gamwell, L., & Wilton G. (2018). *Comorbid mental disorders: Prevalence and impact on community outcomes* (Report No. R-404). Correctional Service of Canada. https://publications.gc.ca/collections/collection_2018/scc-csc/PS83-3-404-eng.pdf

Stewart, LA, & Wilton G. (2017). *Comorbid mental disorders: Prevalence and impact on institutional outcomes* (Report No. R-379). Correctional Service Canada. https://publications.gc.ca/collections/collection_2017/scc-csc/PS83-3-379-eng.pdf

Stewart, Wilton, Kelly, Nolan, & Talisman. (2015). *Intellectual deficits among incoming federally sentenced men and women offenders: Prevalence, profiles, and outcomes* (Report No. R-367). Correctional Service Canada. https://www.publicsafety.gc.ca/lbrr/archives/cn97203256-eng.pdf

Thompson, J (2015). *The needs of women offenders under community supervision* (Report No. R-338). Research Branch, Correctional Service Canada. https://publications.gc.ca/collections/collection_2016/scc-csc/PS83-3-338-eng.pdf

Wendt, B. (2014). *Prevalence of mental health disorders among incoming federal men offenders in three regions - Analysis by age group*. Research Branch, Correctional Service Canada. https://publications.gc.ca/collections/collection_2015/scc-csc/PS82-3-14-14-eng.pdf

Wilton, G., Power, J., & Stewart, L. (2014). *Agreement among three mental health screening assessments conducted at intake*. Research Branch, Correctional Service Canada. https://publications.gc.ca/collections/collection_2017/scc-csc/PS83-6-58-eng.pdf

Not a review of health services

Correctional Service Canada, Internal Audit Sector. (2021). *Audit of emergency response teams*. https://www.csc-scc.gc.ca/publications/092/005007-2556-en.pdf

Correctional Service Canada, Internal Audit Sector. (2015). Review of mental health commitments. https://www.csc-scc.gc.ca/005/007/092/005007-2535-eng.pdf

Helmus, L., & Forrester, T. K. (2014). *Static factors assessment (SFA) in the offender intake assessment process: Relationship to release and community outcomes* (Report No. R-339). Research Branch, Correctional Service Canada. https://publications.gc.ca/collections/collection_2016/scc-csc/PS83-3-339-eng.pdf

Office of the Auditor General of Canada. (2015). *Report 6: Preparing male offenders for release*. Report of the Auditor General of Canada. https://www.oag-bvg.gc.ca/internet/English/parl_oag_201504_06_e_40352.html

Stewart, L., Wardrop, K., Thompson, J., Wilton, G., & Wanamaker, K. (2018). *An examination of the mental health continuum of care for a sample of federal offenders with serious impairment related to mental disorders* (Report No. R-410). Correctional Service Canada. https://publications.gc.ca/collections/collection_2018/scc-csc/PS83-3-410-eng.pdf

Wardrop, K., Thompson, J., & Stewart, L. (2017). *Profile of Inuit offenders in custody and the community: Implications for programming*. Correctional Service Canada. https://publications.gc.ca/collections/collection_2018/scc-csc/PS82-4-16-24-eng.pdf

Other

Reports from the Office of the Correctional Investigator cover ten years. Based on the redundancy across reports consensus was reached with HSO to only include 2021 and 2022.

Sapers, H. (2015). *Annual report 2014-2015*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20142015-eng.pdf

Sapers, H. (2016). *Annual report 2015-2016*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20152016-eng.pdf

Zinger, I. (2017). *Annual report 2016-2017*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20162017-eng.pdf

Zinger, I. (2018). *Annual report 2017-2018*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20172018-eng.pdf

Zinger, I. (2019). *Annual report 2018-2019*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20182019-eng.pdf

Zinger, I. (2020). *Annual report 2019-2020*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-06/annrpt20192020-eng.pdf

Two reports from the Office of the Correctional Investigator have been published after the search process for this report was completed and are listed below.

Zinger, I. (2023). *Annual report 2022-2023*. Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-10/Annual%20Report%20EN%20%C3%94%C3%87%C3%B4%20Web.pdf

Zinger, I. (2023). *Ten Years since Spirit Matters: A roadmap for the reform of Indigenous corrections in Canada.* Office of the Correctional Investigator. https://oci-bec.gc.ca/sites/default/files/2023-10/Spirit%20Matters%20EN%20%C3%94%C3%87%C3%B4%20Web.pdf

Question 2

Not a model

Council of Europe (2019). *Organisation and management of health care in prison* [Guidelines]. https://rm.coe.int/guidelines-organisation-and-management-of-health-care-in-prisons/168093ae69

Flanigan, C. (2020). *Health and healthcare in prison: A literature review 2020*. NHS Highlands. https://www.scotphn.net/wp-content/uploads/2020/12/Prison-Literature-Review-Dec-2020.pdf

Health, Social Care and Sport Committee, Welsh Parliament. (2021). *Health and social care provision in the adult prison estate in Wales*. https://business.senedd.wales/documents/s114322/Health%20and%20social%20care%20provision%20in%20the%20adult%20prison%20estate%20in%20Wales%20-%2031%20March%202021.pdf

Heard, C. (2019). *Towards a health-informed approach to penal reform? Evidence from ten countries*. Institute for Criminal Policy Research, Birkbeck University of London. https://www.prisonstudies.org/sites/default/files/resources/downloads/icpr_prison_health_report.pdf

HM Prison and Probation Service. (2020). HMPPS prison regime recovery planning exceptional delivery model (EDM) NHS England Clinical Service: Dental service. https://pogp.hmppsintranet.org.uk/wp-content/uploads/2020/08/EDM-24-Dental-Services-FINAL-v1.0.pdf

House of Commons, Health and Social Care Committee. (2018). *Prison health: Twelfth report of session 2017–19*. https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf

NHS England and NHS Improvement. (2020). Service specification: Primary care service – medical and nursing for prisons in England. https://www.england.nhs.uk/wp-content/uploads/2020/03/primary-care-service-spec-medical-nursing-for-prisons-2020.pdf

NHS England. (2018). Service specification: Integrated mental health service for prisons in England. https://www.england.nhs.uk/wp-content/uploads/2018/10/service-specification-mental-health-for-prisons-in-england-2.pdf

Office of the Inspector of Prisons. (2020). *A framework for the inspection of prisons in Ireland*. https://www.oip.ie/wp-content/uploads/2020/09/OIP-Inspection-Framework-Single.pdf

Sullivan, S., & Mallinson, M. (2019). A mental health service for people in central North Island prisons. *Practice: The New Zealand Corrections Journal, 7*(1). https://www.corrections.govt.nz/resources/research/journal/volume_7_issue_1_july_2019/a_mental_health_service_for_people_in_central_north_island_prisons

Victoria State Government and Justice and Community Safety. (2023). *Healthcare services quality framework for Victorian prisons 2023*. https://files.corrections.vic.gov.au/2023-07/FINAL%20ENDORSED%20VERSION%2017%20JULY%202023%20-%20Health%20Services%20Quality%20Framework%20for%20Victorian%20Prisons%202023.pdf

Welsh Government. (2019). *Partnership agreement for prison health in Wales*. https://www.gov.wales/sites/default/files/publications/2019-09/delivery-plan-for-prison-health-in-wales.pdf

Welsh Government. (2020). *Health and social care in the prison estate: Evidence paper for the Health, Social Care and Sport Committee.* https://business.senedd.wales/documents/s112841/Welsh%20Government%20evidence%20paper%20-%20January%202020.pdf

World Health Organization. (n.d.). *Health in prisons European database (HIPED)*. https://www.who.int/data/region/europe/health-in-prisons-european-database-(hiped)

Model not implemented

Duff, M., Paki, W., (Waikato, Te Arawa, Ngaaruahine), Butler, R., McSweeney, C., & McKenna, B. (2023). The development of a forensic intellectual disability model of care: Synergy to achieve equity. *International Journal of Forensic Mental Health*, *22*(4), 302-313. https://doi.org/10.1080/14999013.2023.2178555

Forrester, A., Till, A., Simpson, A., & Shaw, J. (2018). Mental illness and the provision of mental health services in prisons. *British Medical Bulletin, 127*(1), 101-109. https://doi.org/10.1093/bmb/ldy027

HM Inspectorate of Probation. (2020). *The risk-need-responsivity model*. https://www.justiceinspectorates.gov.uk/hmiprobation/research/the-evidence-base-probation/models-and-principles/the-rnr-model/

Nicholls, T. L., Butler, A., Kendrick-Koch, L., Brink, J., Jones, R., & Simpson, A. I. (2018). Assessing and treating offenders with mental illness. In M. Terns, P. R. Magaletta, M. W. Patry (Eds.), *The practice of correctional psychology* (pp. 9-37). Springer. https://link.springer.com/chapter/10.1007/978-3-030-00452-1_2

Simpson, A. I., Gerritsen, C., Maheandiran, M., Adamo, V., Vogel, T., Fulham, L., Kitt, T., Forrester, A., & Jones, R. M. (2022). A systematic review of reviews of correctional mental health services using the STAIR Framework. *Frontiers in Psychiatry, 12*, 747202. https://doi.org/10.3389/fpsyt.2021.747202

Model pre-2018

Dean, K. (2020). Literature review: Forensic mental health models of care. *NSW Mental Health Commission*. https://www.nswmentalhealthcommission.com.au/sites/default/files/old/literature_review_forensic_models_of_care.pdf

South Australian Prison Health Service. (2017). *Model of care for Aboriginal prisoner health and wellbeing for South Australia*. https://sahmri.blob.core.windows.net/communications/sahmriresearch.org/sah009_modelofcare_v6.pdf

Model not healthcare specific

Northern Territory Government. (20220). *Northern Territory youth detention centres model of care: Territory families, housing and communities*. https://tfhc.nt.gov.au/__data/assets/pdf_file/0009/1132200/northern-territory-youth-detention-centres-model-of-care.pdf

Wrong setting

The Pew Charitable Trusts. (2018). Jails: Inadvertent health care providers - How county correctional facilities are playing a role in the safety net. https://www.pewtrusts.org/-/media/assets/2018/01/sfh_jails_inadvertent_health_care_providers.pdf

Document not in English

Ministère de la Justice. (2019). *Guide méthodologique "prise en charge sanitaire des PPSMJ" 2019*. https://www.justice.gouv.fr/guide-methodologique-prise-charge-sanitaire-ppsmj-2019

Appendix 3: Sources of Information and Search Strategy

Question 1

Websites Searched/Browsed
If a search strategy is not specified, all reports on the website were screened for eligibility.

Canadian Human Rights Commission: https://www.chrc-ccdp.gc.ca/
Searches: Prison = 38 results; Corrections = 39 results

Office of the Correctional Investigator
Annual Reports: https://oci-bec.gc.ca/en/reports/annual
Other Reports: https://oci-bec.gc.ca/en/reports/other

Office of the Auditor General of Canada
Reports to Parliament by Federal Institution: Correctional Service Canada: https://www.oag-bvg.gc.ca/internet/English/parl_lpf_e_1214.html

Correctional Service of Canada
Evaluation reports: https://www.csc-scc.gc.ca/005/009/005009-1002-en.shtml
Internal audit reports: https://www.csc-scc.gc.ca/publications/005007-2500-en.shtml
Publications: https://www.csc-scc.gc.ca/publications/index-eng.shtml
Health and mental health: https://www.csc-scc.gc.ca/research/005008-2005-en.shtml

Google Searches
filetype:pdf "correctional service Canada" health OR healthcare
Results=99* (14,100)

allintitle: canada health corrections OR correctional OR prison
Results=84* (416)

allintitle: canada healthcare corrections OR correctional OR prison
Results=22

*Note that some of these results are after Google has "omitted some entries very similar to the those already displayed," and represents the screening of the first 8-10 pages of results. Actual total is in parentheses.

Question 2

MEDLINE Search
Searched date: October 20, 2023

#	Search	Results
1	(United Kingdom or England or Scotland or Wales or Ireland or Australia or New Zealand or Germany or Switzerland or France or Denmark or Sweden or Norway or Finland).ti,ab,kw.	637773
2	Prisons/ or Prisoners/ or Correctional Facilities/ or (incarcerat* or prison* or penitentia* or correction* or jail* or inmate? or convict? or offender? or detainee? or imprison* or carceral or forensic or justice).ti,ab,kw.	395254
3	(("Delivery of Health Care"/ or Health Services/) and (model? or framework?).ti.) or ((health or healthcare or health care) adj4 (model? or framework?)).ti.	13180
4	1 and 2 and 3	15
5	limit 4 to yr="2018 - current"	6

PsycInfo Search
Searched date: October 20, 2023

#	Search	Results
S1	TI(United Kingdom or England or Scotland or Wales or Ireland or Australia or New Zealand or Germany or Switzerland or France or Denmark or Sweden or Norway or Finland) OR AB(United Kingdom or England or Scotland or Wales or Ireland or Australia or New Zealand or Germany or Switzerland or France or Denmark or Sweden or Norway or Finland)	168,6814
S2	(DE "Prisons" OR DE "Incarcerated" OR DE "Incarceration") OR TI(incarcerat* or prison* or penitentia* or correction* or jail* or inmate* or convict* or offender* or detainee* or imprison* or carceral or justice or forensic) OR AB(incarcerat* or prison* or penitentia* or correction* or jail* or inmate* or convict* or offender* or detainee* or imprison* or carceral or justice or forensic)	186,242
S3	((DE "Health Care Services" OR DE "Health Care Delivery") AND TI(model* or framework*)) OR TI((health or healthcare or health care) adj4 TI(model* or framework*))	2,821
S4	S1 AND S2 AND S3	7
S5	Limit S4 to 2018-present	4

Websites Searched/Browsed

Search notes:

- *Each website was searched using the following keywords, where appropriate:*
  - *Prison healthcare*
  - *Prison health care*
- *For websites devoted to corrections the keyword "prison" was eliminated; For websites devoted to healthcare only "prison" was searched.*
- *In cases where the results were too many to scan manually, an additional keyword was added: "model" OR "framework"*

United Kingdom

- United Kingdom Government: **https://www.gov.uk/**
- Research and statistics: **https://www.gov.uk/search/research-and-statistics?organisations()=hm-prison-service&parent=hm-prison-service**
- Policy papers and consultations: **https://www.gov.uk/search/policy-papers-and-consultations?organisations()=hm-prison-service&parent=hm-prison-service**
- Public health in prisons and secure settings: **https://www.gov.uk/government/collections/public-health-in-prisons**
- Healthcare for offenders: **https://www.gov.uk/guidance/healthcare-for-offenders#healthcare-in-prisons-in-england**
- HM Prison Service (England and Wales): **https://www.gov.uk/government/organisations/hm-prison-service**
- NHS (National Health Service): **https://www.nhs.uk/**
- Scottish government: **https://www.sps.gov.uk/**
- Scottish Prison Services - Publications: **https://www.sps.gov.uk/Corporate/Publications/Publications.aspx**
- Scottish Parliament: **https://www.parliament.scot/**
- The Forensic Network: **https://forensicnetwork.scot.nhs.uk/**
- NHS Scotland: **https://www.nss.nhs.scot/**
- Welsh Government: **https://www.gov.wales/prisons-and-probation**
- Welsh Parliament: **https://senedd.wales**
- NHS Wales: **https://www.nhs.wales/**
- Government of Ireland: **https://www.gov.ie/en/**
- Irish Prison Service: **https://www.irishprisons.ie/**
- Houses of the Oireachtas (Irish legislature) - **https://www.oireachtas.ie/**
- HSE (Health Service Executive): **https://www.hse.ie/**

Australia

- Australian Government: **https://www.australia.gov.au/**
- Government of Western Australia, Corrective Services: **https://www.wa.gov.au/organisation/department-of-justice/corrective-services**
- Government of Southern Australia, Department for Correctional Services: **https://www.corrections.sa.gov.au/**

- Corrections, Prisons, and Parole (Victoria): **https://www.corrections.vic.gov.au/**
- Queensland Correction Services: **https://corrections.qld.gov.au/**
- Tasmania Prison Service: **https://www.justice.tas.gov.au/prisonservice**
- Northern Territory Government, Prisons and probation: **https://nt.gov.au/law/prisons**
- ACT Government Corrective Services: **https://nt.gov.au/law/prisons**
- ACT Government Canberra Health Services, Justice Health: **https://www.canberrahealthservices.act.gov.au/services-and-clinics/justice-health**
- Parliament of Australia: **https://www.aph.gov.au/**
- Victorian Institute of Forensic Mental Health (Forensicare): **https://www.forensicare.vic.gov.au/**
- Australian Government Department of Health and Aged Care: **https://www.health.gov.au/**

New Zealand

- New Zealand Government, Department of Corrections: **https://www.corrections.govt.nz/**
- New Zealand Parliament: **https://www.parliament.nz/en/**
- New Zealand Ministry of Justice: **https://www.justice.govt.nz/**
- Ministry of Health: **https://www.health.govt.nz/**

Germany

- German Federal Government: **https://www.bundesregierung.de/breg-en**
- Bundestag (German Parliament): **https://www.bundestag.de/**
- Federal Office of Justice: **https://www.bundesjustizamt.de/EN/Home/Home_node.html**
- Federal Ministry of Health: **https://www.bundesgesundheitsministerium.de/en/**

Switzerland

- Swiss Government: **https://www.admin.ch/gov/en/start.html**
- The Swiss Parliament: **https://www.parlament.ch/en**
- Swiss Federal Department of Justice and Police: **https://www.ejpd.admin.ch/ejpd/en/home.html**
- Note: Prisons are run by 26 cantons of Switzerland.
- Federal Office of Public Health: **https://www.bag.admin.ch/bag/en/home.html**

France

- French Government: **https://www.gouvernement.fr/**
- Ministry of Justice: **https://www.justice.gouv.fr/**
- French Senate: **https://www.senat.fr/lng/en.html**
- French National Assembly: **https://www2.assemblee-nationale.fr/langues/welcome-to-the-english-website-of-the-french-national-assembly**
- Ministère de la Santé et de la Prévention: **https://sante.gouv.fr/**

Denmark

- Danish Government: **https://denmark.dk/society-and-business/government-and-politics**

- Danish Ministry of Justice: **https://www.justitsministeriet.dk/english/**
- Folketinget (The Danish Parliament): **https://www.thedanishparliament.dk/**
- Danish Health Authority: **https://www.sst.dk/en/english**

Sweden

- Swedish Government: **https://www.government.se/**
- Ministry of Justice: **https://www.government.se/government-of-sweden/ministry-of-justice/**
- Swedish Prison and Probation Service: **https://www.kriminalvarden.se/swedish-prison-and-probation-service/** (website not working currently)
- Riksdag (Parliament of Sweden): **https://www.riksdagen.se/en/**
- Ministry of Health and Social Affairs: **https://www.government.se/government-of-sweden/ministry-of-health-and-social-affairs/**

Norway

- Government of Norway: **https://www.regjeringen.no/en/id4/**
- Kriminalomsorgen (Norwegian Correctional Service): **https://www.kriminalomsorgen.no/**
- Stortinget (Norwegian Parliament): **https://www.stortinget.no/en/In-English/**
- Ministry of Justice: **https://www.regjeringen.no/en/dep/jd/id463/**
- Helsedirektoratet (Norwegian Directorate of Health): **https://www.helsedirektoratet.no/english**

Finland

- Finnish Government: **https://valtioneuvosto.fi/en/frontpage**
- Prison and Probation Service of Finland: **https://www.rikosseuraamus.fi/en/**
- Finnish Institute for Health and Welfare: **https://thl.fi/en/web/thlfi-en**
- Eduskunta (Finnish Parliament): **https://www.eduskunta.fi/EN/Pages/default.aspx**
- Ministry of Social Affairs and Health: **https://stm.fi/en/frontpage**

Google Searches: Country

United Kingdom

Search: filetype:pdf “united kingdom” prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 43

Search: filetype:pdf "united kingdom" prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 63

Search: filetype:pdf England prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 54

Search: filetype:pdf England prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 181

Search: filetype:pdf Scotland prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 18

Search: filetype:pdf Scotland prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 39

Search: filetype:pdf Wales prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 18

Search: filetype:pdf Wales prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 63

Search: filetype:pdf Ireland prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 30

Search: filetype:pdf Ireland prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 52

Australia

Search: filetype:pdf Australia prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 87

Search: filetype:pdf Australia prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 110

New Zealand

Search: filetype:pdf “New Zealand” prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 30

Search: filetype:pdf “New Zealand” prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023

Results: 49

Germany

Search: filetype:pdf Germany prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 46

Search: filetype:pdf Germany prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 52

Switzerland

Search: filetype:pdf Switzerland prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 30

Search: filetype:pdf Switzerland prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 46

France

Search: filetype:pdf France prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 49

Search: filetype:pdf France prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 59

Denmark

Search: filetype:pdf Denmark prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 14

Search: filetype:pdf Denmark prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 24

Sweden

Search: filetype:pdf Sweden prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 37

Search: filetype:pdf Sweden prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 40

Norway

Search: filetype:pdf Norway prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 25

Search: filetype:pdf Norway prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 27

Finland

Search: filetype:pdf Finland prison healthcare or "health care" intitle:model
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 15

Search: filetype:pdf Norway prison healthcare or "health care" intitle:framework
Limiters: Jan 1, 2018 – Dec 31, 2023
Results: 20

Google Searches: Specific Models
Search note: file type limiter and/or additional keywords added as needed based on number of results

Prison model of care

Search: "Prison Model of Care"
Date limiter: Jan 1, 2018 – Dec 31, 2023
Results = 15

Risk-need-responsivity model

Search: filetype:pdf "risk-need-responsivity model" healthcare
Date limiter: Jan 1, 2018 – Dec 31, 2023
Results: 145

Assertive community treatment model

Search: filetype:pdf "assertive community treatment model" prison or corrections
Date limiter: Jan 1, 2018 – Dec 31, 2023
Results: 30

STAIR model

Search: "stair model" corrections or prison
Date limiter: Jan 1, 2018 – Dec 31, 2023
Results: 28

Appendix 4: CAN/HSO 34008:2024 Correctional Service Canada Health Services standard

- The new standard will be a chapter in the Correctional Service Canada Health Services Assessment Manual.
- Governance, Leadership, Service Excellence, Medication Management, Infection Prevention and Control, and Emergency and Disaster Management are the core chapters that precede this chapter in the assessment manual.
- The following proposed sections follow the perspective of the people receiving care.

Proposed Sections of the New Standard	Examples of Topics

1. Client-centred care	• Healthy equity
	• Trauma informed care
	• Culturally appropriate care
	• Client-centred approach
	• Peer support
	• Addressing diverse client needs
	• Designated support person
	• Translation and interpretation services
	• Information sharing
	  ○ Between health care team members and incarcerated people
	  ○ Among health care team members
	  ○ Between health care team members and other members of the workforce
	• Developmentally and culturally appropriate resources
	• Client feedback on services
	• Access to non-health services (pertaining to access of health services)
	• Palliative care
	• End-of-life care
	• Self-management
	• Accessibility needs for people with disabilities and others

2. Client rights	• Client rights and responsibilities • Care decision • Informed consent • Substitute decision maker • Confidentiality, privacy and dignity • Complaint process for health rights violation • Ethical decision-making • Family rights and involvement in health care

	• Health records/access to documentation related to care
3. Comprehensive assessments	• Standardized screening tools • Standardized and validated assessment tools • Safety/Clinical risk assessment • Care domains: basic needs, physical health needs, mental health needs, social needs
4. Individualized care plan	• Standardized template for individualized care plans • Clinical risk management plan • Co-designing individualized care plans • Continuously update individualized care plans • Sharing the individualized care plans with appropriate team members • Referral to health services as necessary (internal and external) • Nutrition and hydration management • Oral health management • Pain management • Medication Management • Management of common infections

5. Safety practices	• Least restraint
	• Immunization programs
	• Harm reduction
	• Updated policy and procedures for emergency and disaster management
	• Clear accountability in clinical decision-making
	• Safe and compassionate community release
	• Required Organizational Practices (ROPs) on
	  ○ Preventing Falls and Reducing Injuries from Falls
	  ○ Client Identification
	  ○ Optimizing Skin Integrity Program
	  ○ Information Transfer at Care Transitions
	  ○ Maintaining an Accurate List of Medications during Care Transitions

6. Care coordination and continuity of services	• Understand the specific needs of the target populations • Transition planning • Partnerships with other organizations • Formal agreements with external health service providers

	• Virtual health services • Medical transportation • Continuity of services • Preparing clients for care transfer
7. Healthy and competent workforce	• Dual loyalty • Ensuring relevant qualifications and competencies • Number and skill mix of the workforce • Ongoing education and training to ensure safe care • Ongoing education and training on health equity • Ongoing education and training on Indigenous-specific racism and discrimination • Ongoing education and training on evidence-informed approaches to the use of least restraint • Ongoing education and training on safety practices • Ongoing learning and career development • Recruitment and retention strategies • Mitigation of understaffing • Occupational health and safety • Rights of the workforce • Health care equipment and information and communication technology • Workforce data to support improvements to working conditions • Resources to support workforce health and well-being
8. Quality improvement	○ Client-centred research activities ○ Implementation of research outcomes ○ Disaggregated client data collection ○ Dedicated resources for quality improvement activities ○ Quality improvement action plan ○ Quality indicators ○ Communication of quality improvement outcomes ○ Regular evaluation of quality improvement activities