THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

MEMBER INTEREST GROUPS SECTION (MIGS)
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Prison Health | Santé en milieu carcéral

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Position Statement on Health Care Delivery

Introduction

Worldwide, incarcerated populations have a higher prevalence of physical and mental illnesses and of vulnerabilities in their determinants of health compared with the general population.[1, 2, 3] In addition, prior to their arrest many individuals face multiple and complex barriers to accessing primary health care services. People who are incarcerated may experience deterioration of their physical, mental, and social health because they are in custody.[4, 5]

All provincially sentenced, and almost all federally sentenced, individuals eventually return to the community. Therefore, the health of Canada's prison population is intrinsic to the physical, mental, and social health of Canada's general population.[1] International studies support at least four compelling reasons to improve the health of this population: human rights and equivalence, public safety, public health, and economics. Incarceration also disrupts the health and well-being of the families and communities from which people are removed.

Incarceration provides a public health opportunity and the ethical and legal imperatives to offer exemplary and accessible primary and preventive health care services. Additionally, it provides a forum to address the public health needs of an at-risk population.[7, 8]

Delivery of health care

"Community equivalence" describes prison health care services that provide quality and accessibility equal to, or better than, what is available in the community.[8] In many jurisdictions, despite the best efforts of health care providers, the quality of the health care offered is consistently below the standard that is available in the community, including for prevalent disorders such as substance use, and discharge planning may be lacking or inadequate. The United Nations' *Nelson Mandela Rules* articulate minimum standards for the care of people in prison and state, in Rule 24, "Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services… without discrimination on the grounds of their legal status."[9]

"Throughcare" is the continuity of health care provided for individuals as they transition from the community into the correctional system and then back into the community.[10, 11] The *Nelson Mandela* Rule 24 also states, "Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis, and other infectious diseases, as well as for drug dependence."[9]

The World Health Organization (WHO) Health in Prisons Programme recommends that a country's prison health care and public health services delivery should be integrated into its ministry of health, and that the responsibility for medical/public health services for incarcerated populations should not be under the jurisdiction of the ministry of justice.[12]

Other countries have recognized the importance of prison health care and the need to reform their systems. Norway, France, and the United Kingdom now use their regular health care systems to serve people in prison. This type of integration supports the implementation within correctional facilities of community-equivalent health care standards and procedures.[12] It also fosters the goal of reducing health inequity and improving health outcomes for individuals and for communities during an individual's incarceration and the transition from correctional facility to the community.[14]

In addition, "… the responsibility and the budget for the health care needs of the prison population are transferred to a recognized health authority. The organization and administration of prison health services from outside the prison system means more autonomy with less conflict between health personnel and corrections authorities. Thus, health care professionals working in the prison system will have more regular exposure to the values and ethics that guide usual practice."[15] Due to restricted autonomy in carceral settings, medical care provision should include timely access to high-quality dental, vision, and evidence-based therapeutic interventions (such as physical therapy) that may not otherwise be publicly insured services outside of the institutional setting in that jurisdiction.

The Canadian situation

Despite existing WHO recommendations, few provinces in Canada—Alberta, Nova Scotia, and British Columbia, with Quebec and Newfoundland indicating a plan to do so—have transferred the responsibility for health care delivery within provincial correctional centres to their respective provincial ministry of health.[13, 16, 17] Currently, correctional health care in all other Canadian provinces and territories is under the jurisdiction of the respective ministry of justice. Health care for federal correctional facilities is delivered by stand-alone health care services under the jurisdiction of the Department of Justice Canada.[xviii]

Family physicians are health advocates who are called on to be socially accountable.[19, 20] The College of Family Physicians of Canada (CFPC) promotes social justice as the pursuit and/or attainment of equity in society.[21] Social justice focuses on addressing the social determinants of health and minimizing their negative effects on individuals' health.[22, 23] Accordingly, the CFPC Member Interest Group[24] advocates for best health care practices for incarcerated populations in Canada, for reasons described in the preceding rationale.

Therefore, the purpose of this CFPC position paper is to recommend the closest integration possible of correctional health services with the public health care system, and ideally into provincial/territorial/federal ministries of health to foster best practices of community equivalence and throughcare.

Recommendations

1. All provinces and territories should transfer the responsibility of correctional medical, mental, and public health care delivery from their respective ministry of justice to their ministry of health.
2. The pharmaceutical formulary in corrections should be harmonized to ensure any medication can be easily accessed while detained.
3. Responsibility for delivery of medical and mental health care services in federal correctional facilities should be separated completely from the Department of Justice Canada.

Conclusion

Health care standards in Canadian prison settings must be achieved and maintained at levels that at least meet the standards of medical care available to all Canadians. To optimize the provision of health services such that individual and public health issues are addressed according to national and provincial/territorial standards of best practices, it is recommended that the responsibility for the delivery of health care in our correctional facilities is transferred from judicial to health ministries at all levels.

References

Note: The following references and links were valid for the original document, published in 2016.

1 Fazel S, Baillargeon J. The health of prisoners. *Lancet*. 2011;377(9769):956-965

2 Kouyoumdjian F, Schuler A, Matheson FI, Hwang SW. The health status of prisoners in Canada: Narrative review. *Can Fam Physician*. 2016;62(3):215-222.

3 Correctional Service Canada. *Mental Health Strategy For Corrections in Canada; A Federal-Provincial-Territorial Partnership*. Ottawa, ON: Correctional Service Canada. www.csc-scc.gc.ca/health/092/MH-strategy-eng.pdf. Accessed November 2016.

4 World Health Organization Europe. *Trenčín statement on prisons and mental health*. Copenhagen, Denmark:
World Health Organization. 2008. http://apps.who.int/iris/bitstream/10665/108575/1/E91402.pdf. Accessed November 2016.

5 John Howard Society of Ontario. *Fractured Care: Public health opportunities in Ontario's correctional institutions*. Toronto, ON: John Howard Society of Ontario. 2016. http://johnhoward.on.ca/wp-content/uploads/2016/04/Fractured-Care-Final.pdf. Accessed November 2016.

6 Kinner SA, Wang EA. The case for improving the health of ex-prisoners. *Am J Public Health*. 2014;104(8):1352-1355.

7 World Health Organization. *Prison Health as part of Public Health*. Moscow, Russia: World Health Organization. 2003. www.euro.who.int/__data/assets/pdf_file/0007/98971/E94242.pdf. Accessed November 2016.

8 Lines R. The right to health of prisoners in international human rights law. *Int J Prison Health*. 2008;4(1):3-53.

9 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). Geneva, Switzerland; 2015 [cited 2016 Jun 27]. www.penalreform.org/wp-content/uploads/2015/05/MANDELA-RULES.pdf. Accessed November 2016.

10 Glasgow City Council. Throughcare.
www.glasgow.gov.uk/index.aspx?articleid=17256. Accessed November 2016.

11 Stevens K. The challenges of implementing throughcare. Paper presented at: Probation and Community Corrections: Making the Community Safer Conference; September 23–24, 2002; Perth, Australia.

12 Enggist S, Moller L, Galea G, Udesen C, eds. *Prisons and Health*. Copenhagen, Denmark: World Health Organization; 2014. www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2014/prisons-and-health. Accessed November 2016.

13 Woods D. Alberta Health Services (AHS) Healthcare Delivery In Alberta's Provincial Correctional Centres—Lessons Learned. National Correctional Services Healthcare Conference. Ottawa; 2014.

14 Department of Health, International Centre for Prison Studies. Prison Health and Public Health: The integration of prison health services. Report from a conference. Paper presented April 2, 2004, London, UK.
www.prisonstudies.org/sites/default/files/resources/downloads/health_service_integration.pdf. Accessed November 2016.

15 Flegel K, Bouchard F. Let us get prison health care out of jail. *CMAJ*. 2013;185(4):281.

16 Strang R. Offender Health Services in Nova Scotia. Paper presented at: Canadian Public Health Association Centennial Conference, June 13–16, 2010, Toronto, Ontario. http://resources.cpha.ca/CPHA/Conf/Data/2010/A10-027e.pdf. Accessed November 2016.

17 Iftene A, Manson A. Recent crime legislation and the challenge for prison health care. *CMAJ* 2013;185(10):886-889.

18 Blaney S. *2012-13 Departmental Performance Report*. Ottawa, ON: Correctional Service Canada. 2013.

19 The College of Family Physicians of Canada. *CanMEDS–Family Medicine Working Group on Curriculum Review*. Mississauga, ON: The College of Family Physicians of Canada; 2009. www.cfpc.ca/uploadedFiles/Education/CanMeds%20FM%20Eng.pdf. Accessed November 2016.

20 Buchman S, Woollard R, Meili R, Goel R. Practising social accountability: From theory to action. *Can Fam Physician* 2016;62(1):15-18.

21 The College of Family Physicians of Canada. *The CFPC Social Justice Lens Worksheet*. Mississauga, ON: The College of Family Physicians of Canada; 2015. www.cfpc.ca/uploadedFiles/Health_Policy/_PDFs/SJ_Lens_Final_Print.pdf. Accessed November 2016.

22 Wilkinson R, Marmot M, eds. *Social determinants of health: the solid facts. 2nd ed*. Copenhagen, DK: WHO Regional Office Europe; 2003. www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf. Accessed November 2016.

23 Canadian Nurses Association. *Social Justice: a means to an end, an end in itself. 2nd edition*. Ottawa, ON: Canadian Nurses Association; 2010. www.cna-aiic.ca/~/media/cna/page-content/pdf-fr/social_justice_2010_e.pdf?la=en. Accessed November 2016.

24 The College of Family Physicians of Canada. Prison Health Program Committee. www.cfpc.ca/Prison_Health_Program_Committee/. Accessed November 2016.

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