Transitions in Care Program

From Correction to Connection: Health Starts Here

PROGRAM OVERVIEW

A collaborative initiative connecting individuals released from provincial correctional facilities with culturally appropriate, wrap-around primary health care services — with a particular focus on Black and Indigenous communities.

Key Focus Areas

- Supporting Black and Indigenous communities who face disproportionate barriers in accessing culturally safe primary health care
- Providing safe, culturally appropriate Primary Health Care services including mental health, wellness, and substance use supports
- Ensuring continuity of medication and treatment upon release from correctional facilities
- Healthcare-related discharge planning, complex-needs referrals, and sharing of vital medical information
- Providing healthcare networks with education and training resources to support formerly incarcerated populations

COMMUNITY HEALTH NAVIGATOR

The Vital Bridge

The Community Health Navigator (CHN) serves as the vital bridge between correctional facilities and community health care — providing culturally appropriate, person-centred support to each Transitions in Care client. Each CHN demonstrates resourcefulness and autonomy to connect clients released from corrections to care in their returning community. Each region is unique.

Core Responsibilities

- Create & maintain working relationships with Correctional Facilities
- Build partnerships with Primary Care Providers and community organizations
- Provide culturally appropriate, person-centred support to TIC clients
- Connect & link clients released from Corrections to care in their home community
- Support effective transition to community health care and supports

Regional Excellence

Each region is unique. CHNs demonstrate:

- Adaptability to unique regional contexts
- Resourcefulness in connecting clients
- Autonomy in building local partnerships
- Deep understanding of community needs
- Trusted relationship building

Pre-Release Engagement

Connecting with clients during custody is an important first step for building trust and establishing early connections that support the continuity of care post-release.

Trusted Relationship Builder • Culturally Safe Practice • Holistic Approach • Client-Centered Care • Equity-Focused

"I believe that the TIC program should be offered to everyone in all cities." — TIC Client Feedback, June 2025

CHALLENGES

Justice-involved individuals, particularly those from Black and Indigenous communities, often experience fragmented care upon release. These populations rely more on emergency services due to a lack of formal transition pathways and culturally appropriate supports.

Unmet & Complex Needs
Lack of access and attachment to primary health care services upon release

Communication Barriers
Difficulty maintaining contact with clients post-release; missing or invalid contact information

Competing Priorities
Stable housing, food security, and other social determinants of health may take priority of over health care needs

Early Intervention Gap
Importance of local partnerships and targeted interventions to reach this population

POSITIVE IMPACT

"My experience was amazing. I got just what I needed." — TIC Client, July 2025

57%
Connected to Services*

**Confirmed & Assumed Attachment to Primary Care, and Other Services*

100%
would recommend TIC to others

83.3%
rate experience as 'very good'

50% of clients say they would NOT have accessed health services without TIC

TRAJECTORY & GOALS

Provincial Expansion Vision

Establish a province-wide network of CHNs connected to all correctional facilities across Ontario, ensuring equitable access to culturally appropriate care for justice-involved individuals.

Key Expansion Goals

1. Align CHNs with every provincial correctional facility across Ontario
2. Embed program within Ontario Health Teams and Primary Care Networks (OHTs/PCNs)
3. Target placement of 22 CHNs covering all Ontario correctional facilities
4. Reach an estimated 300 clients per CHN annually (6,600+ clients province-wide)

PROGRAM DATA AT-A-GLANCE

May 2024 – March 2026

958
Total Applications Received

→ **343**
Clients Connected to CHNs

→ **40%**
Attached to Primary Care (Confirmed & Assumed)

→ **183**
Active Cases As of May 2026

Presenters
Shelley West: Central Community Health Centre
Adam Kelly-Colyer: Durham Community Health Centre

Central Community Health Centre

DURHAM COMMUNITY HEALTH CENTRE
Our Health. Our Community. Our Durham.

PARTNER ORGANIZATIONS

Provincial Collaboration & Governance

- Ministry of the Solicitor General
- Ministry of Health
- Indigenous Primary Health Care Council
- Alliance for Healthier Communities

Community Health Organizations

Thunder Bay:
Matawa Health Cooperative • Dilico Anishinabek Family Care • Anishnawbe Mushkiki

Kenora:
Waasegiizhig Nanaandawe'iyewigamig (WNHAC)

Durham:
Durham Community Health Centre

Toronto:
Black Creek CHC • Rexdale Community Health Centre

Guelph:
Guelph Community Health Centre

London:
Central Community Health Centre

Correctional Facility

Thunder Bay Jail Thunder • Bay Correctional Centre

Kenora Jail

Central East Correctional Centre

Toronto South Detention Centre

Maplehurst Correctional Complex

Elgin-Middlesex Detention Centre

Building pathways to health and community reintegration for justice-involved individuals across Ontario

A culturally appropriate, equity-focused intervention that improves health outcomes and reduces reliance on costly emergency services