Abstract

This thesis is a blend of social science methodology and legal interpretation aimed at investigating the quality of life of older Canadian federally incarcerated offenders and whether their rights are being respected. For this study I used social science empirical methodology to answer certain legal questions, such as: what are the needs of older male offenders and how are these needs influencing the exercise of their legal rights? Are institutions prepared to deal with the increased needs of older offenders? If no, is this an infringement of this group’s rights? Is the Canadian legal framework broad or specific enough to offer protection to the vulnerabilities of the older male prison population?

First, I was able to establish a set of acute and chronic needs that older male offenders have. Second, I encountered a series of legal, policy, and institutional limitations in responding to those needs. All these seem to show a diminished quality of life for older male offenders, a profound sense of dehumanization, an erosion of their community ties, and greater fears regarding their release.

Under such circumstances it seems sensible that the CSC approach towards older offenders needs to change. If such change does not come voluntarily, it is the duty of the courts to have a flexible and open-minded approach towards different actions that challenge the current prison regime. A number of legal actions based on statutory and constitutional norms are explored in this dissertation in an attempt to improve the protection of prisoners’ rights in light of the findings presented in this study. I conclude by making three sets of recommendations (legal, policy, and institutional) that could help align the treatment of older inmates with the Canadian societal values, as well as Canada’s international commitments.
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Statement of Originality

I hereby certify that all of the work described within this thesis is the original work of the author.
Any published (or unpublished) ideas and/or techniques from the work of others are fully
acknowledged in accordance with the standard referencing practices.

Adelina Iftene

August, 2015
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List of Abbreviations

AA Alcoholics Anonymous
Art. Article
CCRA Corrections and Conditional Release Act
CCRR Corrections and Conditional Release Regulation
CD Commissioner’s Directives
Charter Canadian Charter of Rights and Freedoms
CSC Correctional Service Canada
DNR Do-Not-Resuscitate Order
NA Narcotics Anonymous
PBC Parole Board Canada
OCI Office of the Correctional Investigator
OP Older Prisoner
S. Section
SHU Special Handling Unit
SOP Standing Operating Practice
UN United Nations
UNODOC United Nations Organization against Drugs and Organized Crime
WHO World Health Organization
Chapter 1

Introduction

I. Introduction

In the last decades there have been substantial discussions regarding the increased number of older citizens in North America, partly because of the aging of the baby boomers, and partly because of an increase in quality of life that results in people living longer. This issue has reverberated in a series of consequences that had to be taken into account for legal and policy reforms. The retiring age had to be pushed back or eliminated altogether, health care systems underwent reforms to adapt to enhanced geriatric demands, medical coverage has been improved to reflect the reality of the seniors’ challenges, insurance companies have dropped the upper age limit as increasing number of people surpassed their initial limit and were still active. Both in Canada and the US, a wave of cases based on age equality have been heard by courts, with different legal consequences.

In the last few years, the problems associated with aging have been noted in correctional environments. While in the US a number of studies have been conducted since the ‘90s,1 Canada has been slow in recognizing the problems associated with the aging of the prison population. A change of direction was noticeable 4 years ago at least at a theoretical level, when the Office of the Correctional Investigator published in its Annual

Report serious concerns regarding the needs and the treatment of older prisoners in Canadian Federal Corrections facilities. The Correctional Investigator continued to express these concerns in the years that followed, with a limited response from the Correctional Service Canada. The CSC published in 1998 the results of a brief study titled “Managing Older Offenders: Where Do We Stand.” This was more of a descriptive paper about programs rather than hard data on the actual problems. Recently, CSC has published a profile of older female offenders and one of male older offenders, mostly based on data from the Offender Management Database. The only study conducted in Canada outside the CSC that considered the problems of older offenders was finalized two decades ago. It was conducted with a small sample in BC.

Aside from the lack of substantial and up-to-date data on the needs, quality of life and treatment of older incarcerated offenders, there has also been a certain amount of indifference regarding this prison population among Canadian legal practitioners and scholars. This is somewhat unusual considering the concerns raised in the American

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literature, the reports of the OCI, and the solid human rights history that Canada has displayed in numerous other areas.

As a result, this study was designed to deal with two matters. First, the social and health sciences aspect was intended to bring the much needed hard data on the needs of older male offenders to the Canadian literature. Second, the legal part was meant to interpret the data on the Canadian prison law and human rights background in an attempt to find the support needed to drive reform in this correctional area. I begin my work from three premises:

1. Prisoners are sentenced to incarceration, not to physical or mental pain above what deprivation of freedom implies or to death. Maintaining some quality of life is important in order to preserve a fair punishment, which in fact gives legitimacy to the correctional system.

2. Prisoners must be treated in a way that supports rehabilitation and decreases disciplinary issues.

3. Considering the first two premises, a cost-benefit analyses should be employed by the federal government when creating the correctional budget.

The study is a broad, interview-based investigation into the quality of life of male offenders over the age 50. I have accepted this age as the threshold of seniority, based both on the Correctional Service Canada documents and the American literature. According to these reports, most offenders have the physical and psychiatric problems of people in the
community who are 10 to 15 years older. Potential causes of this difference are the rigors of incarceration and unhealthy previous lifestyles.\(^7\)

This dissertation is comprised of a theoretical, as well as an empirical part. The theoretical part is meant to offer the background on which the study was carried out. The second chapter will offer a legislative review intended to point out a set of norms, both international and Canadian, that should be applied in the context of older prisoners. Special focus will be given to human rights. This chapter will later be connected to the empirical part in an effort to show that appropriately meeting specific needs of older offenders is mandatory to avoid breaches of some currently existing norms such as the equivalence of care between prison and community, the right to be free from torture and inhumane treatment, the obligation of correctional staff to preserve the necessities of life, the right to a safe environment, and the right to be free from discrimination.

The third chapter is an overview of the federal correctional system in Canada. I will consider the organization, the basic rules on which it works, as well as the financial, logistic and organizational challenges that the CSC is currently facing. The older prisoners will be placed in the context of this system, as I will later show the difficulties the CSC might have in integrating this category of inmates and the institutional modifications that might be required in order to properly respond to this group’s needs.

Understanding the aging process is crucial to understating the needs of older offenders. To do so I looked at medical and social documents that review and explain the

situation of seniors in the community. This literature review sets seniors as a particular demographic group, with enhanced needs compared to the younger population. Hence a premise of my thesis is that the older prison population has at least the same issues as seniors in the community. Because this empirical study is not comparative, and does not provide data on younger prisoners, I will use this fourth chapter to explain that there are indeed numerous medical and social problems associated with aging. If demonstrated by this study, it is likely that they are typical or enhanced in the older segment of the prison population, just as they are in the community.

The fifth chapter is a systematic review of the existing literature regarding the elderly in prisons. I use this information to establish what is currently known about elderly prisoners in other jurisdictions, what are the questions that researchers have tried to answer and what are the specific needs that other researchers have determined. The literature has informed my choice of methodology for the study, and the questions chosen for my interview protocol. However, the literature is largely American. The reality of prison life in the US may be very different from that in Canada, and thus the American findings are not entirely translatable to Canada and will be used only as a starting point for this study. My findings are likely to be somewhat different from those found in similar studies by American researchers.

The sixth chapter is the description of the methodology I used to carry out the study, from the research questions and data collection to the data analysis. The actual findings are presented in the seventh chapter. This chapter has two parts. The first part is a presentation of the statistical findings. These are placed in the context of other similar studies presented in the literature. I will point out whether my data is consistent with the findings of
researchers in other countries. This will add a comparative dimension to the study for the purpose of emphasizing the specificity of the Canadian prison population and the need for tailored responses. The second part of the chapter is a description of the qualitative findings. In completing this part I rely on my own observations as well as the unquantifiable comments of the participants. I find that this portion brings a more humane dimension to the study. It gives a voice to a vulnerable and marginalized prison group and offers a contextual explanation for the numeric data. I used my observations to identify institutional particularities. This will enable me to make, at a later stage, institutional reform recommendations in addition to policy and legal ones. These are important because, as it will be shown, oftentimes the main issues do not necessarily reside within the framework, but rather within how this framework is being applied at an institutional level.

The eighth chapter is the interpretation of the findings. I will start with the concrete impact of the findings and work my way up to more abstract concepts. Thus, this part will assess the impact of the findings on institutions. In the second part I will review the legal impact of the findings. Some of the data points to potential human rights infringements and breaches of existing statutory norms in the treatment of older offenders. I will outline the most pressing issues, presenting some legal claims that could be made to protect this group’s rights and to produce an enhancement in their future treatment. The final part is a short reflection on the compatibility of some of the findings with the principles of imprisonment.

The ninth chapter will be comprised of a three-fold list of recommendations. Based on both the quantitative and qualitative findings, I will suggest institutional, policy, and
legal reforms that would align the correctional practices in this area of study to the constitutional values of Canada.

I will conclude the dissertation by reviewing these findings, and their impact, while urging policy makers and legislators to take action in order to first recognize older offenders as a vulnerable prison group in need of protection, and second, to promote a sensitive, humane, and rehabilitation-conducive approach towards older offenders. This is the only approach compatible with Canada’s claim of being a human rights supporter on the international stage.
Chapter 2
Legal Framework

Before looking into an analysis of the needs of older offenders, it is important to assess where the matter at issue is located in the international and national legal framework. The needs of vulnerable populations, such as those of incarcerated people, can very easily shift onto the side of human rights violations if these needs are not properly met. Human rights laws and other types of conventions or legislation are the legal expression of the protection given to individuals against different types of abuse. This is why we need to examine what legal materials are in force before assessing what the needs are, what institutions do and what institutional and policy reactions to those needs should be.

In this chapter, both international and Canadian materials will be presented. It is important to determine where Canada is placed on the international stage and if it fulfills the recommendations given by international bodies. Some regional documents, such as the European ones, will be briefly presented as a comparative point.

It is important to mention from the start that there is absolutely no international document, convention or declaration that focuses on older inmates. There are no regional documents from other jurisdictions and there are no Canadian laws, regulations, directives, operating standards or guidelines for this category of prisoners. Thus, in order to present their legal rights, I have read all the documents that may impact them and the following is a presentation of those pieces of legislation that can be applied to different issues older inmates may encounter (even if they are not made specifically for them). The documents selected refer to general human rights, rights of prisoners, rights of ill or disabled people (as many incarcerated elderly inmates have acute needs for medical care) and guidelines
for the protection of older prisoners in general. The Canadian legislation discussed consists of the most important legal pieces, such as the Constitutional ones, the Corrections and Conditional Release Act\(^8\) and Regulations,\(^9\) and Correctional Services Canada Commissioner’s directives related to issues that may impact elderly inmates.

2.1 International Materials: Conventions, Declarations, and Principles

There are a few types of international documents. First, there are documents created by two or more states, such as treaties and conventions. Such documents tend to create a direct obligation on the states that sign them. There are two international models for how an international document becomes binding law in a state. In countries adopting a monist model, a signed and ratified convention has the force of law automatically. In countries utilizing the dualist model, like Canada, ratification does not suffice. In order to be nationally applicable, a convention must be translated into the national legislation after ratification. Thus, in Canada, non-implemented international documents serve simply as interpretative tools in national courts. Regardless of the model, there is an obligation on the states to take whatever steps their law requires in order to implement the convention they internationally committed themselves to by signing it. When a dualist state fails to translate the treaty in its legislation, that document will not need to be applied in courts. However, that country will be in breach of an international obligation and it has political consequences.

Second, there are documents emanating from different institutions that countries may be members of, such as the UN General Assembly. These documents are merely

\(^8\) Corrections and Conditional Release Act, SC 1990, c 20 [CCRA].
\(^9\) Corrections and Conditional Release Regulations, SOR/92-620 [CCRR].
declarative. Hence, they do not impose any obligations on the member states to the institution from where they emanate, even though countries may choose to implement them in national legislation. Such declarative documents have a symbolic value. They may be used as guidelines and interpretative tools by national courts.10

For the purpose of this thesis I will refer to “binding documents” when discussing conventions that raise an obligation on the signatory states, even if they are not applied in courts because they have not been translated into the national legislation yet. I will refer to “non-binding documents” to talk about mere declarative instruments such as Declarations and Principles. Finally, when talking about documents that need to be applied in Canadian courts I will refer to “implemented international documents.”

The international documents presented are important because they express the view international community has regarding inmates and describe the minimal protection each state should offer to its prisoners. Canada is signatory to the majority of the conventions that will be presented and has ratified a large part of them. It is also a member of all the bodies from which the non-binding documents presented below emanate. However, as mentioned, on the dualist model Canada follows, in order to produce national effects, the document needs to be enacted as a Canadian law. For example, the Universal Declaration of Human Rights11 is not binding due to signature and ratification. Its principles are compulsory however because they have been translated into Canadian legislation under the

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10 For a description of different international documents and the process of implementation see e.g. Malcolm B. Shaw, *International Law*, 7th ed (New York: Cambridge University Press, 2009) at 902 – 953.
11 *Universal Declaration of Human Rights*, GA Res 217 (III), UNGAOR, 3rd session, Supp no 13, UN Doc A/810 (1948) [*UDHR*].
form of the Canadian Bill of Rights\textsuperscript{12} and the Canadian Charter of Rights and Freedoms.\textsuperscript{13} Nevertheless, states have the obligation to implement the conventions they have signed, sooner or later, so these are likely to exist in Canadian legislation under one form or another. Other documents are adopted by the UN General Assembly and they are not conventions. As a result, they are mostly directive guidelines and are generally not enacted in domestic legislation. Thus, these documents represent minimum standards that should be implemented.

The Universal Declaration of Human Rights\textsuperscript{14} is a stepping stone for the recognition of individual rights on the international stage. Though not a binding convention, the declaration’s principles have been enacted worldwide, on both national and regional stages. They are just general principles and the concrete content of protection is given in national legislation. In Canada, it found its expression in the Constitution Act, Charter of Rights and Freedoms and before that, in the Canadian Bill of Rights.

The principles are not expressly made for prisoners, but they recognize certain inalienable rights that apply to all people. Article 3 grants everyone the right to life, liberty and security of person. Article 5 prohibits torture or cruel, inhuman and unusual punishment. Article 6 gives everyone recognition as a person before the law. Moreover, art. 25 affirms that everyone has the right to an adequate standard of living and well-being, including food, clothing, housing and medical care, and social services and security in cases of sickness, disability, old age and other lack of livelihood beyond his control.

\textsuperscript{12} Bill of Rights Canadian Bill of Rights, RSC 1960, App III [Bill].
\textsuperscript{13} Canadian Charter of Rights and Freedoms Canada Act, Part I of the Constitution Act, 1982 being Schedule B to the Canada Act 1982 (UK), 1982, c 11 [Charter].
\textsuperscript{14} UDHR, supra note 11.
The International Covenant on Economic, Social and Cultural Rights\textsuperscript{15} entered into force in 1975. Article 11 of the Covenant, article 25 of the UDHR regarding the right to an adequate standard of living. Through article 11, the state parties recognize the right of everyone to the highest attainable standard of physical and mental health. The States commit themselves to taking steps towards the creation of conditions which would assure medical services and medical attention to all in the event of sickness.

Canada is also a state party of the International Covenant on Civil and Political Rights.\textsuperscript{16} Article 6 recognized the inherent right to life of every human being. Article 7 guarantees that no person should be subjected to torture or cruel, inhuman and degrading treatment or punishment. Article 26 protects against discrimination and states that all persons are equal before the law without any consideration of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

The principles from the two covenants are very similar to the principles stated in the Universal Declaration. This is explained by the fact that the conventions, unlike the Declaration, have a binding force over states to implement the principles in the national legislation. Canada has done that mainly through its Charter.

The Standard Minimum Rules for the Treatment of Prisoners\textsuperscript{17} is not a treaty, and thus it does not create an obligation upon states to enact the principles in their legislation. These are mostly guidelines on the treatment of prisoners. The standards cover all areas of life in prison in an attempt to regulate it in a minimum way. A few of them can be directly

\textsuperscript{15} International Covenant on Economic, Social and Cultural Rights, 16 December 1966, 993 UNTS (entered into force 1 March 1976, accession by Canada 19 August 1976) [ICESC].
\textsuperscript{16} International Covenant on Civil and Political Rights, 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976, accession by Canada 19 May 1976) [ICCPR].
\textsuperscript{17} Standard Minimum Rules for the Treatment of Prisoners, ESC, Res 663 C (XXIV) 1957 and 2076 (LXII) 1977 [UNSMR].
applied to older inmates, considering the potential difficulties they may have in adapting to life in prison, compared to the younger offenders. To begin with, standard 6 affirms that these principles apply to all prisoners, without discrimination of any sort. Standard 12 states that the sanitary installations must be adequate to enable every person to use them. Standard 13 requires that bathing and shower installations be adequate to allow their use to any person. It is clear that institutions must take into consideration the special needs of prisoners. The medical service chapter sets up a minimum of what each institution must offer. Thus, at least one qualified medical officer must have psychiatric knowledge. The medical services must be organized in close relationship to the general health administration of the community or nation (s. 22). The medical officer must examine as soon as possible each inmate after intake with a particular view to the discovery of physical or mental illness and the taking of all necessary measures. He or she must determine the physical and mental defects that might hamper rehabilitation and the physical capacity of each prisoner to work (s. 24). The medical officer must see all sick people daily, and all who complain of illness (s. 25). Standard 32 requires that prisoners must be physically and mentally fit for the disciplinary punishments that are inflicted upon them. The treatment in prison must be directed towards transforming the prisoners into law-abiding citizens after release and encouraging their self-respect and sense of responsibility (s. 65). Standard 71 requires that all prisoners will work according to their physical and mental fitness levels as established by the physician. As well, vocational training will be provided to prisoners. Recreational and cultural activities must be offered in order to enhance the mental and physical health of prisoners (s. 78). The institution has an obligation to maintain and improve the relationships between a prisoner and his family for the best interest of both (s.
79). Institutions must also help the offender to develop relations with agencies that can help him post-release (s 80). In regard to mental health, standard 82 states that insane people are not fit to be incarcerated and they must be moved to a psychiatric facility. Any sort of mental disorder must be observed and treated in specialized institutions. Also, steps must be taken to ensure that psychiatric treatment be continued after release (s 83).

The Code of Conduct for Law Enforcement Officials is also a set of principles, non-binding, adopted by the UN General Assembly in an attempt to enhance proper training for law enforcement officers. Article 5 forbids officers to inflict, instigate or tolerate any act of torture or cruel, inhuman or degrading treatment or punishment, or to invoke superior orders or exceptional circumstances to justify such an act. Article 6 makes it the responsibility of law enforcement officials to ensure the full protection of the health of persons in their custody, and to take immediate action to secure medical attention whenever required.

Another set of principles for the conduct of correctional staff is “Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.” This 1982 document acknowledges the importance of medical staff in ensuring the well-being of incarcerated people and the fact that, certain intentional medical acts, medical neglect or even an inappropriate standard of care can easily transform a sentence into cruel, inhuman or degrading punishment. Thus,

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19 Principles of Medical Ethics Relevant to the Role of Health Personnel, particularly Physicians in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, GA, Res 37.194, 1982 [Principles of Medical Ethics].
Principle 1 states that medical personnel have the duty to provide prisoners with protection for their physical and mental health and treatment of disease that is of the same quality and standard as that afforded to those who are not incarcerated. Principle 2 also states that it is an offence for medical personnel to engage, actively or passively, in acts that constitute participation, complicity, incitement or attempts to commit torture or cruel, inhuman or degrading treatment or punishment.

An important document to which Canada is a state party is the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.\(^{20}\) As mentioned before, certain actions or inactions can very easily burden the punishment of an individual to a degree where it can become inhuman or unusual or degrading. It is why article 10 requires that training on the prohibition and content of torture be given to law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in custody, or another form of arrest, detention or imprisonment. As well, article 11 demands that each state party keeps under review arrangements for the custody and treatment of persons subjected to any form of arrest, detention or imprisonment in order to prevent any possible forms of torture.

Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment\(^{21}\) is a non-binding UN set of principles intended to encourage a fair treatment towards prisoners. The first principle declares that all people in detention or imprisonment be treated humanely and with respect for their inherent dignity. Principle 6

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\(^{20}\) *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 10 December 1984, 1465 UNTS (entered into force 26 June 1987, ratification by Canada 24 July 1987) [*Convention against Torture*].

\(^{21}\) *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*, GA, Res. 43/173, 1988 [*Body of Principles*].
expressly states that incarcerated people cannot be subjected to torture or to cruel, inhuman or degrading treatment or punishment and no circumstances can justify this type of action. Principle 15 requires that communication between a prisoner and the outside world may not be interrupted for more than a matter of days. Principle 24 reiterated that all prisoners must be medically assessed immediately after intake and treatment must be granted, free of charge, where needed.

The adoption of a new document, Basic Principles for the Treatment of Prisoners in 1990 is proof of the extent of the concern the UN has for the prisoners’ well-being and the fact that improper treatment for this category of people is identified as a particular issue. The first two principles reiterate the need to treat every prisoner according to their inherent dignity and the fact that no discrimination is permitted. As well, for the first time it is specifically acknowledged that aside from those limitations required by incarceration, all human rights set out in the Universal Declaration of Human Rights, and the two International Covenants are retained by prisoners (principle 5). Principle 6 states that all prisoners have the right to take part in educational and cultural activities at the best of their capacity. Principle 8 says that conditions should be created to allow all prisoners to undertake meaningful remunerated employment. Principle 9 requires that prisoners have access to the health services available in the community without discrimination on the grounds of their legal status. The document ends with principle 11, which demands that these principles be applied impartially.

In 1990 the UN General Assembly designated the 1st October as the “International Day of Older People.” In 1991 it adopted the “United Nations Principles for Older

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People.”23 This is not a binding convention, but rather a set of guidelines for the protection of the elderly. Even though this document does not mention incarcerated people, the principles are phrased in general terms and they apply to every type of senior. According to this document, older people need to have access to social and legal services, protection and care (principle 12). They should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment (p. 13). Seniors need to live in dignity and security and to be free from exploitation and physical and mental abuse (p. 17). As well, seniors should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status (p. 18).

“Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care”24 is not directly oriented towards prisoners. However, principle 20 states clearly that these principles apply to incarcerated people who are deemed to have a mental condition. It mentions that the principles should be applied to them to the fullest extent possible, only with such limitation as necessary in the circumstances. Thus, considering the sizeable proportion of prisoners with mental illnesses, especially older prisoners, this body is very relevant to the present discussion. The document states in its first principle that all people have the right to the best available mental health care, which shall be part of the health and social care system. As well, increased protection is owed to mentally ill people against economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment. Principle 9 demands that mentally ill people be treated in the least restrictive environment and with the least intrusive treatment. The

treatment of every such individual should be based upon an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff. It is very important that the treatment of every person must be directed towards preserving and enhancing personal autonomy.

Of similar value, but this time binding, is the “Convention on the Rights of Persons with Disabilities.” This Convention was ratified by Canada in 2010. Article 4 requires that people with disabilities receive all the support they need for exercising their legal capacity, and to which they are fully entitled. Article 13 makes direct reference to offenders. It states the need to ensure access to justice for such people and appropriate training for police and prison staff in order to effectively work with disabled persons. As well, article 15 requires that states take all appropriate measures to ensure that people with disabilities are not subjected to torture or cruel, inhuman or degrading treatment or punishment. Article 25 acknowledges the right of persons with disabilities to the highest standard of health care attainable without discrimination on the basis of disability. The states have to guarantee the same range, quality and standard of free or affordable health care and programs for individuals with disabilities as they do for other persons.

Aside from the UN documents, there are other associations that have adopted different relevant declarations. In 1979, the International Council of Prison Medical Services adopted the Oath of Athens (Prison Health Care Practitioners). Through this declaration, medical practitioners representing countries across the globe are committing

themselves to provide the best health care possible to those incarcerated for whatever reasons, without prejudice and within their respective professional ethics. They should never lose sight of the fact that the person they are treating is, for them, a patient rather than a prisoner. Thus, they must seek patient consent before performing medical treatment.

Adopted in 1983 and revised in 2006, the World Medical Association Declaration on Terminal Illnesses\(^\text{27}\) states that the duty of any physician is to heal, to relieve suffering and to protect the best interest of their patients. There are no exceptions to these principles. Also, it declares that in terminal cases, the primary responsibility of the physician is to assist the patient in maintaining an optimal quality of life through symptom control and addressing psychosocial needs, and to enable the patient to die with dignity and in comfort. Physicians should inform patients about the availability, benefits and potential effects of palliative care. This document is important to prisoners, because together with an increase in the graying of the prison population, there is an increase in the number of people who reach terminal phases of illnesses and die in prison.

2.2 Canadian Materials: Legislation, Internal Documents, and Case-Law

In Canada, the Constitution, which includes the Charter of Rights, is the supreme law. All other legal and administrative documents need to be in accordance with it. Statutes are used to regulate different areas of law. Statutes may be federal or provincial depending on who exercises jurisdiction over a certain domain. Statutes are legal documents and they are binding. That means that they can be enforced in a court of law. Because Canada is a common law country, court decisions are also part of the law. They are binding on lower

\(^{27}\)World Medical Association Declaration on Terminal Illnesses, reviewed WMA GA, Pilanesberg, South Africa, October 2006 [WMA Declaration].
courts than the ones from which they emanated. Finally there are administrative documents, such as institutional directives and rules. These cannot be enforced by a court, but they are mandatory in that they need to be respected in the institution from which they emanate.28

Canadian policies in regard to prisoners, rights, and health are regulated through federal and provincial legislation, as well as directives of the CSC, standing operative procedures, guidelines and institutional regulations. CSC runs federal institutions, so the materials that apply to corrections are either federal or administrative originating from either Parliament or the CSC. However, there are areas, such as health care, where provincial legislation may apply. In this case the CSC’s health care system must be in accordance with provincial health law in regard to standards and procedures.

The first effort to translate human rights into domestic legislation was the Canadian Bill of Rights.29 This is a federal law that provided interpretative tools to all federal legislation in an attempt to have human rights influence statutory interpretation. Its principles are still of importance and can apply to prisoners, since the Corrections and Conditional Release Act is a federal statute. The first article declares the right of any individual to life, liberty and security of person, as well as equality before the law and the protection of law.

Though still in force today, the application of the bill has been limited. It was eclipsed by the coming into force of the Charter of Rights and Freedoms in 1982, which

28 What constitutes law in Canada and what the force of law is, has been examined by the Supreme Court of Canada in Martineau v. Matsqui Disciplinary Bd, [1980] 1 SCR 602.
29 Bill, supra note 12.
was extended as part of the Constitution Act.\textsuperscript{30} This a broader document, covering more rights, and it has constitutional status. The Charter is part of the supreme law in Canada, governing all federal and provincial legislation. Section 7 reiterates article one from the Bill of Rights, acknowledging everyone’s right to life, liberty and security of person. Section 12 acknowledges the right of any person to be free from cruel and unusual treatment or punishment. Section 15 recognizes that everyone is equal before the law, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The Corrections and Conditional Release Act\textsuperscript{31} is the federal legislation that regulates federal penitentiaries. It is the legal framework for the CSC. The Act is accompanied by the Corrections and Conditional Release Regulations. Proclaimed into force in 1992, the CCRA replaced the Penitentiary Act and the Parole Act. The whole act is relevant to the present dissertation, constituting the basic structure within which the discussion takes place. As well, subsidiary documents like the directives and institutional rules have to be in accordance not only with the Constitution but also with this act.

The CCRA defines the purpose of incarceration in the federal system.

3. The purpose of the federal correctional system is to contribute to the maintenance of a just, peaceful and safe society by

(a) carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders; and

(b) assisting the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of programs in penitentiaries and in the community.

\textsuperscript{30}Charter, supra note 13.
\textsuperscript{31}CCRA, supra note 8.
These are the stated goals of the federal correctional system, and its success should be measured by the extent of efficiency with which it attains these goals.

Section 4 (h) states that the correctional policies, programs and practices respect gender, ethnic, cultural and linguistic differences and be responsive to special needs of women and aboriginal peoples, as well as to the needs of other groups of offenders with special requirements. Section 70 states that CSC must take reasonable steps to ensure that the prison environment, living and working conditions are safe, healthful and free of practices that undermine a person’s reintegration into the community. Section 76 directs the Service to provide a range of programs designed to address the needs of offenders and contribute to their successful reintegration into the community.

Though not directly mentioning seniors, the health care section of the CCRA is especially important since seniors are likely the ones with the most health care needs both in prisons and outside. Health care means medical care, dental care and mental health care provided by health care professionals. Mental health care means the care of a disorder of thought, mood, perception, orientation, or memory that significantly impairs judgment, behavior, and the capacity to recognize reality or the ability to meet the ordinary demands of life (s. 85). According to s. 86 the Service is under the obligation to provide every inmate with essential health care, and reasonable access to non-essential health care. As well, the provision of health care shall conform to the professionally accepted standards. Unfortunately the act does not clarify what “essential health care” means, a gap which opens the door to much debate around how CSC should fulfill its medical duties towards prisoners. In addition, s. 87 requires that the health condition of a person be taken into
consideration for all decisions related to transfer, placement, administrative segregation and disciplinary matters, release and supervision. It must also be considered for temporary absence, work release or parole (s. 88.3). Sections 88.1 and 88.2 are concerned with the obligation to obtain an informed consent before a treatment is applied to prisoners.

The Corrections and Conditional Release Regulations\textsuperscript{32} also have provisions related to special needs populations. Section 17 requires that the security classification process take into consideration any physical or mental illness or disorder suffered by the inmate. Section 88 states that CSC shall ensure that an inmate unable to read or write would be able to prepare his correspondence and read it in the official language of the inmate’s choice or, where practicable, in another language of the inmate’s choice.

Because criminal law is a federal matter, the Criminal Code\textsuperscript{33} is a federal act. It applies to acts that can be considered offences. The correctional staff can be held criminally responsible if not properly fulfilling certain duties. Article 215 (C) states that everyone is under the legal duty to provide the necessaries of life to a person under his charge if that person (i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and (ii) is unable to provide himself with the necessaries of life. Paragraph 2 of the same article states that an offence has been committed, if by failing to perform this duty, the life of the person to whom the duty is owed is endangered or causes or is likely to cause the health of that person to be injured permanently. What “necessaries of life” mean, in order to avoid a threat to life or health, should depend upon age and state of health.

\textsuperscript{32} CCRR, supra note 9.
\textsuperscript{33} Criminal Code, RS C 1985, c C-46 [CC].
Medical and correctional personnel also fall under the duty stated in s. 216 of the criminal code. Thus, everyone who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and use reasonable knowledge, skill, and care in so doing. This may very well apply not only to medical acts, but also to the use of force, restraints, and disciplinary punishments.

In regard to health, there is only one federal act, Canada Health Act,34 because this domain falls under provincial jurisdiction. This act does not really apply to treatment procedures, but authorizes the federal government to give grants to provinces which meet certain eligibility criteria spelled out in the act. These criteria are important however, as they are standards the provinces need to meet in order to obtain funds. Nevertheless, the health care domain is the attribute of provinces and it is regulated by provincial statutes and regulations. The treatment in prisons must attain professional acceptable standards, which are elaborated in the provincial health care legislation, such as Hospital Acts, Mental Health Acts and Health Professions Acts.35

The CSC also has sets of internal directives, procedures and guidelines. The CSC Commissioner has the authority to establish directives (CD) which are mandatory to the activity of all institutions run by the CSC. The Standing Operating Practices (SOP) set up procedures that regulate certain domains already covered by directives in general lines.

34 Canada Health Act, RSC 1985, c C-6.
35 See e.g. Hospital Act, SNB 1992, c H-6.1; Health Authorities Act, SNS 2000, c 6; Health Act, RSY 2002, c 106; Health Professions Act, RSBC 1996, c 183; The Regulated Health Professions Act, CCSM 2009, c R117; Mental Health Act, RSA 2000, c M-13; Mental Health Care and Treatment Act, SNL 2006, c M-9.1; Mental Health Act, RSO 1990, c M7.
They are also of general application, to all institutions. Both the CDs and the SOPs must conform to the Constitution and other legislation in force.

Similar to the legislative situation, there are no CSC regulating documents for older offenders. However, there are other directives and procedures that intersect this issue and can be of use for setting standards for this category of inmates.

CD 800\(^{36}\) concerns Health Services and it is the main regulatory document regarding all types of medical physical health care services within the CSC, including services for illnesses mainly found in aging populations, such as terminal or chronic diseases. The focus of corrections health services is promotion and prevention. The act stipulates that each inmate is entitled to screening, referral and treatment services, emergency health care, mental health care (acute and long term), acute dental care, and reasonable access to other health services. Essential health care is guaranteed. However a proper definition of what is essential health care is not provided. Requests from institutional physician for un-essential treatment will be granted at the expense of the inmate, which must cover both consultation and escort. Upon intake, each inmate must be screened within the first 24 hours for communicable conditions, acute, mental and dental conditions, and conditions requiring continuing treatment, as well as potential activity limitations. The findings must determine treatment, hospitalization, special housing and program placement. The document also covers aspects regarding prostheses and appliances. Medical removable dental and optometric prostheses and appliances, if essential, will be provided to the inmate. The need for artificial devices is determined by

the physician, dentist or optometrist. Repair and replacement of such devices is covered if they occur due to the normal wear and tear. If they occur as a result of negligence, the expenses will be covered by the inmate.

The terminal or chronic illnesses provisions refer only to parole eligibility. As such, CSC will consult with the Parole Board to determine the possibility of early parole if the illness an inmate is suffering from is irreversible, leaves residual disability, causes non-reversible pathological alteration and requires a long period of supervision, observation, or care. However, according to the CCRA, early parole on account of illness is limited to non-life sentences.37

Remaining in the area of health care, CD 80338 regulates aspects related to the consent to treatment. It demands that the inmate must consent to all medical procedures, all mental health procedures, including assessments and treatment. The consent must be voluntary, informed and specific. Only risk assessments can be done without consent, based on existing information. As well, if the inmate meets the criteria for involuntary treatment under provincial legislation, this will be administered accordingly. The clinician is the one to determine if the inmate is competent to consent. If she is, she can refuse treatment even if this endangers her life.

CD 80539 concerns the administration of medication in prison. The Regional Administration for prison health services needs to work with the Regional Pharmacy and Therapeutics Services for all pharmaceuticals. As a result, they decide, among other things,
which drugs are appropriate for use in prison and in what amount. An inmate will be given the available medication only if prescribed by a clinician. The institutional pharmaceutical process is monitored by the Institutional Chief of Health Services. Once prescribed by a clinician, the medication is delivered by non-medical staff, after verification by the nursing staff. At pre-established hours, the inmate presents himself to the appointed staff member and self-administers the medication.

CD 821\textsuperscript{40} covers the management of infectious diseases in federal prisons. Each inmate must be screened upon intake through questionnaires and tests. Tests are not mandatory but must be offered, as well as pre and post-test counseling. Immunization has to be available in accordance with the Canadian Immunization Guide. Sick inmates live among the general population unless they need special care. Whatever the case, they must be offered work and program opportunities, as well as counseling and support services. The pre-release planning for these people must include information and relevant contacts in the community.

An extremely important area of health care is medical records. Considering that prisoners enter and leave an institution, and often go through several transfers during their incarceration period, it is very important that there is continuity of health care. This is the case especially for people with chronic and mental health diseases, and these categories include the majority of older prisoners. Consistent health care can be offered only if medical records are complete and available in a timely manner to the medical staff.

attending the inmate. Thus, CD 835\textsuperscript{41} requires that medical records are consistent, confidential and managed by health care staff. They are not part of the confinement record. An inmate can have two medical records – one is the institutional health care record that moves with the prisoner wherever he is transferred, and the other is the Regional Psychiatric Centre Record which stays there. Every interaction with a health care staff member should be noted in the medical record.

The psychological service is of extreme importance for all prisoners. It is regulated by CD 840.\textsuperscript{42} According to it, psychological service should include: assessment, therapeutic intervention, crisis intervention, and program development, delivery and evaluation. All these must be delivered at the same standard as in the community. The focus of the service is on the needs, the risk assessment and the management of the mental health issues. The psychologist is a member in the unit-based multi-disciplinary team responsible for the case management of the offender.

Psychological assessment will be done upon intake and re-done during treatment. The psychologist should also do referrals, pre-release assessments, evaluation of risk level, and recommendations for continuing care. The therapeutic interventions should be focused on behavior directly related to criminality and essential mental health needs. The aim is to reduce symptoms, acquire skills, identify high risk situations, create viable coping strategies, and prevent relapse. The reports made by CSC psychologists are the property of


CSC but the information contained in them can be disclosed only with the consent of the individual.

A more recent and comprehensive document regulating mental health services is CD 850. The directive states that the mental health team must be composed of a psychologist, a nurse, a case management officer, a psychiatrist (when necessary) and appropriate ad-hoc members. The functions of this team are to identify the needs and service requirements of the prisoner, to prioritize the mental health services, and to monitor and document the progress of individual inmates at least once a month. For each of these assessments, consent is needed. The services and programs offered are on a continuum of essential care including assessment and diagnostic, as well as treatment for acute, sub-acute or chronic mental disorder in the appropriate facility. CSC has three types of facilities where it can offer these services: Regional Psychiatric Centres, Regional Treatment Centres, and Regional Mental Health Units. They are all responsible for planning and implementing essential mental health care services. As well, appropriate referrals need to be made to community agencies.

In the context of an increased number of tragic suicide cases within corrections, a recent directive, CD 843, deals with the management of self-injurious and suicidal behavior. Suicide risk assessments need to be done within the first 24 hours after intake, and upon admission to administrative segregation. They must be done by trained non-medical staff, when professionals are not available. For regular suicide watch, the inmate

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is placed in a watch cell. He will be assessed within the first 24 hours, and be visited by a nurse as in administrative segregation. The nurse will consult the psychiatrist or physician for a review after 24 hours. For high suicide watch, where there is an imminent risk, the observation must be direct, not via camera. In modified suicide watch, where the risk has decreased, the observation can be done via cameras. Even after removed from a suicide watch, the inmate must be monitored. The monitoring can be reduced and discontinued only when approved by a professional.

Because many seniors are in need of special diets, the Food Services directive has great impact on their well-being. Thus, the directive states that medical diets must be provided for those who need them as part of a therapeutic regime approved by the head of the institution, in response to a clear and defined diagnosis.

CD 880 is implemented by two Standing Operating Practices, SOP 880-1 and SOP 880-2. SOP 880-1 reiterates that medical diets must be authorized by the institutional physician or recommended by the institutional dietician. They are granted only on the bases of tests or exams. Every therapeutic diet has an expiry and reassessment date. At the expiry date, the diets are automatically discontinued. The inmate is responsible for contacting health services to request a renewal. For minimum security prisons, SOP 880-2 applies the meal preparation in small groups. If an inmate in this situation was prescribed a therapeutic diet, in his house there will be the specific ingredients, or the inmate will be

allowed to buy the type of food he needs. However, the prisoner is responsible for adhering to the requirements of his therapeutic diet.

Aside from these CDs and SOPs, there are other directives that have an impact on older inmates’ needs. CD 085\(^{48}\) states that inmates unable to read or write are entitled to assistance in preparing and reading correspondence. CD 300\(^{49}\) requires that the institutional heads ensure facilities are appropriately accessible to persons with disabilities. In the domain of education and programming, elaborate directives are needed. As it will be later discussed, many seniors are excluded from programs due to their age, in favour of younger offenders with more rehabilitative potential. CD 720\(^{50}\) states that the Adult Basic Education should be a priority and shall be available at all institutions. All educational programs should be available on a 12-month basis. Moreover, CD 730\(^{51}\) states that the institutional head shall provide for a range of programs suitable to the identified needs of the inmate population and the operational requirements of the institution.

To enforce the policies described above, institutions also have a set of regulating documents that apply only at the level of that facility. They generally take the form of Standing Orders, Post Orders, Institutional Operating Procedures, and Medical Physicians’ Standing Orders/Standing Health Services Clinical Orders. Common subjects of these orders are the administration of methadone and the prevention of suicide and self-inflicted


injuries. These regulations need to be in accordance not only with the legislation, but also with the CSC national directives and procedures.\(^{52}\)

2.3 European Principles for Prisoners

In the past decades, Europe has become increasingly known for the strict obligations the Council of Europe and the European Court of Human Rights have imposed upon states. The European system of human rights is considered one of the most efficient in the world, and the first to develop an international court of human rights where individuals can directly claim their rights against states. This is why I have chosen to give a few examples from the European framework that are applied to protect prisoners and to meet their needs. It must, however, be remarked that Europe does not have a document dedicated specifically to older prisoners.

At the heart of the European system lies the European Convention of Human Rights.\(^{53}\) Like the international document presented and the Canadian Charter, in art. 3 the ECHR states that all prisoners must be free from torture and inhuman or degrading treatment or punishment. However, unlike Canada the European jurisprudence has developed a number of decisions in which the meaning of this article has been elaborated. Thus, it is clear that failing to take into consideration the needs of prisoners due to age or illness, whether it is health care, living conditions or general regime, can easily amount to inhuman or degrading treatment, and thus, constitute a violation of art. 3 of the Convention.


The court stated two decades ago that elements such as sex, age and health condition are the most important in determining if degrading or cruel treatment was inflicted. This is to be determined on a case-by-case basis.\textsuperscript{54} In 2001 the court decided that every person with a physical handicap needed to be provided with facilities to assist them along lines similar to those in the outside world. In this case, even the use of a toilet was very challenging due to the lack of appropriate facilities. The Court held that even if there was no intention to humiliate the person, the failure of the prison to consider such special needs amounted to degrading treatment in the sense of art. 3.\textsuperscript{55} In the case of a terminally ill prisoner,\textsuperscript{56} the Court decided that his health state was incompatible with detention. He had advanced leukemia and the treatment needed could not be done in prison. He was only granted chemotherapy, and during those sessions he was handcuffed. The Court considered that this regime was a violation of art. 3, amounting to cruel and degrading treatment. In the case of a 75 year-old prisoner who underwent spinal surgery, the Court considered that handcuffing him to the bed post-operatively amounted to a violation of art. 3. Due to his age and health status he was not a threat and the security measures were cruel.\textsuperscript{57} In another case, the court stated that keeping an 83 year old, physically handicapped person who cannot perform most of the daily routines without any help in prison, is cruel and humiliating. The offender was convicted for crimes against humanity, but the Court believed that his health was incompatible with prison since the institution was unable to meet his needs, both medical and of daily living. Thus a violation of art. 3 occurred.\textsuperscript{58}

\textsuperscript{54} B v France, (1992), A232-C, ECHR [B].
\textsuperscript{55} Prince v the United Kingdom, No 33394/96, judgment of 07/10/2001 (ECHR).
\textsuperscript{56} Mouisel v France, No 67263/01, judgment of 11/14/2002 (ECHR) [Mouisel].
\textsuperscript{57} Henaf v France, No 65436/01, judgment of 11/27/2003 (ECHR) [Henaf].
\textsuperscript{58} Farbthus v Latvia, No 4672/02, judgment of 12/02/2004 [Farbthus].
In 1973 the Committee of Ministers of the Council of Europe adopted the European Standard Minimum Rules for the Treatment of Prisoners,\(^{59}\) which was constructed on the model of the UN ones. They are however more elaborate; the standards are reviewed regularly and enriched with new ones drawn from the Committee for the Prevention of Torture (CPT)’s annual reports. For example, regarding the problem of long-term offenders, the CPT acknowledges the disastrous effects imprisonment can have on these individuals. Thus, it stated that there is a special need to offer these people a wide range of purposeful activities, regardless of their age (work, education, sport, and recreation/association). They should be able to exercise a degree of choice in how they spend their time in order to enhance autonomy. Of extreme importance for people with long sentences are an individualized custody plan, appropriate psycho-social support and contact with the outside world.

In 1987 the Committee of Ministers adopted a new set of European Prison Rules. The revised rules were adopted in 2006 and they were significantly expanded in the health care sector. The rules, even more than the standards, regulate every aspect of prison life in order to bring respect for prisoners’ needs and rights to all European states. The rules, like the standards, are guidelines, they are not mandatory \textit{per se}. However, the European Court defers to both the rules and standards assessing cases, and in numerous situations it has based its findings of rights violations on the state’s disregard for the Prison Rules or Minimum Standards. The decisions of the Court are binding. Thus, indirectly, the European Prison Rules and the Minimum Standards are \textit{de facto} binding as well.

\(^{59}\) Council of Europe, Committee of Ministers, \textit{Recommendation Rec (06) 2 European Prison Rules}, (2006) [\textit{Rec (06)2}].
Though not referring directly to older prisoners, there are several sections in the European Prison Rules that are particularly relevant for this category of inmates. Every institution must have adequate facilities to permit each inmate to bath or shower daily, or at minimum twice a week (19.4). As well, prisoners must receive diets that are in accordance with their age, health, physical condition, religion, culture and nature of their work (22.1). The regime offered to each prisoner must be a balanced program of activities (25.1). Prison authorities shall make arrangements to organize special activities for those prisoners who need them (27.5). Every prison shall provide all prisoners with access to educational programs which are as comprehensive as possible and which meet their individual needs while taking into account their aspirations (28.1).

The health section is more expanded than in previous documents. The prison authorities must safeguard the health of the people in their care (39). Medical service should be organized in close relation with the health administration in the community or nation. Health policy in prison shall be integrated into and compatible with the national health policy. Prisoners shall have access to the health services available in the community without discrimination on the grounds of their legal status. Medical services in prison shall seek to detect and treat physical or mental illnesses or defects from which the prisoners suffer. All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner for that purpose (40.1 – 40.5). The medical practitioner examining the prisoner must diagnose physical or mental illnesses and take all steps necessary for treatment and for the continuation of existing medical treatment. She must identify any psychological or other stress brought on by the fact of deprivation of liberty. She must also determine the fitness of each prisoner to work and to exercise
The medical practitioner must report to the director whenever it is considered that a prisoner’s physical or mental health is being put seriously at risk by continued imprisonment or by any condition of imprisonment, including conditions of solitary confinement (43.3). All prisoners must be seen and treated under the conditions and with a frequency consistent with health care in the community (43.1). In regard to mental health, the document requires that the prison medical service provide for the psychiatric treatment of all prisoners who are in need of such treatment and pay special attention to suicide prevention (47.2).

The safety sections are very important. Many times elderly prisoners refuse to participate because they fear their younger peers. They live a life of anxiety and isolation due to the fact that they are prime targets for victimization. The rules state that procedures shall be in place to ensure the safety of prisoners, prison staff and all visitors and to reduce to minimum the risk of violence and other events that might threaten safety (52.2). As well, every effort shall be made to allow prisoners to take full part in daily activities in safety (52.3). National health and safety laws shall be observed in prison (52.5).

Finally, prison work is regarded as public service. Prisons shall be managed within an ethical context which recognizes the obligation to treat all prisoners with humanity and with respect for the inherent dignity of the human person (72.1). It is important to note that the duties of staff go beyond those of mere guards and shall take into account the need to facilitate the reintegration of prisoners into society after their sentence has been completed through a program of positive care and assistance (72.3).
A relevant recommendation made by the Committee of Ministers refers to long-term offenders. These are the prisoners that grow old in prison and struggle with the effects of aging behind bars. Similar to the provision of the European Standard Minimum Rules, this resolution emphasizes the importance of granting appropriate work, remuneration, access and encouragement to participate in all activities, and contact with the outside world, to these prisoners. In addition, it states that proper training is needed for staff working with this category of prisoners. They have special problems and the staff should ensure a deeper understanding, personal contact and continuity in the treatment of prisoners. Studies by multi-disciplinary teams should be promoted, in order to establish the effects of long-term sentences on the prisoner’s personality. Also, steps should be taken to ensure a better understanding by the general public of the special problems of long-term prisoners, thereby creating a social climate favorable to their rehabilitation.

A recommendation of the Council of Europe makes direct reference to older inmates. In Rule 50 the Committee of Ministers recommends that the elderly prisoners should be housed together with other prisoners to ensure that they lead as normal a life as possible. Rule 51 states that a decision to transfer a person with a short-term fatal prognosis should be considered only on medical grounds. While awaiting such a transfer, the patients should be given optimum nursing care during the terminal phase of their illness within the prison health care centre. In such cases, provision should be made for periodic respite care

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60 Council of Europe, Committee of Ministers, Resolution (76) 2 on the Treatment of Long-Term Prisoners, (1976).
61 Council of Europe, Committee of Ministers Recommendation No R (98) 7 “Concerning the Ethical and Organizational Aspects of Health Care in Prisons” (1998).
in an outside hospice. The possibility of a pardon for medical reasons or early release should be examined.

This chapter presented the most important legal framework that affects Canadian prisoners, both the international documents and the Canadian legislation and internal regulations. For comparative purposes, some European documents dealing with the same issues were presented.

It must be remarked that no matter what type of documents we are talking about, or where they originate from, very few refer in their body to older inmates. This category of prisoners is almost completely ignored in the legal framework. Based on the assumption that seniors have more health issues, terminal illnesses, adjustment issues, more disabilities, and more problems with daily routine activities, we can infer that some documents dealing with these sets of concerns are more relevant to older offenders. However, this study will reveal that older prisoners have special needs and they react differently even to the above mentioned problems than their younger counterparts. Thus it should be of crucial importance to have regulations that take into account those needs and establish guidelines on how to meet them.

Another problem is the sometimes vague legislation presently existing in Canada, especially regarding the health care of prisoners. It is hard to determine if the health needs of prisoners have been duly met since there are no appropriate definitions as to what is essential or non-essential health care. Other lacunae are in the regulation of the medical record system, of the programs that could reach all prisoners, of compassionate release etc.
Chapter 3

The Canadian Correctional System

The issue of older prisoners is an emerging problem, barely researched in Canada and little investigated elsewhere. Because of the number of unexpected challenges presented by an older population, the correctional system is often unprepared to deal with them. A number of issues will be pointed out in this chapter. There are budget issues in the context of an increasing prison population, which will likely impact prison resources, programs, staff and the health care system. In addition, I will discuss the further burden an older prisoner places on the correctional system and the special needs which need to be addressed in order to meet the international and national human rights standards, as well as the stated purpose of corrections.

However, in order to assess the place of this category of inmates in the prison community, to see how it changes and challenges it, a discussion of the prison system is required. The first section of the presentation will be focused on descriptive details of the federal prison system as a whole, as well as a short analysis of the general challenges currently being faced by corrections.

Of the 5,914 complaints received by the Office of the Correctional Investigator (OCI) – the ombudsman for the federal corrections- in 2010-2011, 797 were regarding health care. As chapter 4 will show, almost all elderly prisoners have health problems and they are the majority of health care users. Moreover, an impressive number of them have mental illnesses, disabilities, substance abuse history and concurrent chronic illnesses. General issues like overcrowding, violence, and lack of programming will likely result in a negative
impact on their health care. Thus the health care system is crucial. It is why the second section of this chapter will focus on a general overview on the prison medical system.

3.1 Overview of the Correctional System

In Canada, criminal law is a federal matter, applied uniformly all over the country. Thus, establishing the criminal responsibility of an offender, as well as sentencing, takes place according to the Criminal Code.

Nevertheless, the correctional issues that come into play after sentencing are not uniformly regulated in Canada. In fact, there are several correctional systems in this country. According to the Criminal Code, people sentenced to less than two years imprisonment will do time in provincial or territorial prisons. Every province and territory has its own correctional system, regulated by provincial and territorial legislation. Aside from prisons, the provincial correctional systems include jails, reformatories, local gaols, and detention centres. There are about 160 provincial and territorial facilities with different levels of security in Canada. 62 Jails and detention centres are the point of entry into institutional corrections and are classified as maximum security. They hold offenders on remand, and sentenced people awaiting transfer to a federal institution. Some treatment centres are also available. As well, each province has its own probation service. The provincial systems are financed entirely by the provincial government. The funding and organization of non-custodial sentences are also provincial matters.

People sentenced to two years and a day or more of imprisonment will spend time in a penitentiary. Penitentiaries fall under federal authority and they will be the research focus

of this thesis. Penitentiaries are regulated by the Corrections and Conditional Release Act and Regulations and are administered by Correctional Service Canada (CSC). This federal agency is under the responsibility of a member of the federal cabinet, the Minister of Public Safety.63

The stated purpose of the federal correctional system is “to contribute to the maintenance of a just, peaceful and safe society, by

a) Carrying out sentences imposed by courts, through the safe and humane custody and supervision of offenders, and

b) Assisting the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of programs in penitentiaries and in the community.”64

In order to meet these goals, currently there are 57 penitentiaries, 16 community correctional centres, and 84 parole offices and sub-offices. There are five regions (Atlantic, Quebec, Ontario, Prairies, and Pacific), each with its headquarters and the CSC’s national headquarters in Ottawa. CSC is directed by the Commissioner. The institutions include penitentiaries for men and women, five mental health treatment centres (one in each region), and Aboriginal healing lodges.65 Each institution is either minimum, medium or maximum security. Currently, there are also some multi-level institutions and one Special Handling Unit or “super-maximum” facility, for prisoners of the highest level of risk (Ste-

64 CCRA, supra note 8, s 3.
Some institutions have “protective custody” units. Certain groups of prisoners, such as sex offenders, are particularly at risk in the general population in some institutions, and thus they may be segregated and kept for 23 hours each day in their cells. There are also other forms of segregation, such as administrative or disciplinary segregation which are largely used for unstable people or as a punishment for people who have committed disciplinary offenses. At least theoretically, a person in administrative segregation retains all rights and privileges that the general population has, aside from the right of association with other prisoners. Though there are rules which limit the use of segregation, Canada has a history of abusing this form of control. For a disciplinary offense, segregation is limited to 30 days but administrative segregation has no statutory limit. On 1st of April 2013, there were 797 people in segregation. 16.7% of them had been there for more than 120 days, while 22.7% stayed between 30 and 60 days. As well, the paradox of having 7,619 placements in segregation, when the places in general population in maximum and medium institutions (the only ones that have segregation) total 10,000, has been pointed out.

Upon intake, there is a requirement to determine the risk and needs of each offender. Classification is an ongoing process whose purpose is to place the offender in a correctional setting that meets his or her needs, while recognizing and addressing the risk that the individual poses to society. The classification system includes psychological, behavioral

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and personality assessments, that place the offender into a certain category. Federal inmates are assessed and classified using the Offender Intake Assessment and Custody Rating Scale. These tools are supposed to help identify the risk upon intake and during a person’s incarceration, while also taking into account disabilities, mental and emotional problems, suicidal tendencies, and the need for special programming or care.

CSC has approximately 17,400 employees of which 84% work in institutions and communities. The latest statistics show that the number of incarcerated prisoners in 2012-2013 was 14,747, which is 63.4% of all federal offenders. This is approximately a 2.3% increase in incarcerated people compared to the previous year. Aside from the increasing number of incarcerated offenders, pertinent to this study is the fact that, within the last decade, the age of offenders has been increasing as well. In 2012-2013 21% of the prison population was 50 years of age or over. In the community, 34% of the federal offenders were over the age of 50.

The CSC is federally budgeted. In 2013 – 2014 the CSC budget was $2,597 million. Of this, 60% was dedicated to custody, and 20% to correctional interventions. In its Reports on Plans and Responsibilities, the CSC estimated that the budget will decrease to $2,334,682,392 for 2014-2015. Of this, $1,471,011,448 will be spent on custody (security, health care, and food) with $714,163,506 assigned to security alone, and a similar number for intelligence and supervision. Only $189,610,528 is dedicated to institutional health

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70 Griffiths, supra note 66 at 284.
72 Public Safety Canada Overview 2014, supra note 68.
73 Ibid
services, with an addition of $121,167,564 for clinical health care services. $465,029,970 is dedicated to correctional interventions which include programming and case management.75

The most important monitoring mechanism in federal corrections is the Office of the Correctional Investigator, which acts as a prison ombudsman. Though an independent agency, the functions of the office are regulated in the CCRA, starting with s. 157. The Correctional Investigator makes visits to the federal institutions in order to prevent, detect and rectify breaches of human rights. The Correctional Investigator also receives complaints from offenders, and based on them and on his observations during visits, he makes recommendations for improvement to the CSC. His recommendations are not binding, but because he acts as part of an independent institution, he enjoys a great amount of credibility. Thus, he has access to the Minister, to whom he presents the unsolved prison issues, and his reports are tabled in Parliament. All the assessments he makes have, as a starting point, the internal legislation and the international prison standards ratified by Canada.76 In 2012 the Correctional Investigator received over 5,700 complaints in areas such as institution conditions, segregation, transfers, double-bunking, and availability and access to programming and health care. In his 2010-2011 Annual Report he identified as problematic overcrowding, physical health care access for older inmates, access to programs and some aboriginal issues.77

76 See above, Chapter 1.
An ongoing concern is overcrowding. The Annual 2009-2010 Report of the Correctional Investigator states that overcrowding has increased by 50% in the last few years resulting in many prisoners sleeping in bunk beds or on the floor. The Correctional Investigator expressed his opinion that double bunking is never a solution, regardless of whether it is for a long or short time. Numerous cells are noisy, crowded and without natural light. Even in segregation areas, two prisoners may be locked in the same cell because of overcrowding. In the Atlantic, Quebec and Prairies regions, women are locked up in segregation because of a shortage of appropriate cells.

In the 2010-2011 report, the Correctional Investigator looked carefully at the issue of double-bunking. He relied on CSC data that showed that currently about 13% of the population was double-bunked, a number that was expected to increase to 30% in the next three years. The situation in the Prairies is the most acute, with a current double-bunked population rate of 20%, followed by Ontario with 14%. The Correctional Investigator expressed the concern that overcrowding leads not only to health issues regarding transmissible diseases but also to managerial problems. Thus for 2010-2011 there were 19,769 security incidents, of which 1,258 required use of force to manage. There was at least one homicide attributable to improper cell assignment. One year later, the OCI reiterated its concerns regarding double-bunking, which had not been addressed by the CSC in the meantime. Effects exist on a financial line as well. Regardless of new capital expenditures, one can expect that these increasing demands on correctional systems will necessarily affect allocations for internal programs including health care.

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78 Sapers, Report 2009-2010, supra note 2 at 31, 38.
80 Sapers, Report 2012 – 2013, supra note 77 at 20.
Other sources pointed out that 25% of federal prisoners share cell space. Double-bunking was identified as increasing pressure on inmates, increasing inmate-on inmate assaults and compromising treatment programs by taxing program resources.\(^81\)

In regard to work, all prisoners physically able must work and it is a disciplinary offense to refuse. In addition to labor, a number of organized activities qualify as work, such as educational-based programs. A very important agency within the CSC is CORCAN which provides work experience and training for prisoners.\(^82\) As well, a variety of core and specialized treatment programs are available in prison facilities. However, the programs rarely reach all prisoners.\(^83\) In 2009-2010, the CSC spent 1.8% of its budget on correctional programs,\(^84\) which is very little. The last report of the OCI has shown that the number of people receiving work in prison has decreased by almost 70%. In 2009-2010, 9,207 offenders were required to participate in nationally recognized programs. Only 5,539 did so.\(^85\) The biggest shortage of programs is for people in maximum security, and generally those who are serving long-term sentences. Canadian prisons are not able to properly respond to the needs of “lifers” or long-term prisoners.\(^86\) In April 2013, 5,335 inmates were serving life sentences or indeterminate sentences. That amounted to 23% of the total offender population. Of this, 64.4% were in custody. The rest were supervised in the community.\(^87\) We must also keep in mind, that for the purpose of this study, many of the lifers or long-term prisoners are currently over the age of 50 or will be at one point during

\(^{81}\) Griffiths, \textit{supra} note 66 at 274.
\(^{82}\) Manson, “Canada,” \textit{supra} note 63 at 136-137.
\(^{83}\) Griffiths, \textit{supra} note 66 at 285-286.
\(^{84}\) Sapers, Report 2010-2011, \textit{supra} note 3 at 43.
\(^{85}\) \textit{Ibid}
\(^{86}\) Fleming, \textit{supra} note 67 at 190.
\(^{87}\) Public Safety Canada, Overview 2013, \textit{supra} note 68.
their imprisonment. Thus, many seniors are spending time in medium or maximum security institutions. In 2009-2010 the Correctional Investigator reported an increase in security in medium and maximum security prisons. He noted that there is a lack of meaningful and constructive interactions between staff and inmates. At the higher security levels, a stricter control on movement means substantially less access to common resources such as the yard, recreation and hobby crafts. Lockdowns are often used and for long periods of time, sometimes just for permitting staff training exercises or staff assemblies. As a result, interruptions in education and program delivery are common.\textsuperscript{88}

A very challenging problem is that of incarcerated women. The Correctional Investigator pointed out that the average daily number of women in federal custody in 2010 was around 500. In the last 10 years, the number of Aboriginal women incarcerated has increased by 86.4%, compared to a 25.7% increase of Aboriginal men. The number of women is increasing, but there are only 5 regional facilities for women. Three of them have requested double-bunking in their secure units. One of them has housed inmates in interview rooms, which lack running water, toilets, and beds. In 2010-2011 the investigator received 436 complaints from women, mostly revolving around conditions of confinement, physical health care, cell effects, mental health services, administrative segregation, and discrimination and harassment from staff.\textsuperscript{89}

Many of these women have histories of being abused, as well as alcoholism and drug consumption. In 2010, 86% of them reported having been physically abused prior to incarceration. 77% of the women were found to have abused alcohol and/or drugs. As well,

\textsuperscript{88} Sapers, Report 2009-2010, supra note 2 at 33.  
\textsuperscript{89} Sapers, Report 2010-2011, supra note 3 at 49-51.
31% had been identified as having a past mental illness diagnosis. These women are obviously in need of special programs. There have been some initiatives designed to address women’s issues such as physical and sexual abuse, drug and alcohol dependency, self-injurious behavior and parenting skills.\(^{90}\) Nevertheless, considering the overpopulation, the existing programs are not sufficient.

Inmate-on–inmate violence is, as expected, a problem. Prisons are not safe places and the rate of harassment, mental and physical abuse is considerable. The general data shows that in the last decade (1999-2009) homicide in federal prisons accounted for 5.8% of the prisoners’ deaths. Statistically, this means 24 of 100,000 inmates were killed, which is significantly higher than in the community, where 1.6 people out of 100,000 were killed in 2007.\(^{91}\) This is only the most extreme form of violence, but numerous other forms are milder, from verbal harassment to sexual and physical attacks. As a study pointed out, staff is rarely the target of inmate aggression. Reported assaults on other inmates included kicking (33%), clubbing (19%), sexual assaults (4.7%), and burning (2.4%). Stabbing accounted for almost 40% of all violent acts.\(^{92}\) Though violence is a generalized problem, certain groups are more vulnerable, such as sex offenders, younger inmates\(^{93}\) and, as it will be discussed later, elderly inmates. As mentioned above, protective custody is an option, but most do not volunteer for it, because of the long time spent in a cell, with no programs available. Thus, correctional intervention is needed for the most vulnerable groups.

\(^{90}\) Griffiths, supra note 66 at 288
\(^{92}\) Fleming, supra note 67 at 194.
\(^{93}\) Griffiths, supra note 66 at 280-281.
An inmate can be released earlier through the Parole Board of Canada (PBC), an independent agency with the mandate of the Solicitor General. The types of releases mentioned in the CCRA are day parole, statutory release and full parole. Currently, a prisoner is eligible for full parole after serving one-third of his sentence or seven years, whichever comes first. For inmates convicted of murder, parole ineligibility is determined by the sentencing judge and can vary between 10 and 25 years. Each person applying for full parole will have a hearing with the PBC to assess if the individual is rehabilitated. Among other things, PBC will take into account the history of disciplinary offenses, the programs and work attended, etc. If a prisoner serving a fixed term sentence is not granted full parole, or does not apply for it, she is entitled to statutory release after serving two-thirds of her sentence. Statutory release can be denied by the PBC only if the individual has committed one of the stipulated offenses during his incarceration and meets the criteria for detention. The other type of release is through clemency. This is exercised by the Governor in Council only in exceptional circumstances. Compassionate release and release on medical grounds are not mentioned in the legislation. Section 121 of the CCRA regulates a type of “parole by exception” that allows the early release of terminally ill prisoners in a number of limited circumstances. However, prisoners serving life sentences are not eligible to apply for this type of parole.

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94 CCRA, supra note 8, ss 99-145.
95 Manson, “Canada,” supra note 63 at 140-141.
96 See the Parole Board Canada site, Fact Sheet, online. http://www.pbc-clcc.gc.ca/.
97 CCRA, supra note 8, s. 121.
3.2 Health Care in Federal Penitentiaries

CSC is responsible for the health care of their inmates. Unlike health care in the community, health care in federal custody is not a provincial or territorial matter. The offenders’ health becomes the responsibility of the province only when they are released.

According to the CSC documents there are four main types of health facilities within federal correctional settings: institutional health units (ambulatory care centres), CSC Regional Hospitals, CSC reception centres, and CSC Regional Treatment Centres (for mental health).98

Each region has a reception centre which conducts the standardized admission process (health and security). The health assessments included are: mental health assessment, tuberculosis assessment, and comprehensive health assessment.99

Health promotion and illness prevention is a high priority. There is a list of items available at the canteen in order to encourage self-care (such as antacids, analgesics, cold remedies, throat lozenges, cough syrup, multi-vitamins, heat rubs, sunscreen, skin lotions, dandruff shampoo, cold sore ointment, foot powder, hemorrhoid ointment, skin cleanser, dental floss, calcium pills etc.).100

At the institutional level, primary care is offered on-site, generally by nursing staff. This is the most common level of care in prison. In some institutions there is a 24-hour nurse present. The nurse makes assessments, provides counseling, dispenses medication,

98 Correctional Service Canada, Health Service Sector, June 2010, online: www.csc-scc.gc.ca [CSC, Health Service].
99 Ibid
takes blood samples, gives immunization, does blood pressure checks, etc. The primary care physician is generally available, by appointment, two or more times/week. Other services, such as x-rays, dental and optometrist care, and psychotherapy, are available at pre-arranged times of varying frequency. There is also a range of specialist physicians who make regular visits to institutions depending on need, location and availability. For major surgeries and specialized treatment, prisoners are transferred to community hospitals.\(^\text{101}\)

All but one region have regional hospitals. In the Prairies the in-patients are sent into the chronic wing of the mental health treatment facility. The regional hospitals are intended to provide care for a mixture of acute and chronic patients, who generally rest there between 4 days to 18 months. The care offered includes post-operative care (following surgery in community hospital), treatment and care for head injury, overdose/self-injury, muscular-skeletal injuries/fractures, skin ulcers/infections, diabetes (for control and education), respiratory illnesses (asthma, pneumonia, TB investigation), thrombosis, UTI, lung puncture, stroke, as well as palliative care. Of course, the use of these services is limited by resources, space and distance considerations.\(^\text{102}\)

For mental health issues, prisoners may be sent to the in-patient Regional Treatment Centre. In these centres CSC has a consolidated number of 675 beds with 781 full time equivalent staff positions. They are hybrid facilities according to the CCRA: they constitute a penitentiary, but also operate as a hospital under provincial mental health legislation. They are multi-level security facilities, and four of them are operating within other CSC institutions (aside from the Prairies). Three of the treatment centres are accredited

\(^{101}\) Ibid at 11-13.  
\(^{102}\) Ibid at 20.
psychiatric facilities. The average stay of a prisoner at these treatment centres is between 147 and 232 days. The centres offer assessments and stabilization of acutely disordered inmates (psychotic, suicidal etc.), rehabilitation of inmates with chronic conditions, and treatment for violent and sexual offenders. Some inmates are transferred to provincial mental health systems, but this is subject to the approval of the provincial institution. However, the majority of prisoners with mental health problems, especially those with non-acute symptoms, remain in their own institutions where they receive pharmacological interventions if ordered by a physician.

Prisoners are much more likely than the population in the community to use health care services or to take medication. This can be explained by their precarious health condition at the time of incarceration. Many prisoners have led lives of abuse, and did not benefit from appropriate health care prior to incarceration. In custody, they are faced with the stressors of imprisonment such as cultural shock, fear of victimization and violence, isolation, shame, anxiety, depression, contagious diseases and susceptibility to drug use. As a result, it has been suggested that the biological age of a prisoner is 10 -15 years older than his chronological one in terms of health conditions. With this background, it is clear that the prison population presents far more acute and chronic conditions than the general population, with an average of 3 diseases per inmate over the age of 50. Research has shown that prisoners use health services more than the general population, with an average of 20 nursing visits per prisoner per year. Studies in both Canada and the US show that

103 Sapers, Report 2010-2011, supra note 3 at 14.
104 CPHA, supra note 100 at 36.
105 Delgado & Delgado, supra note 1 at 87-123.
106 CPHA, supra note 100 at 28-29.
107 Aday, Aging Prisoners, supra note 1 at 17-19.
108 CPHA, supra note 100 at 29.
there are large percentages of prisoners, especially the elderly, with chronic diseases such as hypertension (37%), diabetes (10%), heart disease (30%), hearing impairments (32%), arthritis (90% of elderly show some signs) and cataracts (17%). 20% of prisoners over 65 die of cancer.  

In terms of infectious diseases, the 2009-2010 Annual Report of the Correctional Investigator showed that the rate of HIV infection among prisoners was 7-10 times higher than in the community (approx. 2% of the prison population), while the rate of infection with Hepatitis C was reported to be 30-40 times higher than in the community (approx. 30% of the prison population). These impressive numbers are also influenced by needle-sharing. The CSC takes a series of measures to prevent the spread of diseases, such as: providing inmates with condoms and bleach kits, and providing methadone maintenance programs for people addicted to heroin. However, the Correctional Investigator criticized the CSC for not providing the same harm reduction measures as those available in the community. In his opinion, a needle exchange program would be beneficial. The Canadian Legal HIV/AIDS Network showed that in 2009, 30 to 40 prisoners might use the same syringe to inject drugs. They reported that in Joyceville Penitentiary up to 90 prisoners used the same needle, without even taking the time to use the bleach available to them beforehand. An increase in the number of prisoners is expected to enhance these problems, given that the CSC is reluctant to introduce programs like a needle exchange.

111 Griffiths, supra note 66 at 276.
112 Sapers, Report 2009-2010, supra note 2 at 22.
The Network stated that since needle exchange programs are available outside the prison, the “highest level attainable of health” is not being reached in prisons.\textsuperscript{114}

Criticism of the health care system in prisons has increased, despite some solid progress. Both internal audits and reports of the Correctional Investigator point out some still existing problems. In the physical health care area, an internal audit mentioned that the framework is not clear, since there is no clear definition of what is essential and non-essential health care. This is crucial because according to the legislation, the inmates are entitled to essential health care. The same audit pointed out that there are delays in the completion of intake assessments, that documents in health care files are not complete, and that there are inconsistencies in regard to operating hours of health care services. In regard to infectious diseases, harm reduction measures are not always taken, not all sites have support groups, no national training for the proper cleaning of blood and other bodily fluids exists, and health care facilities are not always clean. As well, the audit reported that 75% of staff had concerns about the facilities, 30% about medical supplies, and 50% about equipment and funding.\textsuperscript{115}

In 2006 an internal audit assessed the situation of people with disabilities in prisons. The audit mentions that there are a few different program codes corresponding to specialized programs. Staff generally was found to be able to identify physical disabilities and the CSC was providing the required aids for these disabilities. As well, CSC tries to incorporate into their practices the legislative norms regarding people with disabilities, presented in the first chapter. However, the audit considered that there was a lack of overall

\textsuperscript{114} Canadian HIV/AIDS Legal network, “Clean Switch: The Case of PNSPs in Canada,” 2010, online http://aidslaw.ca [“Clean Switch”].
\textsuperscript{115} CSC, Audit 2008, supra note 52.
accountability in ensuring that CSC meets its responsibilities for accommodating the needs of offenders with disabilities. Again, there was no definition of what were disabilities, and there was no standardized manner to share this type of information among staff. As well, the identification, assessment and provision of strategies for learning disabilities were not done on a regular basis. Moreover, the audit could not establish if disabilities were considered in case management decisions. A required number of cells had wheelchair access, but other areas were less accessible, especially in older buildings. Staff was generally not trained to use specialized equipment. In regard to programs, the Program Inventories did not consistently include correctional programs, and work assignments which reflected the needs of offenders with disabilities. The programs were not matched to the learning style of the inmate. Finally, the audit mentioned that at that time they could not track correctional programs or work assignments which were offered to inmates with disabilities.116 As will be later shown, an impressive number of prisoners over 50 years of age, have some sort of physical disability which interferes with their capacity to adjust to prison life.

The OCI focused on the issue of mental health in his 2009-2010 report. He reported that there is a 20% vacancy in mental health staff positions, while 37% of male prisoners and 50% of females have some symptoms of mental health problems and need an additional assessment.117 In the 2012-2013 report the OCI reiterated his concerns regarding the improper care for mentally ill prisoners, the fact that they are being segregated, pepper-

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117 Sapers, Report 2009-2010, supra note 2 at 22.
sprayed and restrained instead of being sent to a community hospital for help. As well, current CSC educational material states that upon intake, 12% of men and 21% of women are discovered to have some sort of mental health problem. A study of 1,300 incoming prisoners found that 38.4% had a mental health problem. Of these, 20% were suicidal, 29.9% suffered obsessive-compulsive disorder, 36.9% had depressive symptoms, 31.1% suffered anxiety, 30.6% had paranoid ideation, and a startling 51% had a form of psychosis. A CSC study showed that 44% of inmates suffered from anxiety, 22% from depression and 8% were psychotic. The same study pointed out that mentally ill inmates are more likely to be placed in a higher security facility, are granted fewer conditional releases and are more likely to return to prison for technical violations.

Suicide accounted for 19% of the deaths in a decade (1999-2009). That means the suicide rate is 77 per 100,000 inmates. The rate is significantly higher than in the community, which had a rate of 10.2 per 100,000 people in 2007. The OCI estimated that about 25% of female offenders have engaged in some sort of self-harm behavior during their incarceration. He also noted that all too often it is responded to with use of force and segregation instead of clinical intervention for this type of behavior. It is rare that self-injurious behavior is treated as a mental health issue. Aside from the relationship between drugs and transmittable diseases, studies have shown a co-occurrence of substance abuse and mental illnesses. 80% of the prisoners use drugs in prison and most of them

120 Sapers, Report 2010-2011, supra note 3 at 11.
122 PSC 2010 -2011, supra note 91 at 65.
123 Sapers Report 2009-2010, supra note 2 at 15.
present some mental illness symptoms.\textsuperscript{124} There are demands on psychiatric care due to a shortage of personnel. An increased number of prisoners risks overwhelming an already over-burdened system unless more is invested in mental health care. The correctional investigator strongly advocated against the practice of using the Special Handling Unit for mentally ill inmates who do not meet the admission criteria for regional centres or who are too difficult to handle in more open environments. He also warned that the SHU is not conducive to the treatment of mental illness. The numerous mentally disturbed offenders who are sent to the SHU do not receive the services, treatment or programming they need to have their underlying psychiatric conditions treated.\textsuperscript{125}

In a 2014 report on inmate suicides, the OCI established that almost half of the suicides were committed while the prisoner was in segregation. The OCI’s investigation found that segregation was the number one way of dealing with suicidal inmates even though segregation is a risk factor. The report concluded that all of the suicides investigated could have been prevented had a better strategy been in place.\textsuperscript{126}

Dying in prison of “natural” causes has been identified by the Office of the Correctional Investigator as the main cause of death among inmates, especially in the context of an acceleration in the growth of an aging population. An increasing number of people develop terminal illnesses and die in improper conditions, with the CSC being unable to deliver sound palliative care. The OCI was also critical of the fact that the investigations of deaths

\textsuperscript{124} Kevin Sorensen, Standing Committee on Public Safety and National Security, House of Commons, Canada “Mental health and Drug and Alcohol Addiction in the Federal Correctional System,” December 2010, 40\textsuperscript{th} Parliament, 3\textsuperscript{rd} Session at 13 [Sorensen].

\textsuperscript{125} Sapers, Report 2009-1010, supra note 2 at 21.

occurring in prison are episodic rather than systemic. At the end of 2013, the OCI released a report on the mortality review process. By reviewing medical files of inmates who have died “naturally” in prison, the OCI found that over half of those files were incomplete. Also, the report stated that the procedures adopted as treatment were not stated in almost any of the files, and that half of the inmates reviewed had been diagnosed later than they should have or had not been treated in a timely manner. In addition to the concern about the state of the medical files and the issues raised by how dying prisoners were treated, the OCI stated the need for employing alternative sentencing for terminally ill offenders.

A variety of programs have increased in number to meet mental health needs: life skills training, anger management programs, cognitive skills and substance abuse programs. However most programs do not contain an evaluative component so it is hard to evaluate just how beneficial they are. The Correctional Investigator pointed out in his 2011 report that access to treatment and intervention services remains inadequate in most penitentiaries. Segregation is used all too often as the only alternative for acute mentally ill prisoners. As well, there is still a shortage in specialized staff, and the CSC’s strategies for recruiting have not, as yet, paid off. In 2010, the Standing Committee on Public Safety and National Security raised a series of concerns in its report on mental health and substance abuse. The main issues were the use of segregation for the mentally ill, lack of appropriate correctional programs, mental health issues not properly addressed in custody.

127 Sapers, Report 2012-2013, supra note 77 at 20-22.
129 Griffiths, supra note 66 at 290.
130 Sapers, Report 2010-2011, supra note 3 at 10.
and the situation of federally sentenced women who are even more predisposed to mental illnesses in custody than their male counterparts etc.\textsuperscript{131}

In 2011, a CSC internal audit evaluated the Regional Treatment Centres and the Regional Psychiatric Centre. In the audit a number of issues were identified. First, responsibilities between the roles of medical and correctional staff are not clear in the centres. Second, there are no organized plans that identify staffing and resource needs. Third, all centres have funding gaps and none has stable funding. Fourth, compliance with National Training Standards varies greatly. About 65\% of staff has done the Mental Health Awareness Training. Fifth, there are no performance indicators that would allow the regional centres to demonstrate they have met their goals. However, there are quality improvement programs in place. Sixth, no documents were found to sustain that a voluntary informed consent was obtained prior to treatments in accordance with s. 88(1) CCRA. As well, it could not be proved that mental state is taken into account before transfers, segregation or other disciplinary measures, as required by s. 87 CCRA. It was found that there are programs offered at all centres, but there is no systemic mechanism to track the program offerings. In addition, the audit mentions inconsistencies in what use of force is, when it begins and when it ends. As well, not all instances of use of force were video-recorded as required after the Arbour Report.\textsuperscript{132} As well, the policy requirements for use of restraints are not always applied (CD – Use of Restraints). The same inconsistencies

\textsuperscript{131} Sorensen, \textit{supra} note 123.
were identified in compliance with the requirements for use of medication (CD – Administration of Medication).\textsuperscript{133}

Aware of the issues existing with mental health care, the CSC started a “mental health strategy” implementation. In 2010, the Office of the Correctional Investigator made an assessment of the progress of this strategy. The criticism revolved mainly around the fact that for the intermediate level of care, the continuum of care, there was no plan available. As well, the intake screening system is not yet implemented in a comprehensive, standardized fashion. Also, the resources and services for primary care were found to be insufficient and said to need an annual increase. The third sector, the inpatient one, is enhanced on an annual basis, increasing the number of beds available, and the therapeutic role of the correctional officers. As well, correctional officers mentioned that it is important that the CSC achieves accreditation for the continuum of care as soon as possible.\textsuperscript{134}

One of the newest problems CSC is facing is the aging population and their set of special needs, chronic and terminal diseases. As previously pointed out through statistical data, the number of elderly prisoners is rapidly increasing. Adult-onset diabetes is becoming endemic, and as well, numbers of other diseases are increasing – heart disease, stroke, Alzheimer’s, etc.\textsuperscript{135} A review of existing materials on aging behind bars will be separately provided, in the fourth chapter.

\textsuperscript{135} Fleming, supra note 67 at 205.
Only rudimentary data are available on the cost of health care in Canadian federal penitentiaries. In the recent budget documents, health care is included in the overall custody budgets. In one of the recent reports available, 60% of the correctional budget was allocated for custody.\textsuperscript{136} While it is not known how much of this global amount was devoted to health care, specific figures for physical health care are available from an audit conducted in 2007-08. In the year 2008, $108,253,332 was spent on physical health care (including health policy, quality improvement and accreditation, clinical services, and public health),\textsuperscript{137} representing less than 10% of the custody budget. With respect to mental health care, a 2011 audit disclosed that $25 million was spent on the Regional Treatment Centres.\textsuperscript{138} In addition, the Report on Plans and Priorities for 2014 – 2015 contains a breakdown of the expected expenditures on different types of health care.\textsuperscript{139}

\textsuperscript{136} CSC, RPP 2011 – 2012, supra note 65.
\textsuperscript{137} CSC, Audit 2008, supra note 52 at 35.
\textsuperscript{138} CSC, Audit 2011, supra note 133.
\textsuperscript{139} See above page 47; CSC, RPP 2014 – 2015, supra note 75 at 16 -33.
Chapter 4

Overview of Seniors in the Community: Needs and Responses

This chapter will focus on the most common diseases and needs of older people in the community, as well as the care available. First, this is important because seniors have been studied in more depth in the community than in prison. The data collected for this study shows that numerous issues identified in older offenders are typical for aging persons. Thus the point of this chapter is to introduce the common problems associated with aging where they have already been studied: in the community. Second, the care available in the community and the typical response to seniors’ problems is relevant because, as shown in the first chapter, the main conventions and national legislation require an “equivalence of care” for incarcerated people. Thus, this chapter is an attempt to establish what “standard care” in the community is. Third, while community care for seniors is far from ideal, at the very least there are some choices that older people can make. There are also discussions and projects designed to improve care in the golden years. Seniors in prison are completely denied this choice. Their problems are typical for seniors, while their choices are not. The point made in this study is that ailing older offenders are treated as second class citizens, and that the state often does not fulfill the responsibility it undertook when it moved to exercise full control over these people through incarceration.

In the medical literature, an older person has been defined as an individual over 65 years of age. However, a more nuanced approach creates three categories of people over 65: elderly people (70-80 years old), very elderly people (over 80 years old), and younger
people (under 70 years old).

Aging has been generally associated with a decline in expectations regarding levels of health. It is also mentioned that in older people the early discovery of a disease is vital, as it is the best option to avoid the expensive and discouraging results of late discovery.

4.1 Most common diseases in older people, prevention, and primary care

As a general rule, in order to prevent serious health problems, all older people need a customized nutrition plan, exercise program, and screening. Specialists have identified a series of common diseases that older people in the community are generally facing. Numerous chronic diseases of the system are seen in the elderly, such as: coronary artery disease, congestive heart failure, peripheral arterial disease – circulation problems (13-32% of the very elderly population), cerebro-vascular disease (such as strokes), thyroid disorders, cancer, chronic obstructive pulmonary disease (COPD), urinary tract infection, Parkinson’s disease (1% in people over 65 in US and 3% in people over 85), skin problems, prostrate diseases, acute abdomen, oral problems (dry mouth, edentulousness – toothlessness, cancer, caries etc.), foot problems (which can be very disabling and painful - ingrown toenails, dryness, lesions, deformities etc.), etc. For the management of the majority of these problems a proper diet, exercise, regular monitoring and often medication, are all crucial.

141 Ibid at 149.
142 Ibid at 169.
143 Richard J. Ham, Philip D. Sloane, Gregg A. Warshaw, Marie A. Bernard, and Ellen Flaherty, Primary Care Geriatrics. A Case-Based Approach, 5th ed (Philadelphia: Mosby Elsevier, 2007) at 425-600 [Ham].
144 Ibid at 470.
145 Ibid at 591.
Certain types of cancer often occur (breast, colon and other gastrointestinal types, lung, prostrate, gynecologic, and hematologic malignancies).\textsuperscript{146} In most situations, cancer requires medical interventions, often chemotherapy, radiotherapy, and sometimes surgeries. Screening for cancer is generally covered by OHIP and recommended especially at a higher age. Mammography is routinely done yearly after age 50 until 75 years of age and afterwards, every 1-3 years. Prostate cancer screening is done annually, while cervical cancer screening is done every three years. For other types of cancer testing is not reliable.

Immunology problems increase with aging as well. Infectious diseases are more aggressive and have a more serious impact on an older body. Influenza, bronchitis, and pneumonia lead to chronic obstructive pulmonary disease (COPD). The best option is to prevent them by aggressive vaccination (e.g. for influenza A and B and pneumoccocal).\textsuperscript{147} Tetanus vaccine is also recommended, as 60 \% of all cases occur in older individuals.\textsuperscript{148}

Diabetes has very serious effects, especially at an older age. Management means improving the quality of life and cardiovascular control. A proper diet, pharmacological therapy and exercise are very important for a diabetic person.\textsuperscript{149} The use of glucose monitoring kits is recommended in order to prevent end-organ damage.\textsuperscript{150}

Rheumatological diseases and problems due to skeletal fragility are often encountered. Hip fractures often occur after a fall. In elderly people, 30-50\% of the falls result in serious injuries or death. Mobility problems have been identified in 20\% of people over 65 and 54\% of people over 85. These issues have been associated with falls, depression, functional

\textsuperscript{146} Cassel, supra note 140 at 361.
\textsuperscript{147} Ham, supra note 143 at 551-552.
\textsuperscript{148} Cassel, supra note 140 at 170-171.
\textsuperscript{149} Ham, supra note 143 at 487-488.
\textsuperscript{150} Cassel, supra note 140 at 174.
dependency and death. Chronic dizziness and vertigo are also causes for falls. This is why, for these people, the environmental adaptations are crucial. Osteoporosis also occurs very frequently in the elderly and thus requires that serious prevention methods be taken (intake of calcium, regular exercise program, avoidance of tobacco and alcohol, and reduction of the risk of injury). Arthritis and related disorders are also common and need an aggressive pain-relief intervention. Aside from the environmental modifications, exercise and balance training are very important to prevent the negative effects of these problems.\(^{151}\) One of the most common conditions for people over 65 is hypertension. In order to prevent dramatic negative effects, regular blood pressure management is needed, as well as a reduction in sodium intake, a regular exercise program and weight maintenance, and a strict composition of diets.\(^{152}\) A complete screening is normally done annually or at least every second year. Left untreated, it can lead to renal diseases, and rupture of aortic aneurysms.\(^{153}\)

Seniors are also faced with numerous conditions or symptoms that are not catalogued as chronic diseases but which are typical for an older age. Falls can occur even in the absence of a chronic disease and the impact can be just as strong due to the vulnerability of the aged skeleton. In the most recent Canadian report on the topic, it was mentioned that between 20% and 30% of seniors fall each year. The majority of these falls result in injuries, and the average hospitalization period is nine days. The study reports that most falls are preventable by living a healthy life style and adapting the environment to seniors’ capabilities.\(^{154}\)

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\(^{151}\) Ham, supra note 143 at 300-301, 507.
\(^{152}\) Ibid at 428-441.
\(^{153}\) Cassel, supra note 140 at 173.
Dizziness occurs in percentages from 4 to 30, increasing with aging. Urinary incontinence is one of the major geriatric syndromes and occurs in 10-30% of the community. It is however, under-reported. Constipation and fecal incontinence has been identified in about 20-25% of elderly people. To manage these problems a proper lifestyle is required, such as dietary changes, increased fluid intake and fiber laxative use. Hearing impairments have been observed to increase with aging from 16% (in younger persons) to 64% (in the very elderly). A similar phenomenon occurs with visual impairments, where the cases grow to up to 89% at a very advanced age. Malnutrition and feeding problems also increase with aging from 25% to 60% in institutionalized elderly, while 15% of the elderly in the community suffer from it. Malnutrition increases the risk of cognitive impairment, depression, and delays wound healing. In these cases, diet therapy, counseling, nutrient dense foods and liquid supplements are required. Ultimately, an aggressive nutritional support might be needed. The risk of hypothermia and hyperthermia also increases with age and health degradation. Some medication also increases heat loss and decreases heat production. The prevention of hypothermia is very important in aging, by assuring a proper temperature, warming, and avoiding the use of alcohol, coffee and other fluid overload. Hyperthermia occurs due to skin aging,

155 Cassel, supra note 140 at 263-270.
156 Ibid at 307-315
157 Ibid at 324-330.
158 Ibid at 334-342.
159 Ibid at 344-348.
160 Ibid at 362.
161 Cassel, supra note 140 at 175.
162 Ham, supra note 143 at 366-368.
vasodilatation due to heat loss of subcutaneous fat and alcohol. It is important that the elderly have access to fans and ice water soaks.\textsuperscript{163}

Skin care is very important in the elderly, not only for the prevention of hyperthermia but also to prevent pressure ulcers and other skin conditions. Skin must be kept clean, and hydrated to prevent cracking. Regular warm baths are needed with an agent that prevent skin dryness, the use of non-alcoholic moisturizing agents is recommended, as well as the avoidance of high temperatures and humidity. People with diabetes, vascular diseases, low blood pressure, poor circulation, and low serum protein are particularly vulnerable to pressure ulcers. It is important to prevent ulcers by the proper use of cushions and blankets, and strategies to reduce pressure on vulnerable body parts, especially the boney ones. When ulcers occur, cleansing, debridement, dressing and infection control are required.\textsuperscript{164}

Aging has also been associated with sleep disorders. There is a tendency for the elderly to need daytime sleep due to nighttime awakenings. These disorders have a great impact on the overall quality of life. To manage them, a good control of time spent in bed, light, noise, temperature, and a special mattress is needed.\textsuperscript{165}

Persistent pain is also often experienced by the elderly. There are no autonomic signs and it extends over prolonged periods of time. It may or may not be associated with a recognizable disease. It is estimated that between 2\% and 40\% of the population suffers from persistent pain, depending on definition and method of detection. In the elderly, it is estimated that 25\% to 50\% suffer from it. In nursing home residents, it was identified in 45\% to 80\% of cases. The most common response to pain is the use of analgesics, from

\textsuperscript{163} Ibid at 385-389.
\textsuperscript{164} Ibid at 612-622.
\textsuperscript{165} Ibid at 391-398.
mild to very strong. The under treatment of pain leads to depression, social isolation, gait problems, and sleep disturbances. In turn, these conditions, lead, as shown, to others, even more dangerous.\textsuperscript{166}

Certain psychiatric conditions, some of them chronic, also endanger the health of the elderly. Dementia is a typical illness of old age (Alzheimer’s, but also other types), which often leads to full dependency on a caregiver. Medication and psychosocial interventions are also required.\textsuperscript{167} If undiagnosed at an early stage, mild cognitive impairments have a high risk of progressing to dementia (6-25% in 1 year).\textsuperscript{168} Delirium, or “acute brain failure,” is also common at an older age. It induces lethargy, aggression and hallucinations. To prevent it, it is important to manage other cognitive impairments, sleep deprivation, anti-cholinergic burden, pain, constipation and retention, alcohol withdrawal and dehydration.\textsuperscript{169} Depression also increases with age, varying from 5% to 20 % in people over 65. In hospitals there is a prevalence of 25% in the same age group, while in nursing homes the prevalence is very high, between 25% and 40%.\textsuperscript{170} Moreover, 83% of the elderly have a sensitivity towards depression, and 78% have a predisposition.\textsuperscript{171} The suicide potential is very high in depressed seniors, and is undertreated even in the community.\textsuperscript{172} However, as disabling and dangerous as it is, it is also treatable. Other mood disorders, such as anxiety are also increasingly present with aging. Finally, late-life psychosis can

\textsuperscript{166} Ham, supra note 143 at 350-355.  
\textsuperscript{167} Ibid at 219-235.  
\textsuperscript{168} Cassel, supra note 140 at 175-176.  
\textsuperscript{169} Ham, supra note 143 at 210-217.  
\textsuperscript{170} Ibid at 238.  
\textsuperscript{171} Cassel, supra note 140 at 175-176.  
\textsuperscript{172} Ham, supra note 143 at 242.
also occur. For all these, aside from psychosocial intervention, a pharmacological intervention is often needed as well.

4.2 Acute and Chronic Pain and Disease Management

The assessment and management of pain in older people is different than in a younger one. Pain generally appears with concurrent illnesses and multiple problems in the elderly. As well, for this age group there is a higher incidence of adverse reactions to medication. They also encounter complications and adverse effects from many treatment procedures far more often than their younger counterparts.173

The main sources of suffering (which can have numerous sources) include shortness of breath, cough, nausea and vomiting, constipation, diarrhea, bowel obstruction, oral ulcers, dry mouth (for the prevention of which good hydration and fluoride toothpaste are needed), pressure sores, foul-smelling wounds, dizziness/disequilibrium, spiritual suffering (especially when facing a life-threatening disease) and suffering associated with transfers. The underlying illness needs to be addressed in all cases, together with the treatment of symptoms.174

Acute pain is generally triggered by acute injury or disease. If left untreated it leads to chronic pain. The chronic pain is intense and of long duration (more than 3 months). It is associated with chronic diseases and it is less curable. The intervention needs to be multidimensional – both analgesic drugs and non-drug strategies (sensorial, emotional, and behavioral). However, any person who experiences pain that impairs their functional status and their quality of life needs analgesic drug therapy. It is considered safe and effective in

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173 Cassel, supra note 140 at 325-329.
174 Ibid at 312.
the elderly. Non-drug therapies include a strict physical exercise program and cognitive therapy. Education on pain diaries, pain assessment instruments, appropriate use of medication, and self-help non-drug strategies are also very important.\textsuperscript{175}

It has been found that the majority of people over 75 suffer from chronic medical conditions with the prevalence of congestive heart failure, hypertension, diabetes, depression, osteoarthritis, and Alzheimer’s and other dementias. In Atlantic Canada it was assessed that 80\% of seniors have one chronic disease and about 70\% have two or more conditions that may limit life expectancy.\textsuperscript{176} What is particular about these diseases in older people is that attention needs to be given not only to the disease, but also the syndrome, because co-morbidities are frequent. There is also a high prevalence of functional dependencies. The care programs include: care in the patient’s home, office-based care, care in acute hospital settings, and specialized units with sophisticated monitoring (e.g. inpatient stroke unit). Often lifelong therapies with anticoagulants or analgesics are required. Thus, training on self-management of these drugs and education in dietary interactions with them is important.

Community-based self-education courses on more or less specific chronic diseases are generally available. Also, upon discharge, a nurse makes a management plan and sometimes, post-release home visits are made. The purpose of these community management plans is to increase the quality of life and to decrease the costs.\textsuperscript{177}

\textsuperscript{175} Ibid at 330-331.
\textsuperscript{176} Canadian Institute for Health Information, \textit{Health Care Use at the End of Life in Atlantic Canada}, 2011 at xv [CIHI 2011].
\textsuperscript{177} Cassel, \textit{supra} note 140 at 163-166.
In Canada there are two main categories of services for long-term care – IHS, Insurance Health Services and EHCS, Extended Health Care Services. IHS provides universal coverage and includes the hospital care and services provided by physicians. EHCS includes nursing homes, long-term residential homes, home care and ambulatory health care services. They are not covered by the Canada Health Act and are not always covered by insurance.

Long-term care is different from province to province, but there are some services that are considered core services, which are supplied in all jurisdictions. These include: long-term care institutions, palliative care, respite care, home-care nursing, rehabilitation services such as physiotherapy and occupational therapy, domestic help and personal care services. Some of the other wide-spread programs include meal programs, day-care, group homes, equipment and supplies, and quick response teams. Institutional long-term care, though supplied in all provinces, is financially covered to different degrees and upon a needs assessment. Home-care and rehabilitation services are available upon need as well, but generally they are free of charge. Other home services, such as homemaker services, personal care, adult day care, and meal programs generally carry a fee which relates to a proportion of the cost together with the user’s monthly income. However, in most jurisdictions there is a limit on how much home care services a person is entitled to, which cannot exceed the cost of a residential facility.\(^\text{178}\)

In New Brunswick, the long-term care system (LTC) includes in-home services, special care homes and nursing homes. LTC is offered to individuals who have a limited capacity

of performing daily activities. The clients are responsible for paying for the services. If they are not able to pay, assistance is offered by the government.\footnote{CIHI 2011, \textit{supra} note 176 at 50.} In Newfoundland and Labrador long-term care services are offered both at home and in hospital or health centres. LTC services adopt a holistic approach, with an emphasis on spiritual, cultural, physical, and psychological needs. Financial assistance can be granted if needed. Private companies also offer long-term care services.\footnote{\textit{Ibid} at 51.} In Nova Scotia, the Department of Health and Wellness is in charge of approving LTC facilities. There are community-based options, residential care facilities and nursing homes or homes for aged. LTC is paid jointly by the provincial government and the residents.\footnote{\textit{Ibid} at 51-52} In PEI there are nine public nursing homes and eight private ones that provide long term care services in the province. Generally, in order to be admitted, an individual has to be 60 or older. Care can be subsidized by Health PEI as payer of last resort, if the individual cannot afford it.\footnote{\textit{Ibid} at 52.}

Mental health is another more challenging area for older adults. In 2011, the “Guidelines for comprehensive mental health services for older adults in Canada” came out. These guidelines are intended to help policymakers, service planners and advocacy groups working to ensure that all senior Canadians receive the range of support they need. The guidelines refer to Alzheimer’s diseases and age-related dementias, serious and persistent mental illnesses complicated by aging issues and illnesses that occur for the first time in old age.\footnote{Mental Health Commission of Canada, “Guidelines for Comprehensive Mental Health Services for Older Adults in Canada. Executive Summary,” October 2011 [MHCC].}
4.3 End-of-Life Care

End-of-life care comes into play when a patient is terminally ill. A patient is considered terminally ill when he has been given up to six more months to live. In these months many seniors remain without treated pain, which can be caused by different diseases (cancer, arthritis etc.). While life prolonging interventions are less frequent, intensive care and ventilators are commonly used. Often, the elderly are very dependent during these last months. They are either taken care of by their families or placed in nursing homes. The nursing homes are normally focused on improvement of function, maintenance of weight, and nutritional care.184

The main goal of end-of-life care, as defined by the World Health Organization, is to improve quality of life.185 End-of-life care is generally broader than palliative care. End-of-life care includes any type of care – respite; home care etc. Palliative care alone refers to the prevention and relief of suffering by early identification, assessment and treatment of pain and other problems (physical, psychological and spiritual). Palliative care relieves pain, affirms life, and regards dying as a normal process; it intends neither to hasten nor postpone death. It integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope; uses a team approach to address the needs of patients and their families, including bereavement counseling; and enhances quality of life. Palliative care may positively influence the course of illness, and together with other therapies may prolong life.186

184 Cassel, supra note 140 at 281-284.
186 CIHI 2011, supra note 176 at xi-xii.
In 2007, in the Maritime Provinces the mortality rates corresponded to the national ones. The highest rates for causes of death were neoplasm (tumours) (31%), circulatory diseases (30%) and external causes of death (6%), the most common being falls. Other causes were HIV, diabetes, Alzheimer’s, and digestive diseases. The leading cause for people 65-74 was neoplasm and for people 75 and over was circulatory diseases.\textsuperscript{187}

Many terminally ill people have acute or chronic pain. The general principle for hospice and palliative programs is that the etiology of pain needs to be established. Thus, a careful physical assessment will be done together with radiographic and radionuclide imaging, screening for corroborated illnesses before the symptoms start appearing, echocardiograms, Doppler venograms (for deep vein thrombosis), and prothrombin ratio (monitor anticoagulants), etc.\textsuperscript{188}

Some interventions are useless at the end of life. However, pain management may include more aggressive treatments even at that point. Other procedures that should be done in palliative care if needed, but which are not always available, include orthopedic surgery, palliative amputation, bowel surgery or endoscopic procedures, radiotherapy for bronchial obstruction or laser therapy and expandable metallic stent placement, metallic stent placement for vascular obstruction, pleural effusion (tube thoracostomy and sclerotherapy or pleural catheter), etc.\textsuperscript{189}

Intravenous antibiotics are needed by about 62% of terminally ill patients. They are useful for a variety of infections, from urinary tract infections to lower respiratory tract

\textsuperscript{187} Ibid at 3.
\textsuperscript{188} Kinzbrunner, supra note 185 at 445.
\textsuperscript{189} Ibid at 451-462.
infections and soft tissue skin wounds. Often the antibiotics should be continued for the rest for their lives and the selection should be appropriate.\textsuperscript{190}

For patients suffering from cancer, chemotherapy and radiotherapy is generally a treatment. However, it can also be used in palliative care to preserve the quality of life at the end of life or prolong life in some tumor types.\textsuperscript{191}

Many terminally ill patients have cardiovascular problems. An AICD (Automated Implantable Cardiovascular Defibrillator) can be recommended, since the device automatically resuscitates patients. Other commonly used devices, even at the end of life, are pacemakers and left ventricular assistance devices (for heart failure). Sometimes inotropic agents are used (intrusive heart medication) or a heart transplant may take place if there is a heart available (which however is rarely the case for a terminally ill senior, whose name would never appear on a transplant candidates’ list).\textsuperscript{192} For respiratory insufficiency, oxygen therapy is administered or mechanical or portable volume ventilators are used.\textsuperscript{193}

Terminally ill people are often placed in hospices or are part of other palliative care programs where they can benefit from the support they need (medical, spiritual, and psychological). People enrolled in these programs are encouraged to give advance directives (how invasive should the procedure be, does he want to be connected to life support and for how long etc.). “Do Not Resuscitate” orders are also common. They can

\begin{flushleft}
\textsuperscript{190} Ibid at 462-463. \\
\textsuperscript{191} Ibid at 472-473. \\
\textsuperscript{192} Ibid at 499-502. \\
\textsuperscript{193} Ibid at 508-511.
\end{flushleft}
be general or “out-of-hospital DNR.” Some hospices request that the patient sign a DNR order upon admission, for responsibility reasons.

In Canada there are several programs available for end-of-life and palliative care. For example, in New Brunswick the Extra Mural Program is available. The program offers a wide range of health services at home and in community settings. EMP includes acute care, rehabilitation and palliative care. The Extra Mural Palliative Care Program provides total care to ill people who do not respond to curative treatment. This includes pain and symptom management, together with psychological, social and spiritual support. The patient remains under the care of his physician, while EMP offers 24-hours services and assistance with medication, equipment and home services.  

In Newfoundland and Labrador palliative care services are covered by provincial funds. Patients are entitled to receive care in a hospital (certain acute care facilities have palliative care beds as well), or in locations coordinated by community health nurses. As well, a patient can receive up to four weeks of home care services. The Respite Support Program provides respite care and personal and behavioral support aiming at helping individuals to maintain their independence. Home support is also supplemented by private companies, and can be purchased by individuals or may be subsidized based on functional and financial assessments.

In Nova Scotia, hospice palliative care includes compassionate therapies for physical, psychological, social, spiritual, and practical needs for terminally ill individuals and their families. Services are offered both in hospital and community. At home they are offered

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194 CIHI 2011, supra note 176 at 45.  
195 Ibid at 46, 48.
through the Continuing Care Branch of the Department of Health and Wellness. Home care is intended as a supplement to community and personal care resources. The nursing services are free of charge; other services like home support or home oxygen are fee-based, depending on the income of the patient.\textsuperscript{196}

The PEI Provincial Integrated Palliative Care Program has different components: Provincial Palliative Care Unit, the Integrated Palliative Care Program, the Palliative Care Drug Pilot Project and other related programs. The Care Unit has eight beds and offers pain and symptom management, together with supportive services shared with other services and facilities such as hospices, dietary services, physiotherapy, occupational therapy, spiritual care, social work, etc. Home Based Care manages the client’s registry, houses his information, provides case management and coordinates the delivery of services to his home (assessments, nursing, community-based dialysis, community support services, integrated palliative care, occupational therapy, respite care, personal care, and physical therapy).\textsuperscript{197}

4.4 Financing the Canadian Health Care System

In Canada 1/10 of the economic input goes into health care (around $130 billion). The financing is a mixture of payments from the public and the private sector. In 2004, public spending was $94 billion (public health programs, hospital care, physician care, care for Inuit and Native Canadian populations, and part of home care, drug prescriptions and ambulances). The remaining $39 billion came from the private sector (insurances, out-of-

\textsuperscript{196} Ibid at 46, 49.
\textsuperscript{197} Ibid at 47-50.
pocket, and donations.\textsuperscript{198} Canada’s Health Act requires that public issued services be financially covered by the government – hospital, physician, and surgical/dental interventions. In some cases, extended health care may also be paid from public funds (nursing home care, home care and ambulatory care).\textsuperscript{199}

In regard to continuing care, 73\% of spending on residential care was covered by public funds in 2004. This included home care, supported living options and continuing care facilities. In most parts of Canada, medical and nursing care is delivered without charge at home, though the quality varies. There are also government programs to support assistive devices, but they differ across Canada in types of devices covered and level of coverage. These devices include medical equipment, mobility aids, information technologies, practical daily aids etc.

Mental health care is the second biggest source of funding. About 61\% to 72\% people have full coverage when consulting medical health specialists. Across the age groups, seniors seemed to be the most content with the services received for mental health issues. 9\% of people over 65 reported having mental health care needs but did not receive help, while the overall unmet needs was 21\%.\textsuperscript{200}

4.5 Canadian Care for the Elderly – “Alternate Level of Care” study\textsuperscript{201}

Recently, Prof. David Walker finished his study on “Alternate Level of Care for the Elderly in Canada.” He pointed out the challenges the medical system has faced with the

\textsuperscript{198} Canadian Institute for Health Information, Exploring the 70/30 Split: How Canada’s Health Care System is Financed, 2005 at 16-18 [CIHI 2005].
\textsuperscript{199} Ibid at 19.
\textsuperscript{200} Ibid at 108.
\textsuperscript{201} David Walker, “Alternate Level of Care,” - “Granddad Is in the ER, What’s Wrong with That? Orientating a Health System to Care for an Aging Population” (Paper delivered at Queen’s University, Faculty of Political Sciences, 4 November 2011) [unpublished].
“aging boomers.” He predicted that the aging population will increase by 32% by 2021 and their life expectancy will increase. Currently, 81% of the elderly in Canada (over 60) suffer from one chronic disease and 33% have at least two.

Prof. Walker stated that the current strategy for dealing with the elderly relies heavily on acute care hospitals. In 2011 it was believed that those hospitals would have to increase their bed number by 75% by 2012 to accommodate all people in need. Increasingly, emergency rooms are faced with older people who have nowhere to go and need a bed until they find a place in a nursing home. The problem is that emergency rooms and acute care hospitals are not intended for long term care and the elderly are occupying beds intended for serious and urgent conditions. Also, in this context, seniors are exposed to other infections.

The study describes the three levels of care in Canada – downstream (community and long term care), upstream (community and home) and midstream (hospitals and post-acute care). The least critical at the moment and the best funded is the midstream. However, this is the least practical for rehabilitation applications. Acute hospitals are not prepared and should not have to deal with respite and rehabilitation as currently happens.

Long-term care needs serious modifications to take the burden from hospitals and provide proper care for the elderly. First, the capacity of long-term care needs review and reform (both nursing homes and home care). Second, they must increase their sophistication in meeting high needs especially cognitive and behavioral needs (which currently are not addressed).

The upstream care also needs much improvement. The study emphasizes the need of early identification and screening for certain diseases in order to avoid the overcrowding
of emergency rooms with seniors that should have been treated much earlier. Also, there is a need to integrate primary care with community care access. The community based/home care resources must be enhanced. Multi-disciplinary teams should be organized and used in order to supplement the reduced number of gerontologists.

The study concludes by stating the main improvements needed including a better balance of finances between hospitals and home care. Currently only hospitals are completely free of charge. The normal process for care of an elder should be: regular reassessment, chronic medication and management, team help (occupational therapy, exercise etc.), advice on home safety issues, physiotherapy, social programs to avoid isolation, temporary moves to group homes for a caregiver’s break, and finally, to help him die at home and not in an institution.

As a result of the concerns raised by studies like the one above, governments have taken initiatives to improve the life of seniors. The Canadian Government has set up a site with information for seniors (www.seniors.gc.ca) and has worked on improving its policies. The government recognizes that seniors are a vulnerable group in the community, that they are increasing in number, and that they have special needs that must be addressed. The government is advised on these matters by the National Senior Council and the Federal/Provincial/Territorial Ministers Responsible for Seniors Forum. In 2013 “Government of Canada: Action for Seniors”202 was released. The paper elaborates on the strategies currently implemented by the government to respond to seniors’ needs and to increase their quality of life. The plan includes increasing financial stability and organizing

programs that would increase seniors’ financial literacy. New Horizons for Seniors Program is set up to promote active aging and involvement of the seniors in the community life. “Aging in place” and the Assisted Living programs are focused on helping seniors live at home for as long as possible, while providing different types of funded support. The federal government has also committed itself to transferring additional funds to provinces and territories with the purpose of enhancing the health care available to seniors. A number of guidelines have also been created and distributed among the senior population. They are related to the prevention of falls, stair safety and safe living. In addition, the study contains in its appendix dozens of studies and information brochures that are meant to offer support to seniors and guide them towards the services available. These brochures are available online and are distributed in the community by Service Canada’s Mobile Outreach Service.\footnote{The guidelines and brochures are available online www.seniors.gc.ca.} None of this information is available in prison (and there is no internet so prisoners cannot research on their own) or as part of a release program. Also, in prison there are no initiatives similar to those described in this chapter.
Chapter 5

Literature Review

The number of aging prisoners is increasing rapidly. However, this category of people has, for many years, been systematically ignored by correctional systems and by society in general. The aged prison population has increased rapidly in North America due to sentencing policies (tough on crime legislations, mandatory minimums, truth-in-sentencing, etc.), aging of the baby boomers in general, longer life spans, and a growing number of first-time older offenders.\textsuperscript{204} It was estimated that in the US, by 2030, the older inmate population will constitute 1/3 of the prison population.\textsuperscript{205}

In 2007 it was reported that there was a total of 4,339 older prisoners in Canadian Federal Corrections. This amounted to 20\% of the offender population. Of these, 2,068 were incarcerated and 2,271 were serving their sentence in the community.\textsuperscript{206} By 2012, the Correctional Investigator estimated that the number of older offenders reflected a more than 50\% increase in the last decade. He also mentioned that, considering that 25\% of the prison population serves life or indeterminate sentences (and the majority of these people are incarcerated), the proportion of older federal offenders will continue to rise in the following years.\textsuperscript{207} Confirming this prediction, in 2013, the percentage of incarcerated


\textsuperscript{205} Delgado & Delgado, \textit{supra} note 1 at 87.

\textsuperscript{206} Special Senate Committee on Aging, “Canada’s Aging Population – Seizing the Opportunity,” April 2009 at 178, Online: http://www.parl.gc.ca/Content/SEN/Committee/402/agei/rep/AgingFinalReport-e.pdf [Special Senate Committee on Aging].

older prisoners alone had increased to 21%. Correspondingly, 34% of the community-sentenced offenders were above 50.\textsuperscript{208} In April 2013 the number of incarcerated men over 50 was 3,030.\textsuperscript{209}

Obviously, the needs of older prisoners are at their core the same as those of seniors in the community, presented in the previous chapter. Nevertheless, it is to be expected that the typical aging problems are enhanced for incarcerated offenders due to their previous lifestyle and the rigours of prison.

This chapter focuses on the needs of older inmates, as they have been previously described in the literature. There are not many materials and the research studies have mainly been conducted by a handful of dedicated American specialists. A few European materials will be presented, but they constitute a thin body of documents. As well, Canada has only a few studies completed that relate to older prisoners’ needs. All were conducted a couple of decades ago. In 2015, the CSC released “A Brief Profile of Incarcerated Men Offenders.”\textsuperscript{210} Two similar profiles were created for the female older offenders.\textsuperscript{211} Nonetheless, the profiles only touch upon the types of crimes and the recidivism rates of older offenders. Thus, the core of this review consists of American materials.

When discussing the needs of inmates we need to remember the national and international materials that apply. They guarantee a set of defined rights which are retained by prisoners. If breached, human rights violations likely occur. For instance, equivalence of care is required in health matters. Thus the standard of care in prison must be similar to

\textsuperscript{208} Public Safety Canada Overview 2013, supra note 68.
\textsuperscript{209} CSC 2015, supra note 5.
\textsuperscript{210} Ibid
\textsuperscript{211} CSC 2010, supra note 5.
the one in the community. As well, older prisoners need to have access to meaningful activities, and to safety, just like the younger inmates, in order to avoid age or illness-based discrimination. Moreover, requiring that an aged person do the same tasks as a younger one may amount to inhuman treatment and punishment considering the special characteristics of an older person. As a Human Rights Watch recent report puts it, two major concerns are raised by the incarceration of the elderly. First, are the conditions of detention, including medical treatment, consistent with human rights requirements? Second, when does the incarceration of aging and infirm prisoners become disproportionately severe punishment - even assuming acceptable conditions of confinement?

In 2009, The United Nations Office on Drugs and Crime (UNODOC) manifested a set of concerns regarding the older prison population worldwide in its “Handbook on Prisoners with Special Needs.” The concerns listed included the accelerated growth of the older inmate population while the prisons’ physical structures and programs are designed for younger inmates. It is also mentioned that considering the age, health, and health care opportunities of prisoners, prison can be a disproportionately harsh punishment for certain prisoners. UNODOC raised human rights concerns regarding the treatment of the elderly and the body called for special policies and strategies to address the special needs of OPs in all countries.

212 For details on the standard of care for older people in the community see above Chapter 4.
213 For details on conventions and legislation applicable to the topic at issue see above Chapter 2.
5.1 Demographics - Who are the older prisoners?

In most of the American states and Canada the older prisoner has been described as the inmate over 50 years of age. The age limit has been explained by the accelerating aging of inmates due to their prior lifestyle and the tough prison environment. The CSC has mentioned as accelerating factors of aging the economic status, difficult lifestyle, and limited access to health care prior to incarceration. Aday mentions that in a study he conducted he found that the typical inmate in his 50s had the appearance and accompanying health problems of someone at least 10 years older. He also mentions that this may be due to the lower socioeconomic stratum the majority of them come from. The people in this stratum have been found to have the chronic conditions at the age of 45-55 that are not seen in the highest socioeconomic stratum until after age 75. The majority of elderly prisoners are likely to have poor health histories and a high incidence of alcohol or drug abuse, which makes them more vulnerable to aging. Other authors state that accepting 50 as the age when an inmate is placed in the “older inmates” category enables


217 Special Senate Committee, supra note 206 at 178.

218 Aday, Aging Prisoners, supra note 1 at 16-17.
corrections to implement preventive programs that may reduce or delay expensive medical and other costs associated with aging.\textsuperscript{219}

The CSC created a few age categories for older offenders, similar to the ones described in the community. Thus, all people over 50 are considered “older offenders” (OP). People below 50 are “younger offenders” (YP). In the OP categories there are the elderly, the people above 65, and geriatric offenders, who are inmates above 70.\textsuperscript{220}

In the US the older inmate has been profiled as being a non-Hispanic white male, without a high-school diploma (average achievement is around grade 7 or 8). He is more likely to be married than a younger inmate and he was probably convicted of a violent offence (generally homicide).\textsuperscript{221} Another author described the older inmate as a male with a low IQ, probably divorced, an alcohol abuser and with mental health issues. An older inmate commonly suffers from organic brain disorder, senile dementia, depression, personality disorder, functional psychosis or paranoid schizophrenia. He is likely to cause fewer disciplinary problems than his younger counterpart.\textsuperscript{222} An older inmate is likely from the poorest segment of society, he experiences poor health and received less routine care than other people.\textsuperscript{223} Aside from being a substance abuser and having little formal education, the older offender has little family support, poor health, and few coping skills.\textsuperscript{224}

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\item \textsuperscript{220} CSC, 1998, \textit{supra} note 4 at 4.
\item \textsuperscript{221} John J. Kerbs, “The Older Prisoner: Social, Psychological and Medical Considerations” in Max Rothman, Burton D. Dunlop, Pamela Entzel (Eds), \textit{Elders, Crime, and the Criminal Justice System} (New York: Springer, 2000) at 211. [Kerbs] [Rothman]
\item \textsuperscript{222} Ornduff, \textit{supra} note 1 at 174-175.
\item \textsuperscript{223} Mahon, \textit{supra} note 204 at 213.
\item \textsuperscript{224} Aday, \textit{Aging Prisoners, supra} note 1 at 113.
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In regard to the older offenders’ offences and familiarity with the prison environment, three categories have been identified. First, there are the OPs incarcerated for the first time after the age of 50. They are the most vulnerable to victimization, and have the least coping skills. They are in for serious crimes and many of them will die in prison. The second category is formed by habitual offenders, who have been in and out of prison for most of their lives. Many of them have coping skills, but are not functional due to heavy substance abuse. Third, there are the offenders incarcerated before the age of 50, for a long sentence. Basically, they grew old in prison. They have circulated in and out of disciplinary segregation and mental health units. They likely lack community ties and would have difficulties readapting upon release.\textsuperscript{225} A study conducted in the US, shows that about 46% of the OPs were career criminals, 41% were first incarcerated after the age of 50 and 13% were long-term offenders.\textsuperscript{226} An older study conducted in Canada on this matter shows that in 1996, 10% of the Canadian OPs were long-term offenders, 17% were habitual offenders and 72% were incarcerated for the first time after the age of 50.\textsuperscript{227} Aday describes the new older inmates as being stressed, feeling vulnerable and being afraid of younger inmates. Since they frequently have committed a violent crime, a split will likely appear between them and their families which leads to loneliness. They suffer great shame for being incarcerated at that age and probably suffer a culture shock. They will tend to sleep excessively and remain highly passive. Their anxieties will constitute barriers for them to remain calm and under control. The long-term offender was incarcerated for a serious

\textsuperscript{225} Morton, \textit{supra} note 219 at 240-241.
\textsuperscript{226} Burton D. Dunlop, Max Rothman, and Pamela Entzel “Policy Implications for the 21\textsuperscript{st} Century” in Rothman, \textit{supra} note 221 at 336. [Dunlop]
\textsuperscript{227} CSC, 1998, \textit{supra} note 4 at 5.
crime, as a young person, for a minimum of 25 years. He is legally ignorant, undereducated and poorly represented. He makes little efforts to be released; he works and settles into prison routine. Most likely, his family has forgotten him.\textsuperscript{228}

A study done in BC showed that the majority of OPs were in for sexual offences (38%), followed by homicide (24%), robbery (13%), and drug offences (10%).\textsuperscript{229} Other authors, noticing that older offenders are more likely to serve time for violent crimes than younger people, believe this occurs due to the fact that judges are reluctant to incarcerate seniors for less serious offences.\textsuperscript{230} It can also be explained by the fact that the most dangerous criminals receive long sentences and they grow old in prison.\textsuperscript{231} In terms of release possibilities, there are two categories: OPs that will be released at one point and those that will die in prison. The needs of these offenders differ greatly and prison has to be prepared to embrace both categories.\textsuperscript{232}

Age itself does not change the rights of prisoners, but it may change what officials must do to ensure that those rights are respected in particular cases. The more barriers an inmate is facing to an independent and active life, the greater the risk for physical and mental problems.\textsuperscript{233} Because the needs of OPs cross multiple departments within correctional systems, the following subchapters cover not only the medical needs but also related aspects of life that can influence the physical and mental health (such as relationships, physical, psychological and spiritual programming, safety, and discipline). As WHO

\begin{footnotes}
\item[228] Aday, \textit{Aging Prisoners, supra} note 1 at 114-119.
\item[229] Gallagher, \textit{supra} note 6 at 327.
\item[231] US Department of Justice, “Correctional Health Care – Addressing the Needs of Elderly, Chronically Ill and Terminally Ill,” 2004, online: www.nicic.org at 8 [US Department of Justice].
\item[232] Aday, \textit{Aging Prisoners, supra} note 1 at 113.
\item[233] HRW, \textit{supra} note 214 at 43.
\end{footnotes}
describes it, health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”234 This is something I am using as a corollary as I continue both the literature review and the empirical study.

5.2 Health care issues

Health problems are not typical only of older offenders. They appear in younger prisoners as well. However, there is great overlap between aging people and those who are chronically, seriously, terminally ill or incapacitated.235 Chronic illnesses, even in the general population, are linked to normal aging. This is why it is important that correctional systems understand what the normal aging process is in order to implement programs and policies.236 The predictable changes that occur with aging include: the decline of body’s ability to produce antibodies to fight diseases, a decline in the kidney’s filtering capacity, an increase in blood pressure, and an increase in accidents due to declining eyesight, arthritis, vertigo, reduced motor skills, and poor physical condition.237

Moreover, due to the specific situation of incarcerated people, OPs have on average more chronic diseases not only than their younger counterparts but also than seniors in the community.238 It has been identified that an OP has an average of 3 chronic diseases or more, and this situation places the deterioration of health as the major source of stress for lifers and long-term offenders.239 Another study pointed out that 85% of OPs have co-

235 Ibid, Delgado & Delgado, supra note 1 at 87.
236 Aday, Aging Prisoners, supra note 1 at 19.
237 Robert G. Falter, “Selected Predictors of Health Services Needs of Inmates over Age 50” (1999) 6 J Correct Health Care 149 at 150 [Falter]; see also above Chapter 3.
238 William, supra note 216 at 58.
239 Aday, Aging Prisoners, supra note 1 at 125.
morbidities (also an average of 3 chronic diseases), which generally include, but are not limited to, cardiovascular diseases, arthritis and back pain, psychiatric conditions, respiratory problems, endocrine illnesses, sensory deficiencies, and substance abuse. Exposure to prison stressors is found to exacerbate these problems.  

Some of the diseases OPs are faced with are common to all seniors: obstructive pulmonary disease, arthritis, diabetes, and heart diseases. Others are more common among geriatric prisoners: paraplegia secondary to gunshot wound, advanced liver disease from alcohol use, viral hepatitis, end-stage renal disease from drug injection, and HIV/AIDS. Also, the OPs are more vulnerable to influenza and pneumonia. They are also more predisposed to polypharmacy (inappropriate use of multiple medication) in prison than in the community. A study shows that about 40% of seniors with chronic diseases encounter polypharmacy in prison at one point. A Canadian Assessments of Health Needs in prison showed that over half of the prisoners over 65 are on medication. They explained it through the risks factors that existed during the life of the inmates: smoking (72% of prisoners are or have been smokers) which leads to heart disease, lung cancer and chronic obstructive lung diseases; not enough physical activity (60% of inmates reported being in some fitness program, but the rest reported barriers in doing so), unhealthy eating and obesity.

In a UK study conducted on older prisoners, 83% of the respondents reported having a long-standing illness and disability, while 19% reported an acute illness. The major illnesses reported were: psychiatric problems (45%), cardiovascular (35%),

\[\text{Loeb}\]
\[\text{supra}\] note 216 at 59.
\[\text{supra}\] note 216 at 20-21.
musculoskeletal (24%), respiratory (15%), genitourinary (13%), gastrointestinal (10%), neurological (9%), dermatological (6%), hearing or eyesight (6%), hematological (3%), other (6%) and none (15%). 45.8% did not smoke. In the medical records, the rate of morbidity was 85%. A study conducted in Canada, showed that while the medical problems of OPs are not vastly different than those of people in the free world, some appear with much more frequency, such as respiratory diseases. Moreover, the OPs use medical services much more often than the general population. 54% were already in poor health at admission, and 14% had a bad diet in prison (twice as many as younger offenders). Many were heavy smokers, were going on fasts and fad diets, acknowledged having a hard time coping with stress and were abusing drugs and alcohol.

UNODOC pointed out that this abundance of chronic conditions is most likely not going to be properly addressed in prison. Moreover, UNODOC stated that even the seniors who are healthy have different needs (like nutritional ones) that must be met in order to prevent a deterioration of health.

5.2.1 Physical Health

Physical health conditions generally overlap with mental health problems and disabilities. Physical illnesses may include chronic, acute, as well as terminal diseases. Though, as mentioned before, OPs are more vulnerable to transmittable diseases, such as influenza which can easily become acute or other conditions that often go through acute phases, the illnesses more likely to be encountered in this age group are chronic or diseases

243 Seena Fazel, Tony Hope, Ian O’Donnell, Mary Piper, and Robin Jacoby, “Health of Elderly Male Prisoners – Worse than the General population, Worse than the Younger Prisoners” (2001) 30 Age and Ageing 403 at 404-405 [Fazel]; see also Crawley, supra note 216 at 232.
244 Gallagher, supra note 6 at 328-329.
245 UNODOC, supra note 215 at 124.
that are long-term or permanent and typically incurable. Most times, these are sources of pain and distress. Aday pointed out that 90% of seniors have a form of degenerative arthritis or rheumatic disorder, while 20% over 65 die of cancer. Chronic respiratory diseases are extremely common (chronic obstructive pulmonary diseases such as bronchitis, emphysema and asthma are the fourth main cause of death in people over 65), as well as cardiovascular (e.g. diseases of the heart, stroke, arteriosclerosis) and gastrointestinal illnesses. As well, after 65, kidney function is reduced by 50%. For OPs we have to remember that all these occur a minimum of 10 years earlier.246

A study done on 119 (81% of the targeted population) older inmates (over 50) in Iowa showed that 40% suffered from hypertension, 19% from myocardial infarction, 18% from emphysema, 22% from venereal disease, 21% from ulcer, 20% from prostate cancer. Also common were incontinence, sensory and flexibility impairment and limitations in gross physical functioning. 97% were missing teeth. Despite these numbers, 65% believed their health was excellent, but 50% reported their health worsening after incarceration. 61% experienced chest pains, with 8% having a history of angina. 42% had limitations in gross physical functions, and 11% had limitations in routine self-care activities. As for their life habits, 69.8% described themselves as current smokers, and 18.5% as former smokers. 96.6% had a history of alcohol abuse, and 45.4% considered themselves to be heavy drinkers. 29.4% admitted using illicit drugs.247

246 Aday, Aging Prisoners, supra note 1 at 20-21.
Another study with 41 older men revealed that 83% had at least one chronic condition, while almost 50% had three or more. The diseases included: vision problems (17%), cardiac (25.9%), hearing (4.5%), dental (7.9%), lung (14.8%), gastrointestinal (9%), urinary (2.2%), internal medicine (7.9%), and orthopedic (3.6%).

A 2000 US survey on older inmates across the country showed that 4.4% suffered from asthma, 3.6% were in a diabetic clinic, 2.6% in a cardiac clinic, and 7.8% in a hypertension clinic. 17% self-reported conditions such as HIV, heart or circulatory problems, respiratory problems, cancer, neurological issues, skeletal, kidney or liver illnesses, and diabetes.

A 2012 survey done in the US found that 46% of male inmates over 50 and 80% of those over 65 have a chronic physical problem. 32% of OPs in Ohio are in chronic care clinics. Data from Florida shows that prisoners over 50 are disproportionately enrolled in chronic care clinics compared to their younger counterparts and they account for a disproportionate share of medical contacts. In California, 7% of prisoners are over 55 and they take up 38% of prison medical beds. Georgia’s Augusta State Medical Prison provides acute care, specialized medical and mental health services, assisted living, and chronic care. Here, 27% of the prisoners are over 50. In Connecticut, 10.7% of prisoners over 60 have no physical problem requiring nursing attention; 28.5% have a sub-acute or chronic disease that requires occasional nursing attention; 50.7% need predictable access to nursing care 16 hours per day, seven days per week; 7.4% need around the clock access to nursing care and there is a reasonable likelihood that from time to time they will need 24-hour care.

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Lemieux, supra note 7 at 447-448.
US Department of Justice, supra note 231.
nursing care; and 2.7% need 24-hour nursing care, possibly for an extended period of time.  

Cancer is a frequent disease in OPs. Even in the general population, cancer pains go untreated. In prisons, there are unique obstacles in treating cancer pain due to high levels of security. In a study, 50% of incarcerated cancer patients reported severe pain during the last 24 hours. One-third of the patients were taking strong opioids. Poor or very poor pain was treated with analgesics of all categories, which indicated an inappropriate use of opioids. From the sample, 32% received no pain relief, while 47% received 50% or better pain relief. 64% received inappropriate pain treatment. Practitioners estimated that more than half had pains that lasted over one month. 94% of practitioners would prescribe strong opioid analgesics for pain. However, barriers in pain management were identified as follows: fear of drug misuse, concerns about the patients’ credibility, inadequate pain assessment, inadequate staff knowledge of pain management, reluctance of some practitioners to prescribe opioids, restricted pharmacy access time, and no-keep-on-person drug policies.  

An impressive number of senior prisoners suffer from urinary incontinence, generally due to collateral diseases (prostatic hypertrophy, neurogenic bladder, diabetes, medication side-effects, functional and cognitive impairment etc.). 14% of prisoners between 50 and 59 are incontinent, and 38% of those over 60 are as well. Unfortunately, not all prisons carry incontinency supplies and in those that do, sometimes inmates in the

250 HRW, supra note 214 at 73-75.  
US have to co-pay. Incontinence is a serious cause of social isolation and ridicule. However, it improves with treatment so it is crucial to receive attention.\textsuperscript{252}

The results of a study done in Canada by the CSC were in accordance with the above presented studies. The study reported a high incidence of multiple chronic health problems in people over 50, such as: heart problems, diabetes, hypertension, stroke, cancer, Parkinson’s, ulcers, emphysema, diminished hearing, poor sight, loss of memory etc. The study mentions a few of the specific needs – nutritional needs and special diets, nutrition monitoring, long term care, pace-makers, hearing aids, prostheses, walkers, canes, eye glasses, and bath tubs and showers with handrails. Many of the OPs might need help with medication and may need to have it delivered to them. Aging prisoners, due to the high number of illnesses and stronger responses to any diseases, need 24 hours medical staff available, trained to deal with geriatric people.\textsuperscript{253}

5.2.2 Physical Disabilities

People with disabilities have been defined by UNODOC as people with long-term physical, mental, intellectual or sensory impairments which act as barriers to full and effective participation in society on an equal basis with others.\textsuperscript{254} Disabilities can have multiple causes, such as chronic illnesses, traumatic brain injury or may have simply an unknown cause.\textsuperscript{255}

\textsuperscript{252} William, \textit{supra} note 216 at 63.
\textsuperscript{253} CSC, 1998, \textit{supra} note 4.
\textsuperscript{254} UNODOC, \textit{supra} note 215 at 44.
\textsuperscript{255} Delgado & Delgado, \textit{supra} note 1 at 114.
Disabilities overlap with both chronic illnesses and mental illnesses. Under this heading the focus will be on physical disabilities, while the mental ones will be discussed under the mental issues.

Disabilities can be at times hard to identify, and are often a source of discrimination and diminish the quality of life. With the increase of the graying of the prison population, the burden on prisons to meet and adapt to hearing, visual, speech and other sorts of needs is also growing. In a study conducted in US prisons it was shown that speech disabilities were more than three times higher than in the general population (3.7% vs 1%), visual impairments were more than two times higher (8.3% vs 3.1%), while hearing impairments were lower (5.7% vs 8.3%). A later study reported a rate of 3.8% in state prison and 1.5% in federal prisons for speech impairments, 10.3% and 8.6% for vision impairments and 7% and 5% for hearing impairments. These impairments can lead to serious consequences in prisons. For example, deaf inmates find themselves violating prison rules because they lack awareness of verbal orders or other auditory signals. They can also be at higher risk of rape because they have limited auditory awareness of their surroundings.\(^\text{256}\) Vision impairments also place the inmate at a higher risk for falls, especially considering the poor lightning existing in prisons and sometimes the lack of aids, such as handrails. Falls can have extremely serious consequences including injury, loss of function, and death. In prison falls are much influenced by environmental elements (poor lightning, loose rugs, lack of handrails etc.) and specific stressors (strenuous work assignments, quickly moving younger

\(^{256}\) Delgado & Delgado, \textit{supra} note 1 at 115-116.
inmates, top bunk assignments etc). Aside from falls, their vision problems are also associated with social isolation, depression, and other physical disabilities.257

As for ambulatory problems, the rates were between 0.04% and 0.05% in state and federal prisons in 1990. In 1992, inmates that used wheelchairs in state prisons ranged from 0.12% to 1.35%. A 2004 study found that 1.4% of state prisoners and 1.6% of federal prisoners had paralysis, while 2.5% of state inmates and 2.3% of federal ones had mobility impairments (used a cane, a walker, wheelchair, hearing aid, or other aids in daily activities).258 In a study carried out in the UK it was reported that 32% of all prisoners had disabilities, with 212 having mobility impairments.259 Functional ability reflects the degree of independence so it is crucial for the well-being and quality of life. Between 15-50% of the geriatric patients needed help with the ADL (Activities of Daily Living – bathing, dressing, eating, transferring, and toileting). Sometimes prisoners refused to use the aids in order not to look weak. They are more exposed to rape and other victimization, so they might need protective housing and around-the-clock supervision.260 Another study showed that 31.6% of prisoners between 70 and 74 need help with ADLs and 100% of those over 85 do.261 Concerns regarding the treatment of these prisoners always exist. Sometimes they break bones while trying to use the toilet or have to sit in their own bodily wastes. All these might support a finding of cruel and unusual punishment or treatment.262

257 William, supra note 216 at 62.
258 Delgado & Delgado, supra note 1 at 115-116.
260 William, supra note 216 at 61.
261 Mara, supra note 204 at 44.
262 Delgado & Delgado, supra note 1 at 41-42.
Even greater problems occur with PADL (Prison Activities of Daily Life), such as dropping to the floor, standing for head count, getting to the dining halls, hearing staff orders, climbing on and off the top bunk of the bed etc. These obviously call for adaptive devices that at the moment do not exist in all prisons – bathroom handrails, non-slippery surfaces, doorknobs, etc.\textsuperscript{263}

Since 1997, US prisoners, however, have benefited from class actions challenging discrimination against people with disabilities. Recently, a class action was brought by Illinois prisoners who were deaf, fighting for their right to assistance in order to communicate effectively and to participate in prison programs and services.\textsuperscript{264}

UNODOC identified a set of key issues regarding severely disabled offenders: in sentencing, prison should be the last resort for them; their difficulties are magnified in prison due to the restrictive environment, violence resulting from overcrowding, lack of proper differentiation and supervision. Prison overcrowding accelerates the disabling process along with neglect, psychological stress, and lack of adequate medical care. Policies in accordance with the UN Convention on the Rights of Persons with Disabilities need to be implemented; prison can become a disproportionately harsh punishment for people with disabilities; and the number of disabled offenders is increasing due to the increase in the number of older offenders.\textsuperscript{265}

\textsuperscript{263} William, supra note 216 at 64.
\textsuperscript{264} HRW, supra note 214 at 78.
\textsuperscript{265} UNODOC, supra note 215 at 43.
5.2.3 Terminally Ill

Terminally ill people have been described as those who suffer from a fatal disease and generally have less than six months to live.\textsuperscript{266} Correctional systems are forced to provide care to a growing number of terminally ill inmates and are trying to expand their abilities to provide palliative care for the dying. In the US the programs vary from beds for palliative care to hospices and nursing programs. The Canadian experience is much more limited in this respect, the best option available being palliative care beds in a regional hospital, unit infirmary or protective custody.

The subject of death, dying and compassionate care in prison started to enter the literature in the ‘90s, together with questions of how we can care for dying people in a total institution. An increasing number of inmates enter prisons with acute conditions that eventually turn into chronic illnesses, incarceration turning into a death sentence. Palliative care should be mandatory for OPs near the end of their life, in accordance with community standards. Advanced planning is always required so that the patient is part of the decision making, and preventing and relieving pain levels should be a priority. However, in a study carried out on 100 US state prisoners with cancer, 81\% reported a worsening of pain the last 24 hours.\textsuperscript{267}

The main causes of death, among both prisoners and the free population are: heart disease, cancer, cerebro-vascular disease, respiratory disease, influenza/pneumonia, and

\textsuperscript{266} US Department of Justice, \textit{supra} note 231 at 13; also see above Chapter 3.

\textsuperscript{267} Mary Beth Morrissey, Tina Maschi, and Junghhee Han, “Developing Ethical and Palliative Responses among Seriously Ill Aging Prisoners: Content Analysis Implications and Action Steps,” in Be the Evidence Project White Paper, “Aging Prisoners – A Crisis in Need of Intervention,” Fordham University, 2012 at 32-36 [Morrissey] [“Be the Evidence”].
septicemia. Specific for inmates are: chronic liver disease, AIDS, intentional self-harm, and digestive disease. These illnesses are a result of previous lifestyles and the prison environment.268

A nationwide study conducted in the US showed that in 1997 there were 824 terminally ill inmates placed in regular department of corrections infirmaries or prison hospitals, 152 placed in formal hospice settings within the system, and 96 had received compassionate release.269 In 2001, offenders over 55 comprised 33.9% of the deaths in state prisons; in 2007 the percentage grew to 45.7%. Between 2001 and 2007, 8,486 men and women over 55 died behind bars. In Florida, in June 2012, 16% of the prison population was considered older. However, they represented 38% of all inmates expected to die in prison. In Ohio in 2009, prisoners over 55 accounted for 6.5% of the prison population, but they represented 48.5% of deaths in 2008 and 2009.270 A more recent US study reports that 52% of older inmates will die of a chronic illness such as HIV/AIDS, heart or lung disease, or dementia.271

In Canada, in 2004 there was an average of 54 deaths/year in federal prisons during the previous six years (45% higher than expected). Violent deaths and suicides were substantially higher than in the community. According to the Offender Management System and the Coroner’s Report between 1997 and 2001 there were 157 natural deaths in the Canadian federal prison system. Out of these, 34% died of cardiovascular disease, 32% of cancer, 9% of liver disease, 5% of HIV, and 19% of other causes.272 In a 2009 study on

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269 Delgado & Delgado, supra note 1 at 127.
270 HRW, supra note 214 at 83-84.
271 Morrissey, supra note 267 at 32.
272 CPHA, supra note 216 at 18-19.
the natural causes of death in Canada, it was reported that 36% of prisoners died of cardiovascular disease, 33% of cancer, 14% of respiratory problems, and 7% of infectious diseases. The first three are associated with aging.\(^{273}\) In his 2010-2011 report, the Correctional Investigator stated that, in Canada the CSC struggles to deliver palliative care in a non-judgmental and compassionate manner. However there are many challenges in a correctional system and positive, commendable and dignified practices in the system occur thanks to local initiative, committed individual staff members and inmate peers rather than the correctional system. The Correctional Investigator also believes that the solution, in the cases where community and family support exist, should be compassionate release rather than palliative care in prison.\(^{274}\) In the 2011 – 2012 report the OCI confirmed that “natural” death is the main cause of death in the Canadian federal correctional system due to aging and longer sentences. He reiterated that the CSC had not acted yet on his previous recommendation and that individuals continued to have an “undignified” death in prison, with little proper care, and very few compassionate releases. Between 2011 and 2012 there have been 35 natural deaths in prison, some due to terminal illnesses.\(^{275}\)

It was pointed out that the needs of dying prisoners are not at all addressed in a way comparable to what occurs in the community. Many times a prisoner is isolated, and has no say in his health treatment. He fears abuse from health care staff, and he often lacks the support of family or friends. A survey conducted on prison practitioners pointed out that generally prisoners do not give advance directives or living wills. They do not trust the system and do not believe their directives would be respected. The exact number of

prisoners who leave advance directives is not known. However, roughly only 30% of all terminally ill designate a surrogate. It was also remarked that the issue of advanced directives is not routinely addressed in prisons, and when it is, it happens when the prisoner is terminally ill, meaning at the least optimal time.276

Aday reported, based on discussions with older prisoners, that the fear of dying in prison is one of the greatest stressors for long-term offenders. Quality of life has been correlated to death anxiety. Poor health, family separation, and institutionalization contribute to a higher fear of dying. Higher levels of fear of death have been associated with living in restrictive places such as nursing homes. Dying in prison is so much worse, especially because the terminally ill are even more isolated that the rest of the prison population. Dying in prison is what inmates dread most.277 It is because this generally means dying alone, with people treating him with indifference. Moreover, prisoners consider that dying in prison will have a negative impact on their families, who do not get to see them as free people again. A majority of older inmates in Aday’s study, who characterized their health as poor, expressed fear of getting sick, having cancer or a heart attack and especially of dying a painful death in prison.278 In another of Aday’s studies those feeling lonely and unloved feared death 70% more than the ones that did not.279 There are many challenges in providing proper palliative care: limited access to urgent care facilities, restricted pharmacy access, impediments in dispensing medication on an “as needed” basis, limited patient autonomy in regard to DNR use and advance directives, staff

278 Aday, Aging Prisoners, supra note 1 at 127-128.
279 Aday 2005 – 2006, supra note 277 at 204.
training, and lack of cooperation from patients’ families. Pain management has been identified as particularly vexing.\textsuperscript{280}

In the US there are some hospice programs for the terminally ill. They offer end-of life-care, but they have different rules than the programs in the community, which makes inmates reluctant to use them. For example, they request a physician’s certificate that the patient has 6 months or less to live, and a DNR from the inmate.\textsuperscript{281} Moreover, even if they provide a multidisciplinary team, this is reduced to health staff, clergy, and security personnel. Sometimes, the prisoners have the option to stay in hospice only half a day, and then return to the general population so they can attend to their ADL needs.\textsuperscript{282}

In the UK, medical evidence needs to be given to the Prison Service of England and Wales that the prisoner has a maximum of three months to live. If the evidence is accepted, the prison medical staff can seek community hospice care for the prisoner. Inmates who do not meet the criteria of three months, are expected to stay where they are even if they have a terminal or very serious condition. Palliative care is not provided inside English prisons.\textsuperscript{283}

UNODOC stated that all terminally ill prisoners are entitled to the same standard of care as those in the community, in accordance with international standards. However, most times this does not happen. UNODOC also noticed the deficits in pain management for the terminally ill and pointed out that many patients receive either less than they need or more than they need in terms of aggressive treatments. These situations increase the

\begin{flushleft}
\textsuperscript{280} Linder, supra note 268 at 896. \\
\textsuperscript{281} William, supra note 216 at 66. \\
\textsuperscript{282} Mara, supra note 204 at 50. \\
\textsuperscript{283} Crawley, supra note 216 at 234. 
\end{flushleft}
rigors of the prison sentence. There should be multidisciplinary teams to manage each terminally ill prisoner. Palliative care should always be available, as well as an individual plan for each person that considers illness, age, family links etc. Nursing should be available for 24 hours, 7 days per week and access to medication should be comparable to the access in the community. More specialists from the community should be involved, especially in palliative care, and possible transfers to community hospitals should be considered more often.  

5.2.4 Mental Health

In describing mental illnesses, UNODOC defines mental disability, psychiatric disorder, and intellectual disability. A psychiatric disorder is a major (schizophrenia, bipolar) or minor (mild anxiety disorder) mental illness. An intellectual disability is an incomplete development of the mind (impairment of skills and intelligence in areas such as cognition, language, motor and social abilities). A mental disability is a combination of psychiatric disorder and intellectual disability. Mental health care includes everything from psycho-social support, counseling, speech and occupational therapy, and behavioral therapy to psychiatric treatment and medication.  

Mental health problems are often associated with suicide and self-harm, as well as substance abuse, HIV/AIDS, and aging. These factors increase the challenges for providing efficient therapy and counseling.  

WHO pointed out that one million prisoners worldwide suffer from psychosis or depression. Of the 9 million, half struggle with personality disorders. Nearly all experience depressed moods and stress symptoms, while thousands commit suicide annually. 4% of

284 UNODOC, supra note 215 at 145-146.
285 Ibid at 9.
286 Delgado & Delgado, supra note 1 at 82.
male and female prisoners suffer from psychotic disorders. 10% of male and 12% of female prisoners have major depression. 42% of women and 65% of men struggle with personality disorders (including 47% of men and 21% of women who have antisocial personality disorder). 89% present with depressive symptoms, while 74% have stress related somatic symptoms. WHO considers that the main contributing factors are loss of liberty, limited connections to family and friends, overcrowding, dirty and depressing environment, poor food, inadequate health care, aggression, lack of purposeful activity, availability of illicit drugs, solitude, lack of privacy, and guilt or shame. 287

According to WHO, 40% of European prisoners suffer from some sort of mental disability and they are 7 times more likely to commit suicide than the general population. In the US, in 2006, 56% of state prisoners, 64% of prisoners in jail, and 45% of federal inmates were treated for major depression, mania, or psychotic disorder. In Australia, 80% of the prisoners had a psychiatric disability, compared to 31% of the community population. 288

The psychological profile of an OP points to a predisposition to mental health problems. He is considered more neurotic and introverted. He experiences more anxiety, apprehension, concern with physical functioning, and despondency. He is more insecure and fearful of authority, of the future, illness, pain, and younger inmates. He is less active, has lower expectations, and often feels helpless. However, the profile suggests that an OP

288 UNODOC, supra note 215 at 10; for Canada see the rates presented above in Chapter 3.
is better adjusted psychologically to prison than a younger inmate. Very common among
OPs were depression, family conflicts, fear of dying in prison, and thoughts of suicide.289

Older inmates have significantly higher proportions of mental illness than their
younger counterparts. In the United States, 15%-25% of the older prison population has
some form of mental illness. The Florida Corrections Commission reported in 1999 the
most common forms among older prisoners were: depression, followed by dementia,
substance abuse, organic brain disorder, personality disorders, functional psychosis, and
paranoid schizophrenia. Geriatric medical experience is needed to differentiate these
conditions from organic ones that have similar symptoms, such as thyroid disorders,
medication interactions, or medication side effects.290 A more recent study found that the
prevalence of depression was 50 times more common in older prisoners than in younger
ones.291

Research done in Australia, pointed out that depression and other psychological
problems are significant among older prisoners, and that these are often neglected and lead
to severe adjustment difficulties. 50% of OPs experience a mental health issue, most
commonly depression.292

In a UK study, it was also found that mental disorder is more prevalent among older
prisoners than in the community. Five percent suffered from psychotic illnesses, while 30%
from depression, which makes these problems more common in OPs and the younger
prisoners. However, substance abuse and personality disorders are more common in

289 John J. Kerbs, “The Older Prisoner: Social, Psychological, and Medical Considerations” in Rothman,
supra note 221 at 214-215 [Kerbs, 2000].
290 Delagado & Delgado, supra note 1 at 94.
291 Leigey, supra note 216 at 52.
292 Corrections Victoria, supra note 216 at 14.
younger inmates. The Director of Prisoners Services suggested that as much as 90% of the prisoners might have a psychiatric diagnosis (current or previous). As well, the rate of suicide is 10 times higher than in the community, and also higher than among younger prisoners.293

An old CSC study points out the predisposition of older inmates towards depression, higher risk of suicide, apathy, dependency on staff, routine, concern with release, and interest in the outside world. Alcoholism is said to be frequent and left untreated in prison, aside from enforced abstinence. This exacerbates the mental illnesses, as well as the suicidal and homicidal behavior.294

Suicide is often associated with mental illnesses. In US jails in 2009, the suicide rate among people over 55 was 58/100,000 inmates, and in state prisons was 13/100,000.295 In California, in the last decade, the situation was so critical, that the rate was 1 suicide/week, meaning 80% higher rate of suicide than in the community, until the Supreme Court took action against the Department of Corrections.296 In a UK article, lifers were described as a particularly high-risk group. The suicide risk for them is higher than that of other inmates, at around 176/100,000 prisoners. They are older than the average age of prisoners, and their suicide is generally planned rather than impulsive. A disproportionate number of suicides were identified in English prisons in 2003-2004 in the segregation unit.297

In the US, the prevalence of major depression is 1-2% in older adults, and up to 27% for those who have significant depressive symptoms. In institutionalized seniors (such

293 Howse, supra note 259 at 19-20.
294 CSC, 1998, supra note 4 at 25.
295 Judith F. Cox and James E Lawrence, “Planning Services for Elderly Inmates with Mental Illness” (June 2010) Corrections Today 52 at 54 [Cox].
296 “Be the Evidence,” supra note 267 at 3.
297 Alison Liebling, “Prison Suicide and Its Prevention” in Jewkes, supra note 216 at 432 [Liebling].
as those in nursing homes), the prevalence is up to 43%. Institutionalization and loss of contact with the outside world is one of the main causes that lead to anxiety.\textsuperscript{298} More recently, it was estimated that 50\% of people aged 50-54 and 36\% of those above 55 have some sort of mental health problems in the US.\textsuperscript{299}

In another US study with inmates over 55, 15\% of state prisoners, 9\% of federal inmates, 20\% of jail prisoners, and 16\% of probationers were identified as mentally ill.\textsuperscript{300} In a study conducted on a group of 95 male inmates over 50, it was found that depression, anxiety and psychiatric disorders were much more common than in a similar community sample. The one month prevalence of major depression was 50 times higher in prison than in the community. As well, 54\% fit the criteria for an active psychiatric disorder. Inmates with a previous history of substance abuse were at higher risk of having a current psychiatric disorder.\textsuperscript{301}

Another research study showed that senile dementia is very common among offenders incarcerated later in life. In a study conducted on 52 defendants between 62 and 88 years of age, about 19\% were diagnosed with severe senile and arteriosclerotic dementia. 20\% were suffering from schizophrenia disorders. The rest of the sample was diagnosed with other disorders, such as atypical psychosis, adjustment disorders, and personality disorders. In a similar study, half of the elderly offenders were diagnosed with a psychiatric disease or disorder.\textsuperscript{302} While psychotic illnesses and major depression, which were found to be 2-4 times more common in prison than in the community are very serious,

\textsuperscript{298} William, \textit{supra} note 216 at 61.
\textsuperscript{300} Aday, \textit{Aging Prisoners, supra} note 1 at 102.
\textsuperscript{301} Ibid
\textsuperscript{302} Ibid at 102-103.
dementia in prison raises ethical issues. If dementia was in place prior to incarceration (as
in the above study), an offender is unlikely to be fit to stand trial. For those who develop it
in prison, the incarceration goals do not apply anymore. In a study conducted on 203
prisoners in England and Wales, 2 developed dementia while serving time in prison. They
remained in prison due to the lack of any overwhelming physical disability. One individual,
69 years old, did not have any recollection of the crime, he did not know why he was in
prison and was unable to understand and answer the questions he was asked. However he
was able to perform the activities of daily living. The second inmate was 78. Though he
was insightful and remorseful about his crime, he was diagnosed with Alzheimer’s and his
cognitive impairment was progressively worsening. He also had mobility problems. In
the US, the rate of people with dementia in prison was 1.7%. It is estimated that by 2030 it
will be around 1.9%, and by 2050 around 2.6%. Another estimate was that the number
of cases with dementia will double in the next four decades in the US, while the rate of
cases within the US correctional system will be two to three times greater than the rate
outside prison. The main risk factors for dementia, which are more present in prison than
in the community, are: high rates of mental health issues (which this study places at 2 out
of 3 prisoners), brain injuries for veterans, chronic substance abuse, medication side
effects, poor dietary histories, and a stressful environment (violence and inadequate service
 provision). The problems identified with demented people in prison include their increased
vulnerability to victimization, the fact that they may be aggressive to staff - which will lead

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Med Ethics 156 at 156 [Fazel, 2002].
304 Maschi, supra note 299 at 2-4.
305 Anita Blowers, Jennifer Jolley, and John Kerbs, “The Age-Segregation Debate” in Kerbs & Jolley, supra
note 216, 133 at 136 [Blowers].
to sanctions or charges, and their inability to follow prison rules, which can very likely send them to segregation and compromise even further their mental and physical health.\textsuperscript{306}

Other studies pointed out the causes of these high numbers. There are more stressors in prisons for OPs than for younger inmates. For one, their health problems and the aging process are a significant stressor. The noise, the strenuous prison environment, and the threats from younger inmates can also negatively impact the mental health of an OP. In an old study, out of 148 older inmates, about half were described by being “excessive mentally worried” (about health or family members, safety or other incarceration-related issues).\textsuperscript{307} In a study conducted by Aday, 75\% of older prisoners indicated they were sometimes or often restless, anxious about the future, helpless, bored with life, depressed, lonely, and unhappy. In a similar study, 70\% of the sample indicated the same problems.\textsuperscript{308}

Trauma and stressful life events place the prisoners at a higher risk for mental health problems than their community counterparts. One study showed that, on average, an older prisoner had experienced at least three traumatic events prior to incarceration, such as abuse, loss of employment, and death of a loved one.\textsuperscript{309} In research conducted on male prisoners, 93\% reported being exposed to trauma and prior stressful life events (such as violent victimization, out-of-home placement, and parental substance abuse). 65\% reported PTSD symptoms (re-experiencing the traumatic event, avoidance, numbing, increased anxiety, emotional arousal, etc.). The study concluded that many subjects still had distress

\textsuperscript{306} Maschi, supra note 299 at 2-4.
\textsuperscript{307} Howse, supra note 259 at 103.
\textsuperscript{308} Ibid
\textsuperscript{309} Leigey, supra note 216 at 54.
and mental health symptoms from prior events and experiences. As well, untreated trauma
and grief is related to increased adult recidivism rates. The study suggests aggressive
intervention that targets the individual, the system, and the community. OPs are more
likely than their younger counterparts to report stressors such as witnessing a sexual
assault, a natural disaster, life threatening illness, and death of family or friends. Trauma
services should target the age-specific needs of criminal offenders.

5.2.5 Alcohol and Drugs

Alcohol and drug consumption and dependency have often been treated as mental
health issues that affect both the physical and the psychological well-being of the
individual. Among prisoners, substance abuse is extremely high, contributing to
accelerated aging and health degradation.

The co-occurrence of substance abuse and mental disorders is very common as a
result of poor social functioning, homelessness, violence, arrest and imprisonment. In a
study looking at older inmates between 1991 and 1997, it was noted that substance abuse
had increased by 115% in older inmates in comparison to 84% in younger inmates. The
study was conducted on over 9,741 inmates of whom 180 were over 55. The primary
substance abused by seniors was alcohol, and they were more likely than other age group
to have had an alcohol or drug related arrest. 71% of the older people in the study reported

310 Tina Maschi, Sandy Gibson, Kristen M Zgoba, and Keith Morgen, “Trauma and Life Event Stressors
Among Young and Old Adult Prisoners” (2011) 17:2 J Correct Health Care 160 [Maschi, Gibson, Zgoba,
& Morgen].
311 Tina Maschi and Deborh Courtney, “Age, Cumulative Trauma and Stressful Life Events, and Post-
traumatic Stress Symptoms among Older Adults in Prison: Do Subjective Impressions Matter?” in “Be the
Evidence,” supra note 267, at 46-47 [Maschi & Courtney].
312 UNODOC, supra note 215 at 22.
substance abuse upon admission, which in many cases, remained untreated during incarceration.\footnote{Ardnt, supra note 1 at 735-737.}

Another US study\footnote{Keith Morgen, “Substance Abuse and Older Adults in the Criminal Justice System” in “Be the Evidence,” supra note 267 at 51-52 [Morgen].} showed that in the US between 1/2 and 1/3 of all seniors meet the criteria for Substance Use Disorder (SUD). The disorder often co-occurs with emotional, psychological and medical issues. Thus, 30% of older drinkers have a co-occurrence of substance abuse and depression, while 30% of seniors’ suicides are attributed to alcohol. Another study further showed that only 11.2% prisoners with SUD received prison treatment and only 16.6% were offered specialized treatment.\footnote{Ibid at 53.} Unfortunately, very few facilities provide treatment services specifically designed for older adults even in the community, and none provide it in prisons. This is needed however, because older adults have different reactions to substance use, intoxication and withdrawal. This is why the disorder is often misdiagnosed and mistreated. Alcohol intoxication or withdrawal symptoms are often misattributed to the aging process or Alzheimer’s.\footnote{Ibid at 54.}

Data collected by CSC in the 1990s suggests that older inmates have a different pattern of alcohol abuse. It is more likely that they started drinking at an early age, that they are drinking on a regular basis and are combining alcohol with drugs. They are significantly more likely to drink excessively for leisure and to have a history of drinking binges. Also, they are more likely than their younger counterparts to use alcohol as a means to relieve stress. The side-effects of alcohol consumption are also influenced by age. Alcohol abuse by older offenders seems more likely to negatively impact their employment
and social relations. As well, they are more prone to violence due to alcohol than the younger offenders. Younger offenders also seem to be more likely to have completed some substance abuse treatment than the older ones. However, younger offenders are also more likely to consume and combine drugs, while older offenders are more likely to consume alcohol.\textsuperscript{317}

5.3 Victimization and disciplinary issues

A wide number of studies have identified older inmates as being more predisposed to being abused and to fear of victimization more than their younger counterparts.\textsuperscript{318} An important American study\textsuperscript{319} on older prisoners’ victimization explains that this category of prisoners is more predisposed to being assaulted not only because of their age but also because of the nature of their crimes (a large number are sex offenders). The study was carried out with 65 older prisoners. The questions were grouped into psychological, property, physical, and sexual victimization. For psychological victimizations, results show that 85% of them had been pushed from the line while waiting for something, 40% had been constantly insulted, 25% received threats in the form of fake punches, 19% were labeled (which many times leads to further victimization), and 17% were verbally threatened. As for property victimization, 29.9% were cheated or conned out of their money, 27.7% had things stolen from their cell, 12.3% had their cells broken into while

being away, 10.8% were approached by an inmate who wanted money, 9.2% suffered property damages, 7.7% were pressured into giving goods, and 3.1% had food taken away. Some of these abuses took place on visually impaired prisoners. In regard to physical victimization, 10.8% were punched, kicked, pushed or attacked without a weapon. Thefts, muggings, and attacks with weapons, though present, were not as frequent. A few of the respondents were seriously injured, and came close to losing their lives. Finally, in the sexual victimization category, 10.8% reported being sexually harassed, 1.5% were raped or sexually assaulted, and another 1.5% repaid debts by having sex. Of the respondents, 80% think they would be safer in a prison with people their own age, 75% prefer living in such a prison, and 90% would like to have the choice between a prison for seniors and a general one.\textsuperscript{320}

A number of studies cited by Aday also report that older inmates feel unsafe and vulnerable with younger inmates. Most of them expressed their preference for residing with other older offenders. In an older study cited, 55% of the respondents reported that abusive incidents between them and younger inmates occurred on a daily basis.\textsuperscript{321} In another study conducted in a geriatric facility, isolated from the general population, 74% of the respondents felt safe there, compared to 54% of the elders in the general population.\textsuperscript{322} It was said that that, in particular, the aged newcomers feel unsafe in the prison environment. The seniors that have been in prison for a long time develop a bravado to protect a frail

\begin{footnotesize}
\textsuperscript{320} Ibid at 199-210.
\textsuperscript{321} Aday, Aging Prisoners, supra note 1 at 145.
\textsuperscript{322} Ibid at 146.
\end{footnotesize}
image. When disabilities and illnesses accumulate, the inmate becomes weaker, more isolated and chronically stressed, leading to a very fearful atmosphere.\(^{323}\)

A British report stated that “the values of prisoners’ social world set a premium of strength and endurance – so a physical decline matters more inside than outside.” As a result, they are no longer respected and the vulnerability of the individual increases with age.\(^{324}\) In the English system, there is a clear duty to take care of prisoners. Thus it was said that this duty extends to the duty of the guards to protect the prisoners against third parties, as far as physical safety and possessions are concerned.\(^{325}\)

In a US paper, the relationship between older and younger offenders has also been described as complex. Acknowledging that seniors are more vulnerable to victimization due to age and illness, and that they generally fear victimization from younger inmates, the latter are also used to care for the older offenders. In many prisons there is a care-giving system in which younger inmates provide care to their older counterparts. As well, it was pointed out that seniors often receive prestige and respect from younger prisoners, and guards report that the older inmates have a stabilizing effect on the prison population.\(^{326}\)

UNODOC also places mentally ill people at a higher risk of victimization, both sexually and physically. They also state that they are one of the categories most predisposed to a series of other human rights violations due to their varying inability to protect their interests without assistance.\(^{327}\) UNODOC is also particularly worried about the victimization of disabled prisoners. They are easy targets of violence from both prisoners

\(^{323}\) Ibid
\(^{324}\) Howse, supra note 255 at 30.
\(^{325}\) Dirk van Zyl Smit, “Prisoners’ Rights” in Jewkes, supra note 216 at 575.
\(^{326}\) William, supra note 216 at 65.
\(^{327}\) UNODOC, supra note 215 at 15.
and guards. There have been numerous cases reported where guards confiscated the prisoners’ wheelchairs, crutches, braces, hearing aids, glasses, and medication. People needing help with their ADLs may often be ignored, which is also a form of victimization and a psychological abuse (they are not fed; they are left without assistance to urinate on themselves etc.).\footnote{328}{Previous data showing that seniors are vulnerable due to their age and crimes, connected with data showing high percentages of mental illness and disabilities among older prisoners, place them at an increased risk of victimization.}

Aside from being more exposed to victimization, the older prison population seems to have fewer disciplinary problems than the younger inmates. OPs are more dependent on staff, they require more time and energy, but tend to stay out of trouble. They are less prone to violence, drug activities, fights or violating rules. CSC relies on studies that confirm that seniors are less socially deviant, impulsive and hostile than younger inmates. Being less physically potent, they tend to keep a low profile and have good relations with staff and other prisoners.\footnote{329}{A study}\footnote{328}{Ibid at 45.}

Aday also reported that older long-term offenders, more often than not, are model prisoners with “excellent patterns of behavior in prison.”\footnote{330}{New elderly prisoners avoid trouble as well, especially because they pass through a cultural shock when entering prison later in life which throws them into fear, depression, sadness, coldness, hopelessness, helplessness, hate, and loneliness. They have few coping skills and experience strong shame. They are more likely to be victims than create trouble themselves.\footnote{331}{A study}}

\footnote{328}{Ibid at 45.}
\footnote{329}{CSC, 1998, supra note 4 at 64-65.}
\footnote{330}{Aday, Aging Prisoners, supra note 1 at 116.}
\footnote{331}{Ibid at 114-115.}
conducted on 179 inmates over 50 showed that 9.5% had serious disciplinary problems, 32% had minor disciplinary problems, while the rest had no disciplinary problems at all.\footnote{Kerbs, supra note 221 at 218.}

The inverse relation between age and recidivism and age and prison misconduct has further been reported in American literature. Not only do they not instigate violence and get involved in violent prison activities, but older offenders also choose more passive avenues of protecting themselves (keep more to self, avoid certain areas of the prison, avoid activities, and prefer not to respond when taunted). Age was also negatively associated with aggressive precautionary behavior such as lifting weights, keeping weapons, and getting tough with other inmates. Thus, older inmates, in order to protect themselves prefer to distance themselves from the prison subculture that provides high status for inmates who use drugs, violence, financial schemes and have a general predatory behavior.\footnote{Kerbs & Jolley, 2007, supra note 319 at 129-130.}

Human Rights Watch recently reported that the likelihood of a prisoner to engage in “violence, extortion, escape attempts, or other dangerous or violent behavior” reduces with age. The correctional officers interviewed stated that seniors are far less likely to create trouble than the younger prisoners. They do not “mess with staff;” they just “want to be left alone,” and have better relations among themselves than the younger inmates do.\footnote{HRW, supra note 214 at 61.}

Finally, an American study conducted on older inmates with disciplinary and non-disciplinary records shows that even when such an inmate committed disciplinary offenses, they were likely to be non-violent. The first cause for disciplinary records among this age
group is the refusal to obey an order, and second is possession of contraband. The third reason is creating a disturbance and the fourth, vulgar language directed to staff.\textsuperscript{335}

5.4 Outside and inside relations

Relationships are crucial for any human being. They contribute to well-being and quality of life; they give purpose and motivation to carry on and to better one’s self. Helping prisoners to foster relationships and reconnect is extremely important, and often the only people left to do that are the correctional staff.

The literature has shown that good family relations are important not only for the sake of the family itself, but because they encourage successful resettlement and provide the motivation to desist from criminal activity. These relations are a reminder of the world outside and its responsibilities, and they permit the prisoner to continue his role as a family member.\textsuperscript{336} On the other hand, it is argued that contact with the outside world has three important functions: it is a necessary condition for the prevention of torture and inhuman or degrading treatment; it is an essential element in the normalization of prison regimes and the preparation for reintegration of all prisoners; and it is a prerequisite for the exercise of many fundamental rights that extend to different spheres of personal, social and even public political life (right to correspondence, right to family life, right to freedom of expression, or the right to vote).\textsuperscript{337}

Maintaining ties with the outside is very difficult, especially for offenders with long sentences. Many prisoners gradually lose interest in the world outside and focus only on

\textsuperscript{336} Alice Mills and Helen Codd, “Prisoners’ Families” in Jewkes, supra note 216 at 679-680 [Mills].
life in prison. As this happens, the prisoner becomes more dependent on the institution. The older the prisoner grows the harder it is to keep contacts outside of the institution. Friends and family die, they become old and sick too and have difficulties visiting. Sometimes the prisoner himself has difficulties reading and writing letters. Some relationships deteriorate because of the nature of the crime committed. Sex offenders and those who have committed crimes against their families are rejected and relationships are conflictive.\textsuperscript{338} Among the reasons why relations between OPs and families are disrupted, UNODOC also identified: the long time spent in prison, the history of criminal activity and the type of crime committed, the distance between prison and home, and, in some societies like Japan, the stigma placed on the family when a member is imprisoned.\textsuperscript{339}

Losing contact with friends and families raises a set of concerns for aging prisoners. Many times, the struggle to maintain contact and the realization that events happen in his family which he is not part of, adds to the prisoner’s stress. Breaking with the outside world can be a traumatic experience for the old prisoner who tries to adjust to aging itself. Moreover, the longer these relations are disrupted, the more difficult it will be to reestablish them at potential release.\textsuperscript{340} UNODOC also pointed out the effects the loss of family links or the death of loved ones has on an OP: it affects his mental well-being and the prospect of a successful reintegration into the community.\textsuperscript{341} The OPs with no or little external support actually fear release considerably more than the rest, and are less likely to attempt it.\textsuperscript{342}

\begin{flushleft}
\textsuperscript{338} Aday, \textit{Aging Prisoners, supra} note 1 at 123-124
\textsuperscript{339} UNODOC, \textit{supra} note 215 at 128.
\textsuperscript{340} Aday, \textit{Aging Prisoners, supra} note 1 at 124.
\textsuperscript{341} UNODOC, \textit{supra} note 215 at 128-129.
\textsuperscript{342} CSC, 1998, \textit{supra} note 4 at 78.
\end{flushleft}
In a study conducted with 102 older male prisoners, only 1/3 were married, over 2/3 had living siblings, 72% had children and 53% had grandchildren, 24% often or fairly often received visits, 38% had contact with family through phone calls or letters, 35% had occasional visits and 36% received occasional mail or phones, 41% claimed family never visited them, 25% said their family was not close to them, 10% gave ambiguous answers as family ties are “OK,” “they do the best they can,” or family is ashamed of them. As for friends, 72% said they had never been visited by outside friends, and 67% have never exchanged letters or calls with them.343 A complex review of the literature revealed that while older inmates are eager to communicate with the outside world, and despite the benefits of visitations, seniors receive very few visits. However, despite this fact, some older inmates will report being satisfied with their social networks.344

Another study cited in Kerbs shows that on average, older prisoners receive 1 phone call or 1 letter every 1-2 weeks. Many of the respondents complained of not receiving regular visits from family and friends. Of the three categories of OPs – new offenders, habitual offenders and long-term offenders, the less likely to have stable relations on the outside were the habitual offenders.345 In a study conducted in Florida prisons, 57% of OPs did not receive any family visits, only 10% had regular visits with friends and 90% reported communicating with people on the outside through phone or letters.346 However, in an older Canadian study, Gallagher found that OPs have fairly intact social networks. Compared with younger inmates, they had more phone calls, letters, visitors and friends.347

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343 Aday, Aging Prisoners, supra note 1 at 125.
344 Leigey, supra note 216 at 59 – 60.
345 Aday, Aging Prisoners, supra note 1 at 216.
346 Ibid
347 Gallagher, supra note 6 at 329.
UNODOC was firm in stating the obligation of corrections to encourage family relations especially for the terminally ill prisoners. The report says that if family links exist, an increased number of meeting opportunities should also exist. If not, the prison services should try to reestablish contact and assist, if necessary, with transport and finances. Also, the prison services should bring as many NGOs and volunteers as possible to establish relations with ill prisoners, and to train other prisoners to care for them.\(^{348}\)

However, while outside relationships fade as the years pass by, inside relationships take their place, sometimes becoming more important, and are crucial for the quality of life of seniors. Some sources cited in Aday confirm that friends contribute to an older person’s sense of belonging and meaningfulness. Satisfaction in late life is more closely related to interactions with friends than with relatives. Older adults tend to have friends their age, with the same interests, values, and experiences.\(^{349}\) Close personal relationships were said to be able to cushion the shock of physical deterioration, the loss of loved ones, and other sources of stress in the prison environment.\(^{350}\) However, the health of older inmates has a great impact on their ability to foster friendships. Infirmitities and disabilities may limit their possibilities for making friends. Older men, unlike older women, seem less likely to have deep and long-lasting friendships.\(^{351}\) Kerbs also cited studies that indicate that while many OPs were affiliated with different prison organizations (Alcoholics Anonymous, Narcotics Anonymous, etc), few had personal friendships because they believed confiding in someone was a sign of weakness. In contrast to that, another cited study found that 93% of

\(^{348}\) UNODOC, *supra* note 215 at 152.
\(^{349}\) Aday, *Aging Prisoners, supra* note 1 at 134.
\(^{350}\) *Ibid* at 135.
\(^{351}\) *Ibid*
the OPs fostered friendships in prisons. A British study sustained, with limited evidence, the conclusion that isolation and loneliness occurring from the separation from family and friends exists for OPs both in prison and upon release. In Aday’s study, older inmates reported being more likely to talk with other inmates about food, feelings regarding prison, religious feelings, health and illnesses and life outside prison. They were less likely to discuss death, shameful situations, and financial issues. Most of the inmates asked had at least one confidant they talked to about their intimate feelings. Gallagher also found that OPs are more likely to have friends and a confidant in prison than younger prisoners.

Older inmates are also more likely to report good relations with staff. Sometimes, correctional staff even plays the role of surrogate families for them. Human Rights Watch confirmed that the OPs seem to have a better opinion of the staff than younger inmates, and have better relations with them. Certain categories of OPs have been found to be more dependent on staff and the prison environment than others – unmarried OPs, those incarcerated at an early age, and recidivists. Dependency occurs with the dissolution of outside relations.

Though the results of the research done is sometimes conflicting, what is clear is that relationships, both external and internal are crucial to the well-being of the aging prisoners,
that the lonelier a prisoner is the more likely he is to develop institutional dependency, and that OPs are more likely to have good relations with staff than their younger counterparts.

5.5 Adjustment to the prison environment and programming needs.

The Committee for the Prevention of Torture (part of the European Council) stated in 1992 in its 2nd General Report that “ill treatment can take numerous forms which may not be deliberate but rather the result of organizational failings and inadequate resources. The overall quality of life in an establishment is therefore of considerable importance to the CPT. Quality of life will depend to a very large extent upon the activities offered to a prisoner and the general state of relations between prisoners and staff.”359

As previously pointed out, the capacity of a prisoner to adjust to the prison environment is strongly influenced by his age, health status, relationships that he has, safety, services available to him, and generally, how the system understands and responds to his needs.

Like all other inmates, older offenders try to maintain an emotional equilibrium and self-respect in a total institutional environment. The difference is that they do this while facing the physical, social, and spiritual challenges that come with aging.360 Older prisoners are of two categories – those who will be released and those who will die in prison. The correctional system must be prepared to fulfill the needs of both groups. Some will need release preparation, some end-of-life care. Some will deal with grief and death of dear ones, and loss of family ties; they will watch their bodies age and go to waste in prison. Some will be victims; some will be both old and aggressive and create trouble. Nearly all of them

360 HRW, supra note 214 at 45.
will deal with disease and depression, and some with other types of mental illness. Almost all of them have or had alcohol abuse problems, and some frequently use narcotics. Some will feel rejection and shame, others anger. Some will try to take their lives or harm themselves. Finally, some will die among strangers; others will be released among strangers. No matter what, they need to cope with all these situations and prisons have to provide them with the tools to do so under the threat of seriously violating human rights.

Prison services should be different for older inmates than for the younger ones. OPs have greater need for privacy and access to health care and legal assistance. They are less able to cope with the fast pace and noise of prison life. Many reported feeling cold in prison, complained about the distances to cafeteria or health units, about stairs, and lighting. It is more probable that OPs will need around the clock nursing care, special diets, and different activities than the younger inmates. OPs were generally found to have more difficulties adjusting to the prison environment and to take a greater length of time to do so. Prisons must adapt to the different needs these prisoners present. For example, bedridden inmates should be allowed to sit on the bed or simply be awakened for head count, the sheets of an incontinent inmate should be changed outside the schedule, officers should try talking to elderly inmates who break rules rather than punishing them, help may be needed by some OPs in cleaning their cell on time, etc. Thus, some rules may need to be altered in order to accommodate the capacities of older and ill offenders.

Prisoners with mental illnesses adjust with extreme difficulty and their reactions are often misunderstood. Untreated and inappropriately handled, they display disruptive

361 Aday, Aging Prisoners, supra note 1 at 143-145.
362 CPHA, supra note 216 at 49-50.
363 HRW, supra note 214 at 62,
behavior, can be aggressive and violent, and refuse to follow rules. They are often punished with segregation which only enhances their mental instability. Moreover, the bad behavior goes on their records and diminishes their chances for an early release.\textsuperscript{364} Also, special devices should be available to those who need them to improve their quality of life – corrective aids, and prosthetic devices (eyeglasses, dentures, hearing aids, ambulatory equipment, and special shoes).\textsuperscript{365} Without proper aids, and sometimes even with them, older prisoners cannot adapt to life in prison as they may not hear orders, or have difficulties standing for head count or moving fast enough. These behaviors can also be interpreted as disobedience and sanctioned with discipline, resulting in a negative impact on their early release opportunities.

Prison should be adapted to encourage OPs to live independently for as long as possible. This will help them conserve their mental health and purpose. Modifications to the prison physical plant and operating practices may delay the need to put an OP in nursing care. Modifications should include assignments of lower bunks, more time to eat, separate wings or individual cells for them to minimize the noise, stress, and lack of privacy.\textsuperscript{366} Prisoners with disabilities should be placed in spaces without stairs, and the programs should be accessible to them in order to avoid discrimination.\textsuperscript{367} Accessibility and safety are the two most important elements in planning and designing an institution. There should be ramps and subtle grades for access, with handrails where needed. Doors should be three feet wide with thresholds one-half inch or lower. Instead of knobs, levers should be used,

\begin{footnotes}
\item\textsuperscript{364} UNODOC, \textit{supra} note 215 at 36-37.
\item\textsuperscript{365} Aday, \textit{Aging Prisoners}, \textit{supra} note 1 at 143.
\item\textsuperscript{366} Morton, \textit{supra} note 219 at 243-244; See also Crawley, \textit{supra} note 219 at 229.
\item\textsuperscript{367} Aday, \textit{Aging Prisoners}, \textit{supra} note 1 at 144.
\end{footnotes}
and the pulling force on closing doors should be less than five pounds.\(^{368}\) A lot of prisons are not designed to minimize falls, do not permit barrier-free access to bathrooms and other facilities, or do not allow for short walks to access meals, medical care, and other needed services.\(^{369}\) An English report confirms that prisons are not adapted for older inmates who have mobility problems, hearing or vision impairments, incontinency etc. For these people, imprisonment may have the effect of a double punishment.\(^{370}\) CSC remarked in 1996 that prisons were made to accommodate younger offenders. To be appropriate for OPs, doors needed to be widened for wheelchairs, the toilet space needed to be larger, grab handles in showers were needed, as well as parking space for a wheelchair inside a cell, food delivery to cell, cell calls from medical staff, and adaptation of recreation activities for every capacity.\(^{371}\)

A UK study identified the main strenuous activities for seniors: being kept at gates longer than necessary; not being allowed sufficient time to complete activities or to get to specific locations; being expected to watch TV in communal areas on hard, un-upholstered chairs; being denied additional clothing or bedding in cold weather; having to queue for long periods to obtain medication; having to climb stairs while carrying food trays; having to shower in slippery, tiled cubicles that do not have grab-rails or anti-slip mats; feeling abandoned and “dumped” because of few on-site staff members.\(^{372}\)

\(^{368}\) Laura Addison, Delores Craig-Moreland, and Connie L. Neeley, “Addressing the Needs of Elderly Offenders” (1997) 59:5 Corrections Today 120 at 122 [Addison]. For a similar and more recent opinion see HRW, supra note 214 at 47.

\(^{369}\) Kerbs, supra note 221 at 234.

\(^{370}\) US Department of Justice, supra note 231 at 14.

\(^{371}\) CSC, 1998, supra note 4 at 71-72.

\(^{372}\) Crawley, supra note 216 at 231.
In geriatric units, urinals should be substituted for toilets because for many prisoners standing might be challenging. Also, at least one bathtub should be provided. Grab bars are required as well as sits and flexible nozzles. The floor should be abrasive to minimize the risk of slipping.\textsuperscript{373} The lighting needs to be good but not too bright in all areas where seniors live, as with age a sensitivity to glare is developed which can affect balance, orientation, and memory span. Floor surfaces should not be too glossy or have random patterns. Sound control should be done through acoustical ceilings and low-pile carpets, so that each sound can be clearly distinguished.\textsuperscript{374} Nevertheless, more training for the staff working here should exist in order to prepare them to work with a very particular category of prisoners.\textsuperscript{375}

Work is extremely important for both the institution and the prisoner. His life becomes more bearable if he has something to do. Work allows OPs to be physically active and to be involved in the prison routine. They have less time to be filled with boredom and self-pity. Thus, work can slow down physical and mental decline. Nevertheless, not all OPs are able to work, and more importantly, not all work assignments are suitable for them. Sometimes it can be very challenging to find an appropriate work opportunity for old and sick prisoners. Also, those in sheltered environments have fewer work opportunities than those in the general population.\textsuperscript{376}

In the European literature it has been said that work is very important for OPs because most of them have been working all their lives and it is an important part of their personal

\textsuperscript{373} Addison, \textit{ supra} note 368 at 123.  
\textsuperscript{374} \textit{Ibid}  
\textsuperscript{375} HRW, \textit{ supra} note 214 at 63.  
\textsuperscript{376} Aday, \textit{Aging Prisoners, supra} note 1 at 130.
identity. The activities and jobs offered should be those that tackle their acute fear of physical and mental deterioration.\textsuperscript{377} People in special needs units especially complain about not having anything to do and losing their income upon transfer. A lot of creativity is required in finding appropriate jobs and programs for all kinds of abilities and physical capabilities. Aday suggests that inmates should be more encouraged to do work for each other, thus smoothing the prison operations as well.\textsuperscript{378} In Canada there is no mandatory retirement age. Gallagher actually found that older inmates had higher status and were afforded better prison jobs than the younger inmates. They worked on average 25.5 hours per week, compared to the younger inmates who worked 17 hours. They had kitchen or laundry jobs, yard or office maintenance, clerical and school roles, and manufacturing and craft positions.\textsuperscript{379}

Studies show that the most attended prison programs are religious activities. This helps prisoners find internal stability, and a smooth adjustment to and from prison. A study cited by Aday found that religious background and beliefs were very important for adjustment to prison. Out of 96 people over 50, 37\% attended church services at least once a week and 13\% attended several times per week. 51\% were involved in private religious activities, such as prayer, meditation, and Bible study every day (19\% several times per day). These activities were more frequent among recently incarcerated older men and they decreased with the time spent in prison. One-third of these men reported having a religious experience that changed their lives, of which 77\% said that this experience helped them cope with life in prison, 32\% reported that religion was the most important thing that kept them going.

\textsuperscript{377} Van Zyl Smit & Snacken, supra note 337 at 183.
\textsuperscript{378} Aday, Aging Prisoners, supra note 1 at 131.
\textsuperscript{379} Gallagher, supra note 6 at 332.
40% indicated religion as one of the most important things, and 16% indicated that religion helped them cope with the stressors of life in prison.\(^{380}\) Aday reached the same conclusion in his own study: for most new elderly offenders religion was the most important thing that helped them cope with the pains of the imprisonment. They also tended to be more involved in informal religious activities (like prayer or reading the Bible), than in formal ones (like attending Church). Apparently, religious activities improve the mental outlook, reduce anxiety, depression and management problems.\(^{381}\) As a result of this conclusion, more religious activities are suggested, such as outside religious speakers, permanency of a chaplain or use of the pastors in the community.\(^{382}\)

As for other pastimes, prisoners often complain about the lack of programs available to them. Most programs are designed for younger inmates. As a group, OPs prefer more passive activities: watching TV, visiting other inmates, sleeping, reading, playing cards, religious activities, and writing letters or making phone calls. In a geriatric unit in Texas, prisoners reported mealtimes as the most important activities of the day. The second most popular was watching TV. A few visited with friends, wrote letters, read newspapers or magazines, snacked or napped. Very few went out for fresh air. They were deterred by the security formalities that required a strip search every time they went in and out of the facility.\(^{383}\) Another article mentions as the most popular activities reading, watching TV, exercising, and working. They are less likely to participate in activities that involve interaction (social or recreational, counseling, educational or vocational).\(^{384}\) Gallagher also

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\(^{380}\) Aday, Aging Prisoners, supra note 1 at 132.
\(^{381}\) Ibid at 132-133.
\(^{382}\) Ibid at 133.
\(^{383}\) Aday, Aging Prisoners, supra note 1 at 134.
\(^{384}\) Ornduff, supra note 1 at 184.
found that in Canada, older inmates were most likely to engage in religious activities in prison, and least likely to participate in gym activities or team sports.\textsuperscript{385}

Some authors have recommended that a multipurpose room be created in geriatric units where the prisoners can read, watch TV, play cards, etc. Also, a supervised craft room should be established to encourage creativity. An outside recreational area, which can be winterized, with easy access, shade areas and drinking fountains is essential for elderly prisoners.\textsuperscript{386}

Few prisons have been identified as having any plans for those spending long periods of time inside. Some staff even exclude older inmates from educational and vocational programs to create room for younger prisoners.\textsuperscript{387} Not only are they discouraged from participating, but often the existing programs are of little to no use or interest for older inmates. Nevertheless, the lack of programs for aged or disabled prisoners raises serious issues of discrimination.\textsuperscript{388} A UK survey found that people over 60 are very unlikely to engage in educational programs designed for younger inmates. Also, after 60, inmates are not required to work any longer, even though many still want to. The lack of suitable programs and work throws the OPs into inactivity, avoided in the community through programs for older adults.\textsuperscript{389}

In Canada, in 1996, the study done by CSC on the prison population showed that there are no programs for elderly prisoners. Rather, all programming was concentrated on rehabilitating younger offenders. Thus, older offenders were either discouraged from

\textsuperscript{385} Gallagher, \textit{supra} note 6 at 329.
\textsuperscript{386} Addison, \textit{supra} note 368 at 123.
\textsuperscript{387} Aday, \textit{Aging Prisoners, supra} note 1 at 154; Ornduff, \textit{supra} note 1 at 184.
\textsuperscript{388} Kerbs & Jolley, 2009, \textit{supra} note 318 at 123.
\textsuperscript{389} Howse, \textit{supra} note 259 at 32.

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participating because of lack of room, or they could not participate due to health status, or they were unmotivated to participate in what is offered. The tendency has been to isolate the older offenders and to ignore their programming needs. The most recent CSC profile of older offenders is silent about the needs of the OPs or how they are being met. Recently, the Canadian Correctional Investigator reported that since the programming needs of older inmates are different than those of younger inmates, the programs available may have very little relevance to the OPs’ life. CSC generally offers programs focused on vocational training and employment – building skills to address a lack of job skills, low educational attainment or motivation. These may not be relevant for a person approaching the end of his life. Also, because there are not many programs available, many long-term offenders only access programs very late in their sentence. Other times, inmates themselves refuse to attend counseling, educational or vocational prison programs. Thus, OPs spend long hours locked in their cells during programming or working time. The Correctional Investigator suggests that programs should be tailored for aging prisoners’ needs – they should come in shorter sessions, have enhanced accessibility, assistive devices, and more bathroom breaks.

In many correctional systems, engagement in work and activities is repaid with a set of privileges and counts for conditional release. By depriving the OPs of appropriate work places and programs, a discriminatory system is created, which not only contributes to the decline in the physical and mental health of the individual but also reduces his chances of being released early, independently of his fault. UNODOC is particularly concerned about

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390 CSC, 1998, supra note 4 at 70.
391 CSC 2015, supra note 5.
392 Sapers, Report 2010-2011, supra note 3 at 22-23.
discrimination against disabled. Disability makes the adjustment of these people extremely difficult. They have difficulties in accessing services, complying with prison rules, and participating in prison activities. UNODOC mentions that this category of prisoners is routinely denied participation in work and other programs which increases their imprisonment time, by diminishing their chances of an early release.393

The importance of group participation has been underlined in the literature. Support groups offer help in dealing with difficulties. It also helps people who will die in prison, can offer counseling and minimizes social isolation. The groups can be of different types: dealing with grief, assertiveness training, alcohol abuse support, coping with loneliness and institutionalization, for physical and cognitive impairments, for religious convictions, ethnic pride and dying in prison. Reminiscing groups are peer groups that talk about their past, recalling and reliving past experiences. They are good for increasing interpersonal involvement, social skills, satisfaction and self-esteem. They improve morale, ego integrity, and they help prisoners regain a sense of their uniqueness, and individuality. They also have an entertaining role. Re-motivation therapy is also good for OPs as it increases a sense of reality, and helps them gain maximum benefits from other programs. Mostly, it helps OPs to get and to maintain a sense of purpose from their daily activities. Psychotherapy groups are essential for developing strategies to cope with fear, guilt, loneliness, stress, anxiety, and grief. All prisons should have a variety of these programs for their OPs.394 Human Rights Watch also recommends programs for elderly that would address the realities of aging, or that would help them understand and protect their health

393 UNODOC, supra note 215 at 45.
394 Aday, Aging Prisoners, supra note 1 at 154-158.
in later years. Physical activities should be encouraged by creating age-based activities, appropriate and interesting for their capacities, which can also keep them fit and healthy.\textsuperscript{395}

Human Rights Watch explained in a recent report that when it comes to OPs, the right to safe conditions of confinement does not mean being housed with young, violent offenders or being placed on the top bunk. The right to a safe environment means that OPs should receive extra blankets and clothing in winter, should not have to stand in line to get medications, should have more time to eat, and should receive age-appropriate educational, vocational, and recreational opportunities. Any disciplinary punishment should be adapted to reflect the diminished capacity of mentally ill seniors, and disabled prisoners should receive respectful help with ADLs.\textsuperscript{396}

The literature points to a number of issues that older offenders face behind bars. While data reviewed differs based on the study’s origin, sample size, and date, it is not difficult to establish some common themes. The majority of the studies established a high level of physical and mental conditions in older offenders, including disabilities. Institutions are underprepared to deal with people in frail health conditions. These individuals have difficulty adjusting to an environment that is often not age friendly, both infrastructure and activities wise. This increases the OPs’ fears and isolation, which in turn increases their mental health problems. The most common response to mental illness is disciplinary and has no therapeutic value. In addition, the realities older people face are not properly addressed. Help in dealing with dying, death of close relatives, disease and aging bodies, is much needed. Finally, older offenders are at risk of being victimized. The need to create

\textsuperscript{395} HRW, \textit{supra} note 214 at 68-69.

\textsuperscript{396} \textit{Ibid} at 46.
a safer environment where older people’s health and programming needs can be addressed with priority has been mentioned in most studies reviewed.
Chapter 6
Methodology

The issues explored by this study lie at the crossroads of law, policy, social and health sciences. More specifically, social science empirical methodology was employed to answer legal questions pertaining to the protection of prisoners’ rights. The main research questions were: What are the needs of older offenders and how are these influencing their legal rights? Are institutions prepared to deal with the potentially increased needs of older offenders? If no, is it an infringement of this population’s rights? Is the Canadian legal framework broad or specific enough to offer protection to the vulnerabilities of the older prison population?

In order to answer all of these questions, a methodology was developed to determine the needs of older offenders (which were presumed to be similar to or greater than those mentioned in the existing literature regarding the older community population) and to discover how the institutions were meeting these needs.

From the beginning, the study encountered a number of limitations. The Correctional Service Canada has undergone a period of budgetary cuts which were reflected in the area of the research projects that received clearance (even if those projects were not sponsored by the federal government). For this study, it meant a serious restriction on the time I was allowed to carry out my study, for the number of interviews, and the fact that I was not approved access to a younger prison population that I could use as a “comparison group.” In order to minimize the limitations brought about by the lack of a
younger control group, I reviewed the medical literature on older people in the community in order to have a solid idea of what problems are associated with aging. I was also not given clearance to interview female offenders. As a result, the findings of this study are relevant only for male offenders.

In addition, my request that I have access to the medical files (with inmate consent) of those people that I interviewed in order to put together a more objective set of data, was also rejected. Lastly, I requested that I be allowed to interview officials, correctional officers, and medical staff who worked with senior inmates, in order to hear their perspectives on the impact of the prison environment and how budgetary concerns might affect this population. Having two perspectives - those of prisoners and staff - might have helped put the claims made by inmates into a larger institutional perspective. Unfortunately, this request was also rejected. As a result, I only received clearance to interview up to 200 male inmates over the age of 50 in 7 federal institutions in Ontario. The fact that all institutions were located in Ontario was another limitation of the study. No doubt, even if they belong to the same federal system, institutions across the country may differ because of geo-political influences, as well as demographics and access to volunteer agencies. While it would have been ideal to have a sample of institutions from other provinces, I am confident that the approach towards older offenders is fairly similar to those my study reflects because the Commissioner’s directives, as well as the distribution of resources, including financial and health, originate from the CSC headquarters. The provinces make no financial contribution to federal institutions even in the area of health. I would thus expect that in the area of health care especially, the CSC institutions do not differ greatly based on their location.
However, the lack of access to medical files, to a comparison group and to staff members have reconfigured both the content and the goals of the study. The inability to corroborate the information received in the inmate interviews is obviously a limitation: it needs to be kept in mind that the source of data is the prisoners themselves. As a result, in order to attempt to compensate for this limitation, I increased the number of questions in order to see if there is internal consistency within individuals. I also introduced a number of open-ended qualitative questions to help interpret the answers that were obtained. I use these later to explain the quantitative data.

I carried out 197 interviews in 7 federal institutions. In 2012, when the study commenced, the population of male offenders over 50 in federal institutions was roughly 2000, according to data provided by the Correctional Service Canada. All institutions were from Ontario. All levels of security were represented: there were three medium security (both lower and high medium), and two minimum security and one maximum security institution, as well as an assessment unit.

Recruitment was carried out in each institution separately either via posters and recruitment letters or via group presentations. Participation was purely voluntary and nobody who asked to be interviewed was turned down. On average, 1/3 to 1/2 of the eligible offenders were interviewed in each of the institutions visited. The smallest number of participants in one institution was 7 and the largest 36. The youngest interviewee was 50 and the oldest 82. It was impossible to obtain a truly random sample. Initially I was hoping to do group presentations for all eligible individuals, and invite them to sign up if interested. Afterwards I planned to randomly pick 30-33 of the individuals. However, I was allowed to employ this type of recruitment in only 2 institutions. For the rest, the recruitment was
done by posters or letters. In the 2 institutions where I made group presentations the volunteering rate was high; in the rest it was much lower. As a result, I basically interviewed everybody who signed up. The other main recruitment issue was that my presentation, be it verbal or through letters, probably did not reach the people who did not speak English, who were bedridden, had severe mental illnesses, or were illiterate. I was not allowed to carry out interviews in the inmates’ units. Hence the people with serious mobility problems were precluded from talking to me. This is obviously unfortunate. While many of my participants were seriously ill, none was terminally ill. In each institution I heard about terminally ill people being in excruciating pain. However, this was all second-hand information and I had no access to those individuals mentioned.

The limitations on the sample I was able to interview are obviously unfortunate. It would appear likely, however, that many of those who were not sampled would have been more challenged by their illnesses. Nevertheless, in circumstances such as this one, the choice is not whether to use an ideal sample or a less-than-ideal sample. The choice is to do the best study that is possible or no study at all.

Each interview was pre-scheduled and took between 30 to 60 minutes. The interviews were based on a structured protocol of 72 questions (see Appendix 1). The protocol had a number of sections and the questions in each section were developed based on similar studies that had been conducted elsewhere (especially in the US and the UK)\textsuperscript{397}

\footnotesize{\textsuperscript{397} See e.g. Aday, Aging Prisoners, supra note 1; Howse, supra note 259.}
and on problems associated with aging as identified through a review of the community medical literature.\textsuperscript{398}

The general section reviewed demographic issues (such as age, length of sentence, time spent in prison, previous incarcerations, and parole applications). The second section, Daily Living, was concerned with difficulties regarding activities of daily living and any accommodations that have been made to meet those difficulties. The third section, Programs and Exercise, reviewed aspects related to correctional and recreational activities and their appropriateness to age and needs. The fourth section, Health, included questions related to perceived health status, illnesses, medication, medical visits, medical requests, preventive measures available, place and intensity of different medical interventions, pain management and mental problems. The Safety section explored aspects related to age segregation, perceived dangers, and abuses suffered at the hands of other inmates or staff members. The Relationships section looked at social ties that inmates had inside and outside the institution, as well as their feelings towards them. I ended my interviews with some open-ended questions.

The answers to 71 questions were quantified, by creating variable names and labels based on the similarities of the answers. The unusual answers were labeled “other.” The codified answers were entered into an SPSS data table. The data was analyzed in SPSS by calculating frequency, distributions, and running cross-tabulations between answers in

\textsuperscript{398} See e.g. Ham, \textit{supra} note 143; CIHI 2011, \textit{supra} note 176; Canadian Institute for Health Information, “Health Care in Canada” Annual Report 2010 [CIHI 2010].
different sections of the protocol. Their statistical relevance was determined by using chi-square tests.

Finally, as mentioned, the study had a short but interesting qualitative dimension as well. The observations of the researcher derived from the interactions with prisoners and staff, as well as the comments of the participants were unquantifiable. They are however important because they point to the issues that are institutional rather than systemic.
Chapter 7
Findings

7.1 Quantitative Data

7.1.1 Demographics

For this study I interviewed 197 male offenders over the age of 50 from 7 penitentiaries. Three of the institutions were medium security (Joyceville, Collins Bay and Bath Institutions) and half of the participants were hosted in them (50.3%). The minimum security institutions (Frontenac and Pittsburgh) provided 33.5% of the participants. I only interviewed offenders from one maximum institution (Milhaven) which formed 9.1%. Finally, I also interviewed some offenders in Joyceville Assessment Unit (7.1%).

Table 1: Age distribution of the sample

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage/ Frequency</th>
</tr>
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<tbody>
<tr>
<td>50 - 59</td>
<td>55.3% (109)</td>
</tr>
<tr>
<td>60 -69</td>
<td>33 % (65)</td>
</tr>
<tr>
<td>70 and over</td>
<td>11.7% (23)</td>
</tr>
</tbody>
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Table 2: Distribution based on security level

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<thead>
<tr>
<th>Level of security</th>
<th>Percentage/ Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>33.5% (66)</td>
</tr>
<tr>
<td>Medium</td>
<td>50.3% (99)</td>
</tr>
<tr>
<td>Maximum</td>
<td>9.1% (18)</td>
</tr>
<tr>
<td>Assessment Unit</td>
<td>7.1% (14)</td>
</tr>
</tbody>
</table>

From the participants, a slight majority had been to prison (either federal or provincial) before the current sentence (55.4%). The rest were serving time for their first
offence. The highest percentage was that of inmates who were serving a life sentence, followed by the ones that were serving a short sentence, and those who were serving medium length sentences. Roughly 12% were serving an indeterminate sentence.\textsuperscript{399}

Table 3: Distribution of sentences

<table>
<thead>
<tr>
<th>Length of sentence</th>
<th>Percentage/ Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short sentences (2 – 5 years)</td>
<td>29.9 (59)</td>
</tr>
<tr>
<td>Medium sentences (6 – 10 years)</td>
<td>13.7 (27)</td>
</tr>
<tr>
<td>Long determined sentences (&lt;10 years)</td>
<td>10.7 (21)</td>
</tr>
<tr>
<td>Life sentence</td>
<td>33.5 (66)</td>
</tr>
<tr>
<td>Indeterminate sentence</td>
<td>12.2 (24)</td>
</tr>
</tbody>
</table>

The majority of people serving life sentences, indeterminate or long sentences had been convicted prior to turning 50. Almost half of the participants had already served over 10 years of their current sentence at the time I talked to them, with over 11% having spent between 20 and 29 years and another 11% had spent over 30 years in prison. Aside from the people serving an indeterminate sentence (where the majority had prior convictions) and the assessment unit (where the majority had no prior convictions) the proportion of recidivist offenders was roughly 50% for each category of sentence length.

Most of the offenders were either eligible for parole at the time of the interview or had already passed their first parole eligibility date. Slightly over 33% had not reached their parole date yet. In addition, 18.8% had their first parole date over 10 years ago. Over 15%, while not having had their parole yet, were going to have a hearing within the next year. Only 2.5% would have to wait over 10 years for their first parole date.

\textsuperscript{399} People found guilty of three violent offences may be labelled “dangerous offenders” and sentenced to indeterminate imprisonment. They are technically considered to be serving a life sentence. However, they are eligible to apply for parole every second year.
Twenty four percent of the participants had applied for parole in the past (sometimes repeatedly) but were denied. Fifteen percent had been released on parole during the current sentence but it was revoked for various reasons. Over half of the participants were planning to apply at their next parole date, and over 37% of the entire sample believed they had good chances of being released. 18.3% were close to their statutory release date. 17.8% reported not applying for any parole, either because they had no hopes of being released (10.5% of the entire sample) or because they had an appeal that they hoped would be successful in (6.1%). 1.5% reported not applying because they had no interest in being released.

The number one fear of the participants is dying in prison (29.5%). Only 19.3% reported having no fears, with the rest mentioning family concerns (8.6%), safety (13.2%), parole (6.1%), life on the outside once paroled (5.1%), control of their assets (3%), and other (15.2%). The findings below might shed some light on the reasons behind these fears.

7.1.2 Physical Health Care Findings

a. Main Physical Health Issues and Their Impact on Older Offenders

Health needs and how they are being met are central to this study, based on the presumption that they are of primary importance for the quality of life of an individual. Over 63% of the offenders in the study stated that they believed their health worsened since they were incarcerated for their current sentence, both because of the natural aging process and the rigours of incarceration. Over 19% said their health improved while incarcerated, the main reason being the lack of access to drugs and alcohol. About 17% believe their
health remained the same since they came to prison. These numbers align with American findings.  

All participants to the study reported at least one physical medical condition.

Table 4: Distribution of participants/ number of reported physical conditions

<table>
<thead>
<tr>
<th>Number of physical conditions</th>
<th>Percentage/ Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 5</td>
<td>35% (69)</td>
</tr>
<tr>
<td>6 – 7</td>
<td>36.5% (72)</td>
</tr>
<tr>
<td>8 – 16</td>
<td>28.4% (56)</td>
</tr>
</tbody>
</table>

Regarding their perceived overall health, 27% graded it as relatively poor, 36.7% were in the middle, and 36.2% reported being in relatively good shape. The rates of people who considered their health as good is much lower than that reported in the American literature. The opinion of my participants seemed to be directly influenced by the number of physical conditions they reported. The inverse relationship between medical conditions and perceived health status was also identified in the literature.

Table 5: Overall perceived health distributed per number of physical problems mentioned

<table>
<thead>
<tr>
<th>Overall perceived health</th>
<th>Number of physical conditions reported</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 to 4</td>
<td>5 to 7</td>
</tr>
<tr>
<td>Relatively poor</td>
<td>5.7% (3)</td>
<td>35.8% (19)</td>
</tr>
<tr>
<td>Middle</td>
<td>29.2% (21)</td>
<td>44.4% (32)</td>
</tr>
<tr>
<td>Relatively good</td>
<td>63.4% (45)</td>
<td>28.2% (20)</td>
</tr>
</tbody>
</table>

Chi square= 59.300, df = 4, p < .001

The majority of the rates of certain diseases were higher than those recorded in American and British studies (with some notable exceptions such as heart problems).  

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400 See above page 94; see also Leigey, supra note 216 at 56.
401 See above page 100.
402 Leigey, supra note 216 at 56.
403 See above pages 100-101.
The most commonly mentioned diseases are presented in the table below. 47.7% of the participants also mentioned different isolated conditions such as MS, Lou Gehrig’s disease, etc. 13.7% of the participants had dentures, while 3% had no teeth and no dentures. 1.5% were waiting to receive dentures. Finally, 13.7% reported being incontinent.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>24</td>
<td>12.2</td>
</tr>
<tr>
<td>Arthritis</td>
<td>100</td>
<td>50.8</td>
</tr>
<tr>
<td>Digestive</td>
<td>48</td>
<td>24.4</td>
</tr>
<tr>
<td>Skin problems</td>
<td>53</td>
<td>26.9</td>
</tr>
<tr>
<td>Severe heart problems</td>
<td>54</td>
<td>27.4</td>
</tr>
<tr>
<td>Cancer</td>
<td>14</td>
<td>7.1</td>
</tr>
<tr>
<td>Physical disability</td>
<td>37</td>
<td>18.8</td>
</tr>
<tr>
<td>Wounds</td>
<td>24</td>
<td>12.2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>53</td>
<td>26.9</td>
</tr>
<tr>
<td>Hypertension</td>
<td>83</td>
<td>42.1</td>
</tr>
<tr>
<td>Severe oral problems</td>
<td>48</td>
<td>24.4</td>
</tr>
<tr>
<td>Cerebral–vascular problems/epilepsy</td>
<td>19</td>
<td>9.6</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>28</td>
<td>14.2</td>
</tr>
<tr>
<td>Circulation</td>
<td>39</td>
<td>19.8</td>
</tr>
<tr>
<td>Sleep apnea</td>
<td>16</td>
<td>8.1</td>
</tr>
<tr>
<td>Severe hearing problems</td>
<td>52</td>
<td>26.4</td>
</tr>
<tr>
<td>Severe sight problems</td>
<td>162</td>
<td>82.2</td>
</tr>
<tr>
<td>Pinched nerve</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Back problems</td>
<td>63</td>
<td>32</td>
</tr>
<tr>
<td>Hernia</td>
<td>13</td>
<td>6.6</td>
</tr>
<tr>
<td>Thyroid</td>
<td>10</td>
<td>5.1</td>
</tr>
<tr>
<td>Sciatic nerve</td>
<td>11</td>
<td>5.6</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>48</td>
<td>24.4</td>
</tr>
<tr>
<td>Foot problems</td>
<td>33</td>
<td>16.8</td>
</tr>
<tr>
<td>Bladder</td>
<td>11</td>
<td>5.6</td>
</tr>
<tr>
<td>Constipation</td>
<td>9</td>
<td>4.6</td>
</tr>
<tr>
<td>Severe prostate problems</td>
<td>15</td>
<td>7.6</td>
</tr>
<tr>
<td>Other</td>
<td>94</td>
<td>47.7</td>
</tr>
</tbody>
</table>

According to the literature, the following are associated with aging: muscular-skeletal problems, including arthritis and back issues, digestive problems, heart diseases, skin
issues, cancer, physical disabilities, wounds due to falls, neurological conditions as strokes, visual and hearing impairments, cancer, hypertension, oral problems, and incontinence.\(^{404}\)

*Mobility problems* reported were higher than those identified in the literature.\(^{405}\)

Such problems have also been associated with aging in the literature.\(^{406}\) 53.7\% of the participants reported having mobility problems that interfered with their activities of daily living, mostly walking (37\%), getting on and off bed (16.8\%), and climbing stairs (37\%). However, only just over 6\% of the participants received regular help with their mobility issues, always from a peer assigned as a caregiver. Peer caregivers were available in only three of the institutions studied. Mobility problems that interfere with activities of daily living are statistically connected both with the number of conditions an individual reported and his overall perceived health. 50\% of those reporting mobility problems had over 8 diseases, and 41\% had between 5 and 7. In contrast, only 35.8\% of those not reporting problems with activities of daily living (ADL) had over 5 conditions.

**Table 7: Distribution of ADL problems per overall perceived health rates**

<table>
<thead>
<tr>
<th>Problems with Activities of Daily Living (ADL)</th>
<th>Overall perceived health</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Relatively poor</td>
<td>Middle</td>
</tr>
<tr>
<td>No</td>
<td>7.6% (7)</td>
<td>37% (34)</td>
</tr>
<tr>
<td>Yes</td>
<td>44.2% (46)</td>
<td>36.5% (38)</td>
</tr>
</tbody>
</table>

Chi-square = 41.878, df = 1, \(p < .001\)


\(^{405}\) See above pages 103-105.

\(^{406}\) McKenna, *supra* note 404; Jagger, *supra* note 404; see above p 71.
Individuals with mobility problems appeared more at risk of falling. 35% of the participants reported falling in the last year while in prison, most of them on the ice. 18.5% fell more than twice during the same period of time. This supports the American literature’s request for both improvement of the accessibility and safety features of institutions. 407 Inmates reported falling in a higher rate than Canadian seniors did in the community. 408 Environmental modification was one of the main recommendations made to help seniors in the community cope with aging. 409 Such modifications are not widely available in prison.

Table 8: Distribution of mobility issues per fall rates within the last year

<table>
<thead>
<tr>
<th>Issues with mobility/activities of daily living</th>
<th>Falls within the last year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>73.9% (68)</td>
<td>26.1% (24)</td>
</tr>
<tr>
<td>Yes</td>
<td>57.1 (60)</td>
<td>42.9 (45)</td>
</tr>
</tbody>
</table>

Chi-square = 6.060, df = 1, p = .014

35% of the participants reported having been prescribed a *medical diet*. The number of individuals who reported needing a special diet was proportional to the number of conditions an individual reported and inverse to his overall perceived health status. Only 11% reported being on a medical diet and being able to follow it in prison. The need for a medical diet is often associated with diseases typical for an aging society, especially diabetes. 410 With a percentage of almost 30% among the participants (see above Table 6), the lack of readily available nutritional diets for diabetes is worrisome. In addition, malnutrition has been identified in the community literature as typical in older age. 411 Thus,

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407 See above p 112.
409 See above p 72.
411 See above p 74.
there should be age appropriate diets that are sensitive to the transformations associated with aging.

*Pain management* seems to be one of the main problems. Pain was identified by numerous participants as the most debilitating aspect of their life in prison.

62.4% of the participants reported suffering from severe pain on a regular basis. When asked what the source of their pain was, on the top of the list was arthritis or other joint pains (49.2% of the total sample) and headaches or migraines (8.6%). Other sources were cancer, foot pain, muscular pain, and nerve pain.

The pain individuals reported appeared to be directly proportional to the number of physical ailments the individuals were suffering from.

Table 9: Distribution of pain per number of physical problems mentioned

<table>
<thead>
<tr>
<th>Pain on regular basis</th>
<th>Number of physical problems mentioned</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 to 4 problems</td>
<td>5 to 7 problems</td>
</tr>
<tr>
<td>No</td>
<td>64.9% (48)</td>
<td>25.7% (19)</td>
</tr>
<tr>
<td>Yes</td>
<td>17.1% (21)</td>
<td>43.1% (53)</td>
</tr>
<tr>
<td>Total</td>
<td>35% (69)</td>
<td>36.5% (72)</td>
</tr>
</tbody>
</table>

Chi square = 48.962, df = 2, p < .001

In addition, the physical conditions that appeared to have a relevant connection to pain were arthritis (64.2% of those in pain reported arthritis as opposed to 28.4% of those who were not in pain), physical disabilities (26% versus 6.8%), long term severe back problems (43.9% versus 12.2%), digestive issues (34.1% versus 8.1%), outstanding wounds (18.7% versus 1.4%), diabetes (31.7% versus 18.9%), hypertension (49.6% versus 29.7%), severe oral problems (32.5% versus 10.8%), hernia (9.8% versus 1.4%), sciatic nerve (8.9% versus 0%), high cholesterol (30.1% versus 14.9%), foot problems (22% versus 8.1%).

There is also a tendency for people reporting pain to also report conditions such as pulmonary disease (15.4% versus 6.8%), severe hearing problems (30.9% versus 18.9%),
and severe vision problems (86.2% versus 75.7%). Of these, arthritis, severe back problems, physical disabilities, diabetes, severe oral problems, hypertension, physical injuries, pulmonary diseases, severe hearing and sight problems are commonly associated with aging.412

It also appears that those who were in pain were more predisposed than the others to fall and injure themselves. 42.3% of those reporting pain also reported falling at least once within the last 12 months, as opposed to 23% of those pain free. On the other hand, pain could also be the result of falling.

Sleep was also affected by pain. 52.8% of those reporting regular pain also reported serious sleeping problems, as opposed to 36.5% of those not in pain. This was of particular concern, since a different set of findings resulting from the study also identified sleep deprivation as having relevant connections to other aspects of an inmate’s well-being, especially mental health.

<table>
<thead>
<tr>
<th>Pain on regular basis %</th>
<th>Sleep deprivation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>58.1% (43)</td>
<td>41.9% (31)</td>
</tr>
<tr>
<td>Yes</td>
<td>36.6% (45)</td>
<td>63.4% (78)</td>
</tr>
</tbody>
</table>

Chi- square = 9.271, df = 1, p = .002

Mobility was also directly connected to pain. Hence, people impaired by mobility problems in their activities of daily living were more likely to report being in pain than the

--

rest. While 81.9\% of those with ADL problems reported regular pain, only 40.2\% of those without mobility problems reported pain.

Perhaps not surprisingly, it appeared that those in pain were more likely to self-identify as drug abusers (46.3\% as opposed to 23\%). However, those who were treated for pain efficiently were less likely to report drug abuse than the ones who received inefficient painkillers.

Table 11: Distribution of drug abuse per efficiency of pain treatment

<table>
<thead>
<tr>
<th>Treatment for pain being efficient</th>
<th>Daily Consumption of Drugs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>46.5% (20)</td>
<td>53.5% (23)</td>
</tr>
<tr>
<td>Yes</td>
<td>58% (29)</td>
<td>42% (21)</td>
</tr>
<tr>
<td>N/A (not in pain or not treated)</td>
<td>71.2% (74)</td>
<td>28.8% (30)</td>
</tr>
<tr>
<td>Total</td>
<td>62.4% (123)</td>
<td>37.6% (74)</td>
</tr>
</tbody>
</table>

Chi Square = 8.439, df = 2, p = .015

Finally, the pain individuals experienced was reflected in the way they perceived their overall health status.

Table 12: Distribution of pain per overall health rates

<table>
<thead>
<tr>
<th>Pain on regular basis</th>
<th>Overall health based on two question</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Relatively poor</td>
<td>Middle</td>
</tr>
<tr>
<td>No</td>
<td>12.2% (9)</td>
<td>31.1% (23)</td>
</tr>
<tr>
<td>Yes</td>
<td>36.1% (44)</td>
<td>40.2% (49)</td>
</tr>
<tr>
<td>Total</td>
<td>27% (53)</td>
<td>36.7% (72)</td>
</tr>
</tbody>
</table>

Chi square = 24.603, df = 2, p < .001

The number of conditions seemed to influence or be influenced by the time individuals spent in segregation. The more conditions an individual had, the more likely he was to have spent time in segregation for disciplinary reasons – almost half of those who spent
time in segregation had over 8 conditions. The same relationship can be observed between the ones that graded their overall health as poor and the time spent in segregation.

Table 13: Time spent in segregation per number of physical conditions

<table>
<thead>
<tr>
<th>Time spent in segregation for disciplinary reasons</th>
<th>Number of conditions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 - 4</td>
<td>5 - 7</td>
</tr>
<tr>
<td>No</td>
<td>38.1% (61)</td>
<td>37.5% (60)</td>
</tr>
<tr>
<td>Yes</td>
<td>21.6% (8)</td>
<td>32.4% (12)</td>
</tr>
</tbody>
</table>

Chi-square = 7.467, df = 2, p = .024

Table 14: Time spent in segregation per overall health

<table>
<thead>
<tr>
<th>Time spent in segregation for disciplinary reasons</th>
<th>Overall health</th>
<th>Relatively poor</th>
<th>Middle</th>
<th>Relatively good</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Relatively poor</td>
<td>Middle</td>
<td>Relatively good</td>
<td>Total</td>
</tr>
<tr>
<td>No</td>
<td>22.6% (36)</td>
<td>37.1% (59)</td>
<td>40.3% (64)</td>
<td>100% (159)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>45.9% (17)</td>
<td>35.1% (13)</td>
<td>18.9% (7)</td>
<td>100% (37)</td>
<td></td>
</tr>
</tbody>
</table>

Chi-square = 7.467, df = 2, p = .024

Not only pain has been associated with sleeping problems but also general physical health and mobility problems (56.2% of those with ADL problems versus 35.9% without). In addition, people who have problems sleeping reported a higher dissatisfaction with their overall health. 69.8% of those who rated their health as relatively poor also reported having problems sleeping. In contrast, only 39.4% of those in good health reported problems sleeping.

Table 15: Distribution of physical conditions per sleep deprivation rates

<table>
<thead>
<tr>
<th>Physical conditions %</th>
<th>Sleep deprivation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>1 - 4</td>
<td>66.7% (46)</td>
<td>33.3% (23)</td>
</tr>
<tr>
<td>5 - 7</td>
<td>37.5% (27)</td>
<td>62.5% (45)</td>
</tr>
<tr>
<td>8 - 16</td>
<td>26.8% (15)</td>
<td>73.2% (41)</td>
</tr>
</tbody>
</table>

Chi-square = 22.252, df = 2, p < .001
Table 16: Overall health per sleep problems

<table>
<thead>
<tr>
<th>Overall health %</th>
<th>Sleep deprivation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Relatively poor</td>
<td>30.2% (16)</td>
<td>69.8% (37)</td>
</tr>
<tr>
<td>Middle</td>
<td>38.9% (28)</td>
<td>61.1% (44)</td>
</tr>
<tr>
<td>Relatively good</td>
<td>60.6% (43)</td>
<td>39.4% (28)</td>
</tr>
</tbody>
</table>

Chi-square = 12.736, df = 2, p = .001

These findings are in line with the community literature\(^{413}\) which associated sleeping problems with aging.

Physical health is also connected to **vulnerability**. The greater the number of conditions individuals reported, the more likely they were to also report spending time in segregation at their own request. They also reported higher percentages of abuse both by peers and staff members. Not surprisingly in this context, this category also reported a higher percentage of feelings of vulnerability and of being in danger in prison.

Table 17: Physical conditions per abuse by staff rates

<table>
<thead>
<tr>
<th>Physical conditions %</th>
<th>Abuse by staff members</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>1 - 4</td>
<td>60.9% (44)</td>
<td>39.1% (29)</td>
</tr>
<tr>
<td>5 - 7</td>
<td>51.4% (37)</td>
<td>48.6% (35)</td>
</tr>
<tr>
<td>8 - 16</td>
<td>35.7% (20)</td>
<td>64.3% (36)</td>
</tr>
</tbody>
</table>

Chi-square = 7.883, df = 2, p = .019

Table 18: Physical conditions per abuse by peers rates

<table>
<thead>
<tr>
<th>Physical conditions %</th>
<th>Abuse by peers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>1 - 4</td>
<td>66.7% (46)</td>
<td>33.3% (23)</td>
</tr>
<tr>
<td>5 - 7</td>
<td>43.1% (31)</td>
<td>56.9% (41)</td>
</tr>
<tr>
<td>8 - 16</td>
<td>32.1% (18)</td>
<td>67.9% (38)</td>
</tr>
</tbody>
</table>

Chi-square = 15.970, df = 2, p < .001

\(^{413}\) See above p 75.
Table 19: Physical conditions per concerns for safety and feelings of being in danger

<table>
<thead>
<tr>
<th>Physical conditions</th>
<th>Concerns for safety and feelings of being in danger</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Neither</td>
<td>One or the other</td>
</tr>
<tr>
<td>1 – 4</td>
<td>60.3% (41)</td>
<td>29.4% (20)</td>
</tr>
<tr>
<td>5 – 7</td>
<td>40.3% (29)</td>
<td>27.8% (20)</td>
</tr>
<tr>
<td>8 - 16</td>
<td>33.3% (18)</td>
<td>40.7% (22)</td>
</tr>
</tbody>
</table>

Chi-square = 14.885, df = 4, p = .005

In addition, people reporting abuse by staff (but not by peers) tended to also have problems with activities of daily living. 56.2% of those with ADL problems reported staff abuse as opposed to 39.1% without such problems.

b. Medical Resources Availability

Only a little over half of the people receiving regular treatment for their pain reported getting relief from it. The other half identified the medication they received as not being strong enough for their type of pain.

Table 20: Distribution of treatment being reported efficient

<table>
<thead>
<tr>
<th>Was the treatment for pain efficient</th>
<th>Percentage/ Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>21.8% (43)</td>
</tr>
<tr>
<td>Yes</td>
<td>25.4% (50)</td>
</tr>
<tr>
<td>N/A (not in pain)</td>
<td>52.8% (104)</td>
</tr>
</tbody>
</table>

Tylenol is generally available at the canteen for prisoners to purchase and use at will. Nonetheless, all individuals that I counted as reporting severe pain for the purpose of this study maintained that Tylenol did not ease their pain. The question regarding pain treatment, as well as their answers to it referred to medication prescribed by the prison
physician. The medication the prison physician generally prescribed in cases of chronic or acute pain appeared to be Tylenol 3.

The majority of people not treated for pain identified the reason as either they were not prescribed any by the prison doctor (7% of the total sample) or that they did not want to take it, generally because that would mean going to pick it up every day, which put added stress on their bodies and made the pain worse (6.6%). A number of the 43% who received pain treatment reported it as ineffective in alleviating their suffering. Some of them mentioned being on stronger medication in the community. From the 50% that were responsive to treatment, a small number were not on Tylenol 3. Some were receiving methadone for their drug addiction which also functioned as a painkiller. A few were receiving morphine. It did appear however that between Tylenol 3 and morphine there was nothing else available. Some of the individuals that mentioned still being in pain during treatment acknowledged that they have also been offered morphine at some point but turned it down. They felt it was a “last resort” medication, and were afraid of becoming addicted or that at some point it would not work either and they would have nothing else to take.

The under treatment of pain in older people has been a major concern of physicians. It is believed that much of the pain in seniors goes improperly treated. Looking at the pain options available in the community we can conclude that most of them are not available in prison, even though the pain rates appear to be higher. This supports the finding that there is a serious gap in prison between the existence of pain and effective treatment.

414 Tylenol 3 “is used to treat mild-to-moderate pain associated with conditions such as headache, dental pain, muscle pain, painful menstruation, pain following an accident, and pain following operations,” MedBroadcast, online: http://www.medbroadcast.com/drug_info_details.asp?brand_name_id=1542.
The *preventive measures* available in prison paint a more positive picture. 44.2% of the participants have requested tests at one point after turning 50, mostly cholesterol, or STD, or regular blood checks. While most of them complained about having to wait anywhere from a few weeks to a few months to have them done, over 38% of the offenders have both asked and were granted the tests they asked for. In addition, 86.2% of the participants have been offered some sort of tests, such as routine TB (nearly 50%), blood work (7.1%), cholesterol (26.9%) or blood pressure checks (54.8%) during incarceration. 55.8% received an influenza vaccine every year, and the ones who did not, reported refusing it. Other high rates of vaccinations are reported for hepatitis (42.6%), anti-tetanus (28.9%), and pneumonia (18.3%). A few participants complained about the fact that the shingles vaccination is not available, even when they were willing to pay for it. Physical examinations were not common in prison. Most participants reported never receiving a full physical (75.6%). 18.6% said they received one physical, meaning the intake consultation. Arguably however, the consultation they received upon assessment is not a physical examination within the common meaning of it. Rather, it is a question based-discussion with the nurse. The vaccination program is aligned with the one in the community. However, the cancer screening and physical covered by OHIP on the outside do not appear to be regularly available in prison.\(^4\)

Not surprisingly, the more conditions an individual suffers from, the more demands for *health care items* he will raise. In general, the more conditions they have, the likelier they are to have requested health items and to have been refused. For example, over 30% of those with over 8 conditions have requested health items and were refused, over 27%\(^4\)

\(^4\) See above p 72 for a description of preventive measures in the community.
have asked for items and were granted, over 18% have asked for items and have been partially granted, while only over 23% have never asked for anything else than what they were given by the institution. This is in clear contrast with the people that have up to 4 conditions, of whom over 60% have never asked for anything. However, as a rule, regardless of the percentage, all categories seemed more likely not to be granted the items they requested than to be granted them. We noticed the same relationship between those reporting mobility problems that interfere with their daily living and the items requested and denied.

Table 21: Distribution of ADL problems per rates of health items requested and made available

<table>
<thead>
<tr>
<th>ADL problems</th>
<th>Were health items requested and made available</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None needed</td>
<td>Needed, not granted</td>
</tr>
<tr>
<td>No</td>
<td>58.7% (54)</td>
<td>18.5% (17)</td>
</tr>
<tr>
<td>Yes</td>
<td>30.1% (31)</td>
<td>26.2% (27)</td>
</tr>
</tbody>
</table>

Chi-square = 16.691, df= 3, p = .001

The items most needed were extra pillows or blankets, a better mattress for back problems, vitamins, and walking aids. Finally, pill consumption would also be higher based on the number of conditions reported.

In the community certain conditions that do not fall in the category of diseases per se have been associated with aging. Such conditions include hypothermia, hyperthermia,
incontinence and a predisposition to falls. These issues can often be addressed by providing devices\textsuperscript{416} and aids rather than medication.\textsuperscript{417}

Regarding medical staff availability, 53.8\% of the participants mentioned that there is no nurse available 24/7 in their institution, while 26.4\% did not know. 75.5\% of the participants, after they turned 50, had requested an appointment to see a specialist. The most common requests were the dentist (44.7\%), the psychiatrist (9.1\%), the ear-nose-throat doctor (10\%), and the optometrist (31\%). The average wait time was between 1 and 3 months for the dentist. However, this generally included emergencies, such as abscesses. The same was true for the psychiatrist and the optometrist. Other specialists, such as the oncologist had a waiting time of over 1 year, with the minimum being between 3 and 6 months. Other specialists fell in the middle such as the psychologist, the ear-nose-throat doctor, and the urologist (3-6 months). Some people were denied a chance to see the psychologist (14.3\%), the optometrist (5.1\%), and the cardiologist (14.3\% while 42.9\% were still waiting to see cardiologist).

Post-surgery care is also worrisome. 25.4\% of the participants underwent surgery while in prison, after the age of 50. All surgeries were performed in an outside hospital. However, 11.7\% of the participants did not spend any time in the hospital after surgery. Only 8\% of the total number of participants spent any time in a prison hospital after a surgery. Numerous participants complained about the improper transportation conditions, most of them being transferred back to prison immediately after surgery (such as hernia

\textsuperscript{416} In this context I will use “device” as a general term to describe various physical aids that older people may need to improve their life. It incorporates not only technological medical devices, but also extra pillows and blankets, walkers, canes etc.

\textsuperscript{417} See above p 64.
surgeries) in the steel CSC vans. During surgery the prisoners were shackled even if they were under anesthetic.

The conclusion from looking at this data is that older offenders tend to be in rough physical shape and they tend to get worse progressively. The rates of physical illnesses influence the perceived quality of health of the offenders. The more sick people report being, the more costly they are to the system, raising high burdens on health care such as staff, medication, and medical devices. The more needs they have, the less likely they are to have them fulfilled. The less they have their needs fulfilled, the angrier they are with the system, which seems to increase their fears and their disciplinary problems. The more afraid, sick, or unruly they are, the more likely they are to spend time isolated in the segregation unit, which arguably is of very little therapeutic or correctional value.

Finally, there should be more organized talks with prisoners regarding their health, the transformations their bodies undergo as they age, and ultimately death. The greatest fear prisoners identified was that of dying in prison (29.4%). As one of the prisoners put it “I lived in prison more than I lived outside. I don’t mind living in prison, but I don’t want to die in here.”
7.1.3 Mental Health Findings

a. Mental Health Issues and Effects on Older Offenders

The statistics for mental health problems are within the range determined for this group of people elsewhere in the world. From 197 participants, 39.1% mentioned being diagnosed with 1 or more mental illnesses. Certain mental disorders have been associated in the community with aging. These include depression, anxiety, dementia, memory loss, as well as suicidal ideation.

Table 22: Distribution of mental health illnesses (not mutually exclusive in an individual)

<table>
<thead>
<tr>
<th>Mental Health Conditions</th>
<th>Percentage/ Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>24.4% (48)</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>3.6% (7)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>3% (6)</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>17.3% (34)</td>
</tr>
<tr>
<td>Dementia</td>
<td>4.6% (9)</td>
</tr>
<tr>
<td>PTSD</td>
<td>4.1% (8)</td>
</tr>
<tr>
<td>Other</td>
<td>11.2% (22)</td>
</tr>
</tbody>
</table>

In general, the proportion of people reporting receiving help with their condition on a regular basis is much smaller than those of people reporting mental conditions. Only 14.3% of the people with a mental health diagnosis reported seeing the psychiatrist after they turned 50. However, 26% of the same group said they were receiving counselling.

20.9% of older prisoners have reported having suicidal thoughts while in prison after the age 50. 4.9% overall reported receiving help when suicidal thoughts occurred. Over 10% of the total number had been suicidal but never talked about it, mostly because of fear of repercussions (7.6%) while 5.1% were punished or ignored when they sought help regarding their suicidal ideation. There is also a definite connection between mental

\[418\] See above p 113-114.
\[419\] McKenna, supra note 404; Jagger, supra note 404. See also above p 78.
illnesses and suicidal thoughts (29% of those with a mental illness reported having suicidal thoughts, as opposed to 15% of their counterparts). The difference was even more apparent when they were asked if they ever felt life is not worth living. 55.8% of those with different conditions answered ‘yes’, as opposed to 19.2% of those that did not report any such illnesses.

Of particular interest is the fact that there was a significant inverse relationship between the frequency of family visits and suicidal thoughts. People that never had suicidal ideation tended to report more frequent family contact than those who had suicidal thoughts.

<table>
<thead>
<tr>
<th>Suicidal thoughts</th>
<th>Frequency of family visits</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weekly or Monthly or None</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>56.8% (88) 18.7% (29) 10.3% (16) 14.2% (22)</td>
<td>100% (155)</td>
</tr>
<tr>
<td>Yes</td>
<td>36.6% (15) 17.1% (7) 26.9% (11) 19.5% (8)</td>
<td>100% (41)</td>
</tr>
</tbody>
</table>

Chi-square = 9.574, df = 3, p = .022

The rates of *substance abuse* are also high: 29.4% self-identified as addicts. The rates however might be higher than that. 29.9% of the participants reported drinking alcohol daily at least on the outside, but only 52.5% of them also self-identified as alcoholics. Similarly, 37.6% reported daily drug consumption, but only 41.9% of them self-identified as addicts. Only 5.6% of the participants reported receiving treatment for their addiction, and 8.6% mentioned following at one point a correctional program concerning
substance abuse. Concerns regarding the lack of therapeutic treatment for addicts has been signaled in the American literature.420

Properly addressing the substance abuse might turn out to be important not only for the well-being of the individual but also for that of the institution. Substance abuse is one of the factors, together with mental illness, relationship with staff and family relationships (see below the following subchapters), that appears to be directly connected to the history of disciplinary charges after turning 50.

Table 24: Disciplinary charges per daily substance abuse or self-report addict rates

<table>
<thead>
<tr>
<th>Disciplinary charges %</th>
<th>Daily substance abuse on the outside or self-report as addict</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Neither</td>
<td>One or the other</td>
</tr>
<tr>
<td>No</td>
<td>53.7% (73)</td>
<td>25.7% (35)</td>
</tr>
<tr>
<td>Yes</td>
<td>29.5% (18)</td>
<td>45.9% (28)</td>
</tr>
</tbody>
</table>

Chi-square = 10.989, df = 2, p = .004

It is known that sleep deprivation contributes to a decrease in mental health. 46.7% of the participants reported having sleeping problems on a regular basis, and 8.6% stated that they have occasional issues falling asleep. People with mental health issues reported more sleeping problems. Hence, of those reporting mental illnesses, 70.1% (62.3% + 7.8%) reported sleep problems. In contrast, of those with no reported mental illnesses, only 45.8% (36.7% + 9.2%) reported having sleep problems.

Table 25: Distribution of mental health illnesses per sleep problem

<table>
<thead>
<tr>
<th>Mental Health Illnesses reported</th>
<th>Sleep problems</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>54.2% (65)</td>
<td>36.7% (44)</td>
</tr>
<tr>
<td>Yes</td>
<td>29.9% (23)</td>
<td>62.3% (48)</td>
</tr>
</tbody>
</table>

Chi-square = 12.920, df = 2, p = .002

420 See above p 115.
In particular there appears to be a connection between depression and anxiety and sleeping disorders. 33.7% of the people with sleeping disorders suffered from depression, and 26.1% from anxiety. In contrast, only 15.9% and 6.8% of those without sleeping disorders suffered from depression and anxiety respectively.

The community literature has correlated sleeping problems with aging. It also connected sleeping problems with an array of other conditions, including mental health. The literature recommended addressing this problem by improving environmental factors such as lighting, noise, availability of afternoon naps, quality of mattress and bedding etc.\textsuperscript{421} As established, these are not options that older inmates have.

On the other hand, a positive, relevant connection exists between rates of \textit{mental illness} and exercise. Thus people who reported exercising on a regular basis also reported lower rates of mental illness. This suggests that investing in proper exercise facilities might reduce the costs associated with mental illnesses in prison over the long run (see discussion under Programming and Exercise subchapter).

Table 26: Distribution of rates of regular exercise per mental illnesses rates

<table>
<thead>
<tr>
<th>Regular exercise rates %</th>
<th>Mental Illnesses Reported</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>51.5% (35)</td>
<td>48.5% (33)</td>
</tr>
<tr>
<td>Yes</td>
<td>65.9% (85)</td>
<td>34.1% (44)</td>
</tr>
</tbody>
</table>

Chi-square = 3.889, df = 1, p = .049

\textsuperscript{421} For a discussion of sleeping problems and solutions in the community see above p 72-73. .

162
b. **Mental Health and Behavior**

Mental conditions seem to be of particular relevance for the capacity of the prisoner to adapt to the prison environment. Thus, an individual who graded his overall health in the middle or poor was more likely to also report suffering from mental illness than someone who considered his health relatively good.

Table 27: Distribution of overall health per inmates mentioning mental illnesses

<table>
<thead>
<tr>
<th>Overall Health</th>
<th>Does prisoner mention mental illness</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes (one or more)</td>
</tr>
<tr>
<td>Relatively poor</td>
<td>54.7% (29)</td>
<td>45.3% (24)</td>
</tr>
<tr>
<td>Middle</td>
<td>47.2% (34)</td>
<td>52.8% (38)</td>
</tr>
<tr>
<td>Relatively good</td>
<td>78.9% (56)</td>
<td>21.1% (15)</td>
</tr>
</tbody>
</table>

Chi-square = 16.110, df= 2, p < .001

Mental illness appears to have repercussions on the *general behavior of prisoners*. While the rate of disciplinary incidents is relatively small (about 31% have been charged with disciplinary offences, mostly non-violent and 23% have spent time in segregation since turning 50), those who had disciplinary charges (especially violent ones) tended to also report suffering from mental illness.
Table 28: Disciplinary charges per mental health rates

<table>
<thead>
<tr>
<th>Disciplinary charges since turning 50</th>
<th>Does prisoner mention mental illness</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td>66.2% (90)</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>49.2% (30)</td>
</tr>
</tbody>
</table>

Chi-square = 5.109, df = 1, p = .024

Sadly, but not surprisingly, it appears that the mentally ill are more often sent to segregation than their healthier counterparts (36.4% as opposed to 15%).

Table 29: Mental Illnesses per segregation rates

<table>
<thead>
<tr>
<th>Mental Illnesses reported %</th>
<th>Segregation since turning 50</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td>85% (102)</td>
</tr>
<tr>
<td>Yes (one or more)</td>
<td>Yes</td>
<td>63.6% (49)</td>
</tr>
</tbody>
</table>

Chi-square = 11.961, df = 1, p = .001

As well, prisoners that have been sent to segregation for disciplinary reasons were more likely to have a mental illness diagnosis than their healthier counterparts (59.5% as opposed to 40%). Similarly, of the people that have requested segregation for their own safety, the majority reported suffering from a psychiatric condition (72.7%). These findings are consistent with the concerns raised by American researchers in regard to the use of segregation to control or protect mentally ill prisoners.422

It also appears that mental illness, like physical illness and mobility issues, makes prisoners more vulnerable to peer abuse. 70.1% of those with psychiatric disorders mentioned being abused by peers. However, a similar relationship does not exist between mental illness and staff abuse. This appears to justify the feelings of vulnerability and fear.

422 See above p 113.
of danger that are displayed by this population: of the almost 44% of older prisoners who reported feeling unsafe and in danger, over 56% reported a mental illness.

Table 30: Distribution of mental illnesses reported per peer abuse rates

<table>
<thead>
<tr>
<th>Mental Illnesses Reported</th>
<th>Abused by Peers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>60% (72)</td>
<td>40% (48)</td>
</tr>
<tr>
<td>Yes (one or more)</td>
<td>29.9% (23)</td>
<td>70.1% (54)</td>
</tr>
</tbody>
</table>

Chi-square = 17.053, df = 1, p < .001

From the data presented, the rates of mental illness and substance abuse, like the ones of physical conditions, have high percentages among older offenders. These rates appear to be directly connected to the percentages of people with suicidal ideation. However, the psychiatric help they report receiving does not appear to match the need. Mental illness seems to have repercussions in numerous fields in the life of an incarcerated person. The mentally ill are more disruptive, more often require disciplinary measures and often end up in segregation. It is difficult to say if the mental illness is what causes them to be in segregation in such a high percentage, or if the segregation contributes to an increase in mental illness. Arguably, both statements are true. The same dilemma can be framed regarding the relationship between the people with psychiatric conditions and those that reported peer and staff abuses. There is very little doubt that the mentally ill are easier targets for predatory behavior, hence the increased number of them who have requested placement in segregation for their own protection. In addition, it is relevant that in the community, mental health care was considered the most satisfying by seniors. The gap
between need and response was nearly nonexistent.\textsuperscript{423} That does not appear to be the case in prison.\textsuperscript{424}

7.1.4 Programming and exercise

The literature review revealed that programming, exercise and work are important factors in building a decent quality of life for older offenders. They are likely to contribute positively to their mental and physical health, and thus, when available, they may help reduce the cost on the correctional health system in the long run. Considering how many health problems older offenders reported, this could be an important aspect of prison life.

\textit{a. Program Attendance and Impact on Older Offenders}

Consistent with the findings reported in the literature,\textsuperscript{425} program attendance after the age of 50 appears to have high rates. It is true that numerous offenders have complaints about lack of age-appropriate programming or of the uselessness of the programs they were forced to take. However, in Canada, since the 1990s most inmates receive a correctional plan with programs they need to attend during their incarceration. The failure to do so might result in the denial of parole or of transfer to a lower level of security. “Boosters” of programs taken in the past are often required for people incarcerated for long periods. These are probably reasons why 70.6\% of the participants have taken at least one program since turning 50. Over 20\% of the participants reported not taking a program after the age of 50 because either their recommended programs or other programs that they were interested in were not available or there were no available spots for them.

\textsuperscript{423} See above p 84.
\textsuperscript{424} See also below subchapter 2 Qualitative Data.
\textsuperscript{425} See above p 137 - 138.
Table 31: Distribution of program attendance (not mutually exclusive)

<table>
<thead>
<tr>
<th>Program Type Taken after Turning 50 (Full Program or Booster)</th>
<th>Percentage/ Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational/Vocational Programs</td>
<td>36% (71)</td>
</tr>
<tr>
<td>Therapy</td>
<td>12.7% (25)</td>
</tr>
<tr>
<td>Anger Management</td>
<td>8.1% (16)</td>
</tr>
<tr>
<td>Violence Prevention</td>
<td>28.9% (57)</td>
</tr>
<tr>
<td>NSAP or other substance abuse programs</td>
<td>18.3% (36)</td>
</tr>
<tr>
<td>Cognitive Skills</td>
<td>8.6% (17)</td>
</tr>
<tr>
<td>Religious</td>
<td>4.6% (9)</td>
</tr>
<tr>
<td>Restorative Justice/ Victims’ Impact</td>
<td>7.1% (14)</td>
</tr>
<tr>
<td>Preparation for Release</td>
<td>1.5% (3)</td>
</tr>
<tr>
<td>Sex Offenders’ Program</td>
<td>10.7% (21)</td>
</tr>
<tr>
<td>Other</td>
<td>15.2% (30)</td>
</tr>
</tbody>
</table>

Numerous offenders, especially the ones incarcerated at an already older age complained about the inappropriateness of being forced to take a high school program when they were already in their 60s, arguing that this was not going to help them when they are released. There might me some truth in that claim, considering that not very many of the participants I talked to will be able to do more than a menial job, because of their advanced age and feeble health status, when and if they are released.

It is relevant that the majority of people taking programs were hosted in medium security (56.1) and minimum security (36.7%) as opposed to only 7.2% who were in maximum security. As well, nobody in the assessment unit had taken part in any program. Given the nature of this unit, this is not surprising.

While there is no relevant connection between programming and overall health or physical health, there appears to be a very interesting relationship between *attendance of programs* and *mental health*. It is difficult to say if the difference is caused by the fact that mentally ill prisoners are prescribed more correctional programs or they simply tend to be
more involved, or both. In any case, it is obvious that they are very active prisoners and it speaks to the importance of having programs available.

Table 32: Distribution of program attendance per people with reported mental illnesses

<table>
<thead>
<tr>
<th>Mental Health Illnesses mentioned %</th>
<th>Programs attended since turning 50</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (%)</td>
<td>Yes (%)</td>
</tr>
<tr>
<td>No</td>
<td>36.7% (44)</td>
<td>63.3% (76)</td>
</tr>
<tr>
<td>Yes (one or more)</td>
<td>18.2% (14)</td>
<td>81.8% (63)</td>
</tr>
</tbody>
</table>

Chi-square = 8.593, df = 1, p= .003

b. Programming demands

In the literature review presented above, it was revealed that programs, as well as support groups played a significant positive role in the lives of older offenders. Among the participants in my study, about half (55.8%) have been part of a support group.

Table 33: Participation in support groups (not mutually exclusive)

<table>
<thead>
<tr>
<th>Support group</th>
<th>Percentage/ Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seniors’ Group</td>
<td>13.7% (27)</td>
</tr>
<tr>
<td>AA/NA</td>
<td>16.8% (33)</td>
</tr>
<tr>
<td>Church or other religious groups</td>
<td>17.3% (34)</td>
</tr>
<tr>
<td>Lifers’ group</td>
<td>13.7% (27)</td>
</tr>
<tr>
<td>Maritimers’ group</td>
<td>7.1% (14)</td>
</tr>
<tr>
<td>Spanish or French Group</td>
<td>7.1% (14)</td>
</tr>
<tr>
<td>Native Brotherhood</td>
<td>6.1% (12)</td>
</tr>
<tr>
<td>Other</td>
<td>16.2% (32)</td>
</tr>
</tbody>
</table>

Unfortunately, not all of the above groups were available in all of the institutions. The most widespread groups across penitentiaries were AA and the Native Brotherhood. The rest were each available in no more than three institutions. Where groups were available, the offenders tended to participate in the activities.

When asked if there are programs that they feel should be available for them, 73.5% of the participants answered ‘yes’.
Table 34: Programs requested by inmates, not currently available (not mutually exclusive)

<table>
<thead>
<tr>
<th>Programs requested by inmates</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age appropriate fitness programs</td>
<td>21.8% (43)</td>
</tr>
<tr>
<td>Seniors’ only social activities</td>
<td>14.2% (28)</td>
</tr>
<tr>
<td>Crafts and hobbies</td>
<td>8.1% (16)</td>
</tr>
<tr>
<td>Life skills</td>
<td>6.6% (13)</td>
</tr>
<tr>
<td>Appropriate release preparation</td>
<td>7.1% (14)</td>
</tr>
<tr>
<td>Health programs</td>
<td>6.1% (12)</td>
</tr>
<tr>
<td>Peer support groups</td>
<td>11.2% (22)</td>
</tr>
<tr>
<td>More space in the programs on their corrections plan</td>
<td>6.6% (13)</td>
</tr>
<tr>
<td>Computer literacy</td>
<td>5.6% (11)</td>
</tr>
<tr>
<td>Banking and financing</td>
<td>3.6% (7)</td>
</tr>
<tr>
<td>Other</td>
<td>29.4% (58)</td>
</tr>
</tbody>
</table>

The programs requested that are not corrections-related are generally available to the seniors on the outside. The 2013 “Action for Seniors” government report promoted some new and improved programs such as financial literacy, and information sessions on daily living and self-health care. The “New Horizons Seniors’ Program” created opportunities for seniors to get involved in different activities in order for them to maintain active lives. 426

In light of the correlation between mental illness and programs, making appropriate programs readily available should be a correctional priority. Considering that mental illness is also connected to higher disciplinary issues, keeping this category of prisoners engaged and motivated might act as a disciplinary prevention mechanism. This is particularly true for maximum security, where the degree of idleness was higher than in other institutions, but so were the levels of mental illness reported along with disciplinary problems.

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426 See above p 86 – 89; Actions for Seniors, supra note 202.
c. Exercise and Impact on Older Offenders

65.5% reported keeping active on a daily basis. However only 23.9% were using the gym. They complained about the fact that it was too crowded with young inmates who would bully them and that they were provided with little or no cardio equipment. Hence, 32% of the inmates were walking in the yard. However, in some institutions the yard was closed during winter times and in the evenings, which made it less of an option for certain inmates. As a result some people would exercise in their cells (15.7%), and others on the range (8.6%).

Medium security was the level at which people were the least likely to exercise (43.4% did not exercise as opposed to 25.8% in minimum security, 33.3% in maximum security, and 2.9% in the assessment unit). It is not clear why this difference exists. However, it might be more than a coincidence that the bulk of people that have been in prison for a very long time were in medium security. Facilitating and encouraging physical activity should be a priority. As presented above (Table 33), age-appropriate fitness activities were in the most demand. In addition, the qualitative findings in the chapter below suggest that inappropriate fitness facilities were one of the most serious complaints of older offenders regarding programming in prisons. They complained they could not be active enough, generally because there was no space available aside from the pit room where they were being bullied by younger inmates.

The importance of addressing this issue is indicated by the relevant connection between mental well-being and exercise. As already mentioned, almost 66% of people who kept active on a daily basis did not report any mental illnesses (See Table 24). In addition,

\[427\] See above p 152.
exercise, together with environmental modifications, was the number one community response to an array of issues associated with aging.

7.1.5 Safety and Discipline

The purpose of the safety and discipline section of the questionnaire was to evaluate how vulnerable older offenders are to abuse on one hand, and how disruptive they are as inmates, on the other. Later on this might help determine if their accommodation arrangements are appropriate based on the vulnerability – disciplinary issues dynamic. The literature review presented above reveals that feelings of vulnerability and fears of victimization are strong among older offenders and this contributes to a decline in their quality of life.

a. Victimization and Its Impact on Older Offenders

51.8% of the participants reported being *physically or mentally abused* after turning 50 by their peers. As mentioned in the health care section, there was a relevant connection between people reporting abuses and the rates of mental illness (See Table 30) and physical illnesses and mobility problems (See Table 18).

<table>
<thead>
<tr>
<th>Type of abuse suffered after turning 50</th>
<th>Percentage/ Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma</td>
<td>36% (71)</td>
</tr>
<tr>
<td>Ridicule</td>
<td>44.7% (88)</td>
</tr>
<tr>
<td>Insult</td>
<td>46.7% (92)</td>
</tr>
<tr>
<td>Cut in line regularly</td>
<td>31.5% (62)</td>
</tr>
<tr>
<td>Hit or push</td>
<td>28.4% (56)</td>
</tr>
<tr>
<td>Threatened</td>
<td>27.9% (55)</td>
</tr>
<tr>
<td>Feel isolated because of age</td>
<td>18.3% (36)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>4.1% (8)</td>
</tr>
</tbody>
</table>

See above p 72.
42.1% of the prisoners reported having \textit{property stolen} after they turned 50. The number one item stolen was food (26.9%), followed by clothing (20.8%), and electronics (11.5%). These rates and the ones presented in the table tend to be higher than the ones reported in the literature.\footnote{See above p 125.}

These numbers would justify the support older offenders had for the creation of a \textit{seniors’ only unit}. In this study, 97\% of the participants said there were no designated ranges or units where older offenders were housed. Rather they were mixed together with the younger offenders. For many, this was a source of stress. They felt afraid for their safety, or they simply complained that they could not sleep because of the loud music and shouts. Others were sharing their cells with younger offenders and they complained about the bullying, or the fact that they had to put up with open windows in winter because the younger people worked out all the time. Hence, 81.7\% of the older offenders thought there was a need for a special range for people over 50, which would be quieter and where, perhaps, they would get health care more rapidly. According to the literature review, in the United States the creation of units dedicated to older offenders is an increasingly popular concept, both among officials and offenders (see Good Practices Models in the Recommendations chapter below).

When asked if they had been \textit{abused by staff members} when older, 48.2\% said ‘yes.’ 32.5\% said they were being regularly humiliated, ridiculed, and sent mixed messages for the purpose of confusing them. 11.2\% reported being physically abused by staff, generally beaten or pushed. 4.6\% complained about the way officers treated their visitors. Those reporting peer abuse tended also to report staff abuse (60.8\% of those reporting peer abuse...
v 37.9% of those not reporting peer abuse). As mentioned, it was significant that the highest reported rates of both peer and staff abuse were among those with more health problems (See Table 15) or mobility issues.

Probably because of all of these incidents, safety concerns reported were relatively common. Hence, 29.4% said they were afraid for their safety at the moment of the interview, with 47.7% reporting having felt in danger in prison at one point after turning 50. 13.2% identified safety as their greatest fear in prison. As reported above, safety concerns were higher among people with more physical conditions (See Table 19).

b. Adjustment and Disciplinary Issues

Despite the number of staff abuses reported, the majority of older offenders said that these were not necessarily systemic, but rather they were committed repeatedly by certain individuals. This is in line with the English literature. Overall, 55.3% of the participants reported having good relations with staff members, and 34% said they were acceptable. Only 6.1% reported bad relations with staff.

In addition, older offenders seemed relatively well-adjusted to prison. 63.5% reported having prison friends, and 62.9% said they had regular contact with younger inmates. On a scale from 1 to 5, the majority graded their relations with younger offenders as above average (31% gave it a 4, 24.9% a 5, and 23.9% a 3). The relations with people their own age or older were significantly better, however. Thus, 53.3% graded their relations with older people as a 5, while 33.5% gave it a 4. The capacity of older offenders to foster friendships in prison was confirmed by the literature.

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430 See above p 132.
431 See above p 131.
The fact that older prisoners are well-adjusted seems to be confirmed by the relatively low number of inmates that had *disciplinary problems* since turning 50. 23.4% reported spending time in segregation after 50, with only 20% of the whole number being sent in for violent behavior. Similarly, 31% of the offenders had been charged with a disciplinary offence since turning 50, with only 6.1% charged for a violent offence. The majority had been charged with the possession of an unauthorized item other than a weapon (9.1%) or possession or trafficking of drugs (8.1%). These rates appear consistent with the findings in the literature that older offenders were relatively well disciplined, and even when they did commit an offence, it tended to be non-violent.432

Not surprisingly, there is a relevant connection between people that had disciplinary charges and their relationships with staff. People that had no charges tended to have better relationships with staff members than those who had charges since turning 50. We can notice the same dynamic between inmate – staff relations and being sent to segregation for disciplinary reasons.

Table 36: Disciplinary charges per relationship with staff rates

<table>
<thead>
<tr>
<th>Disciplinary charges</th>
<th>Relationship with staff members</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good</td>
<td>Acceptable</td>
</tr>
<tr>
<td>No</td>
<td>61.8% (84)</td>
<td>33.1% (45)</td>
</tr>
<tr>
<td>Yes</td>
<td>41% (25)</td>
<td>36.1% (22)</td>
</tr>
</tbody>
</table>

Chi-square = 15.919, df = 2, p < .001

432 See above p 125-126.
Table 37: Distribution of segregation for disciplinary reasons per relationship with staff rates

<table>
<thead>
<tr>
<th>Segregation for disciplinary reasons</th>
<th>Relationship with staff members</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good</td>
<td>Acceptable</td>
</tr>
<tr>
<td>No</td>
<td>58.8% (94)</td>
<td>33.8% (54)</td>
</tr>
<tr>
<td>Yes</td>
<td>40.5% (15)</td>
<td>35.1% (13)</td>
</tr>
</tbody>
</table>

Chi-square = 9.797, df = 2, p = .007

In addition, as mentioned in the health care section, disciplinary segregation, as well as disciplinary charges in general seem to have higher rates among people with mental illnesses (See Tables 28 and 29) and substance abuse (See Table 24).

Investing disproportionately in security measures for older offenders might be unwarranted. The findings show that they have good disciplinary records overall and report well to staff. The ones with the worst staff relationships were the ones with the most disciplinary charges, who tended to be mentally ill. Under these circumstances, treating mental illnesses and enhancing staff training in dealing with mentally ill older offenders might be a better investment, with positive security repercussions. In addition, because of the victimization rates that tend to be higher among the sickest, special accommodation for seniors might have positive effects not only on the individuals but also on the institutions. Such a unit would allow addressing mental and physical health risk factors in older offenders while keeping them safe without the same security concerns that exist in the general population.
7.1.6 Family Relationships and Impact on Older Offenders

The profile of the older offender in the American literature included the lack of family support. This was not supported by my findings. 84.8% of the participants reported keeping contact with family and friends on the outside. The majority of contact took place through telephone (76.1%), followed by writing (50.8%), while visits registered a significantly lower rate of 17.4%. 52.3% of the prisoners had at least weekly contact with their families, while 18.3% were in touch monthly, and 12.2% a few times per year.

Sadly, however, 47.7% had never had a visit since they were incarcerated. Nonetheless, 59.4% described family relations as being positive. This exact situation – low number of visits, but relatively high satisfaction with family relations – was revealed by numerous studies presented in the review of the literature.

The literature review pointed out that, in other jurisdictions, people who maintained contact with the outside world were doing significantly better than the rest. What I found was that the more frequent the family contact, the less likely that the offender created disciplinary problems. It appears to be relevant that 60.3% of the people with no charges had at least weekly contact with their families, as opposed to roughly 34% of those that had one charge, and the same percentage of those who had multiple charges.

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433 See above p 94.
434 Leigey, supra note 216 at 59 -60; see above Chapter 5, Literature Review.
435 See above p 130.
Table 38: Distribution of disciplinary charges per family contact frequency rate

<table>
<thead>
<tr>
<th>Disciplinary charges after turning 50</th>
<th>Family contact frequency</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weekly or more often</td>
<td>Monthly</td>
</tr>
<tr>
<td>No</td>
<td>60.3% (82)</td>
<td>18.4% (25)</td>
</tr>
<tr>
<td>Yes</td>
<td>34.4% (21)</td>
<td>18% (11)</td>
</tr>
</tbody>
</table>

Chi-square = 20.392, df = 3, p < .001

These facts suggest that actively encouraging family contact could be beneficial for correctional institutions. At the moment, family contact does not appear to be actively encouraged by staff members. On the contrary, the treatment of family members by correctional officers, as revealed in the qualitative findings below, appears to deter such contact.

7.1.7 Summary of Quantitative Data

Older offenders suffer from a variety of diseases, both physical and mental, many of which have been associated with aging. They are limited in their mobility and this interferes with their activities of daily living. Because of their conditions, they are often in constant pain, require medical diets and a high number of medications, and have sleep problems; suicidal ideation occurs with regularity. This picture is not particular to the prison environment. In fact, all these appear to be rather typical for senior populations according to the community literature review. For the most part, these problems are not inflicted upon individuals by imprisonment but rather by aging.

Nonetheless, aging in prison is nothing like aging in the community. While the same transformations occur in old age, the responses available to them are different. On
the outside, most people have a choice: a choice of doctor, of medication, of environmental adaptations that could correspond to their needs. They have family support and can choose who they associate with and which environment they feel safe in. They can choose to join a seniors’ centre and to participate in appropriate fitness and social programs that are generally recommended for the maintenance of mental and physical health.

In prison, understandably, seniors have very little choice. They are under the control of the institution, and thus the institution has the legal obligation to deal with this category of people at a standard comparable to that in the community. Thus, the problem suggested by the numbers in my study is not that illnesses and age associated limitations exist. This was to be expected. The problem resides in the responses given to aging in the institution. The mentally and physically ill appear to some extent to be preyed upon by staff and inmate peers, and so older inmates sometimes ask to be segregated for their own protection. Segregation is connected to mental illness and might exacerbate it. There appear to be very limited options, medical and otherwise, for managing pain which is connected to sleep problems, and these in turn are connected to mental health issues. Mental health issues lead to disciplinary charges and a common response is segregation which, again, likely enhances those problems. Similarly, more mobility problems place older people at a higher risk of falls. In prison, they cannot avoid the risk factors for falls such as unclean path ways, stairs or double bunks. This is especially true when the yard is the only place where they can keep fit, with the gym being an unsafe and inappropriately-equipped environment for their exercise needs. The services in high demand for older people in the community are quite limited in prison: specialist availability, diets, health products, exercise opportunities, diversity of programs, etc.
Because older offenders lack considerable control over managing themselves in old age, it is up to the CSC to be senior friendly. The different correlations presented in this chapter suggest that while imprisonment is not to be blamed for aging, it might in some cases not only fail to address it, but might intensify its negative consequences through neglect and mistreatment. This concern will be reiterated in the following subchapter that will focus on the qualitative findings regarding the services available to older offenders, based on their comments and on my institutional observations.

7.2 Qualitative Data

Many of the most interesting findings could not be quantified. While of no statistical relevance, numerous participants enriched this study with their comments and descriptions of what it is like to be a senior inmate in a Canadian penitentiary. Their concerns were not unique. Most of the complaints occurred with a certain regularity and they can hardly be dismissed. Numbers do not do justice to the stories the inmates have shared with me or to what I myself have observed during my over 200 hours of interviews. In addition, participants’ comments help explain some of the data presented above, and add to the information regarding the prison services available to older offenders.

This section is a description of the most common issues raised by offenders, as well as my own comments. The final subsection points out a series of good and bad practices in each of the institutions visited, which later on in the thesis will contribute to the creation of the list of institutional recommendations.

7.2.1 Comments of the Participants

Health Care
Health care is one of the recurring concerns reported by the older inmates I talked with. Their deteriorating health and high rates of illnesses are probably a result of aging, lifestyle, and incarceration. However, it appears that for many, their health has further declined in prison. The accounts of these prisoners begin to explain why. The most frequently mentioned complaints related to the lack of proper diets, lack of medical devices, pain management, palliative care, long waiting times to see the doctor, emergency medical response, the treatment of people with mental illnesses, the high risk of falling, the use of heavy cuffs when transported for medical reasons, recovery after surgery in the cell, and the lack of trained caregivers and 24/7 nurses.

One of the things not measured quantitatively in this study but which appears highly problematic is emergency care. A large number of inmates complained about the lack of 24 hour access to medical personnel. A couple of inmates who had suffered strokes said that had the strokes occurred outside the nurses’ work hours they would have been dead. One of the inmates suffered a heart attack outside those hours. The ambulance was called but for security reasons was not permitted to enter the premises of the institution. The correctional officers made the inmate walk through the yard to the ambulance on his own feet. Inmates are generally apprehensive of pushing the emergency button unless they are very sick. A few mentioned that sometimes nobody comes when the button is pushed, but that at other times there are serious repercussions if one pushes the button for mild sickness. Most prisoners agreed that if one has a bad migraine or stomach pain he will need to endure it until morning, because it is not seen as a reason to request help. One of the inmates recalled pushing the button on the first week he was in and the guards yelled at him “you’d better be dying!” On the other hand, the inmates in minimum security who had independent...
living arrangements complained that there was only one emergency button per building. One of the seniors I talked to feared that he will slip in the bathroom and will not be heard by anyone while screaming for help.

As shown by the numbers in my study, falls are a serious situation. Some prisoners had fallen, during the last winter, up to seven times. Most often, the cause was slipping on ice. Some institutions were good at clearing the ice, but some others rarely did so “because they said they don’t have money.” This turned out to be a serious issue, especially in lower security levels where people had to walk outside to get from one building to another. Some of the inmates with mobility problems had been provided with peer caregivers. However, only three of the seven institutions visited offered this service. Even then, some inmates complained about the lack of training available for their caregivers.

As revealed both from my data, and the literature review, mental health is problematic. In addition to the fact that the mentally ill are not properly taken care of, a number of inmates mentioned being concerned for their safety because of dangerous behavior from improperly treated prisoners. Each institution seemed to have its infamous “schizophrenics” that “could snap at any time.” One inmate recalled one of these individuals regularly attacking other inmates “in one of his moments.” Most offenders agreed that those people needed help, and that as long as “they are not treated or sent elsewhere, it is unsafe for everyone in the institution.” Also in the mental care context, PTSD appears to be neglected. Numerous offenders have been in prison for decades. They have lived through riots, stabbings, segregation, and family losses, in addition to previous traumatic life experiences such as residential schools, alcoholic parents, foster care, and abuse. Other inmates appeared to be “burned out” by long imprisonment. Sometimes these
inmates seemed to be aware of their situation, other times they did not. Only a few mentioned a diagnosis of PTSD, but many seemed to have some symptoms of it. A number of individuals were in therapy and they mentioned it helped them. Unfortunately there were also numerous offenders who said they were told that “if they are not suicidal there is no room for them in therapy.”

The number of addictions is also high. Numerous offenders complained that aside from AA and NSAP programs there was nothing therapeutically for them. They did not get treated, but were sent to groups. No rehabilitation program was available and this was a reason for complaint for many inmates. However, some of the addicts were in the methadone program and were happy with it. One of them however mentioned that he fears the moment he will be released. Last time he was paroled there was no continuation of the methadone program in the community which led him to relapse and parole was revoked.

As the statistics show, a high percentage of the inmates are diabetics. Most of them have stated that there either is no special diet available or that the diet is not edible. This led to the diet meal receiving the infamous name of “death on wheels.”

Some were trying to supplement their food with canteen products. However, they complained that the canteen mostly serves chips and cookies. A vegetable and pastry “drive” is irregular in most institutions and never more than twice per month. In addition, during the last year, the wages of prisoners were cut by 30%, and inmates are now charged room and board. Thus, at the end of a workday a prisoner makes about $5. This makes it very difficult for the majority to purchase anything, especially therapeutic products. The

\[\text{\textsuperscript{436}}\text{The term “drive” was used by inmates to describe a food program organized by almost all institutions. Depending on the institution, different types of food (vegetables, pastry etc.) were available bi-weekly or monthly to prisoners, for purchase, in addition to the meals that were provided to them.}\]
same financial complaints were raised in regard to the fact that most medical devices need to be purchased if available at all. Availability for purchase tended to vary from institution to institution. In lower levels of security, if the doctor prescribes a prop, the inmate could purchase it if he had the money (braces, orthopedic shoes, medical mattress). In other institutions, the doctor was forbidden to prescribe any medical devices.

The quantitative data presented describes regular pain in older offenders that is irregularly treated, with mixed results. Numerous prisoners suffering from improperly treated chronic pain complained that the access to proper painkillers is limited. This, they are told, is the result of the policy of the institutions. Numerous lifers used to receive better pain medication, but through the years they have been “muscled” by younger offenders who have been regularly stealing it. They also mention numerous situations of “fake pain” on the part of prisoners, which further contributes to the system being apprehensive in permitting access to medication. While the concerns of the CSC are no doubt justified and need to be addressed, some of the unintended effects might call for a different approach. Half of the prisoners that suffered from advanced-stage cancer complained about improperly treated pain. One such prisoner was also in a high level of security where access to painkillers was even more restricted. He was treated with Tylenol 3. Another inmate from the same institution had been involved in a car accident and had a doctor establish a diagnosis of high intensity chronic pain. He was offered morphine, but he was also a heroin addict. Hence, morphine did nothing for him. In turn, he was switched to Tylenol 3. There was nothing available in between T3 and morphine. This issue was raised by another 2 inmates with severe pain. They were offered morphine but refused it. The only other option
for them was T3. In the same institution, two different inmates complained about access to specialists. They had both suffered a tooth abscess at different moments in time and had to wait for an average of two weeks to see a dentist. In the meanwhile they took Tylenol for the pain.

Unfortunately, it appears that these issues exist at lower levels of security as well. One of the minimum institutions visited had a population of over 70% older inmates. However, the terminally ill ones were out of my reach because of their lack of motivation to talk to anybody. Other inmates, however, described the pain their peers suffered. The fact that there were 10 people terminally ill (within 6 months of death) was confirmed by a number of prisoners in one institution. An inmate described a cancer patient that was transferred to their institution so he could have access to chemotherapy. He waited a few months for it, and in the first week he was not granted any pain medication. Apparently he was screaming in pain most of the day, to the point where the prisoners in his building collected money and bought him the regular Tylenol available at the canteen. When he finally received his chemotherapy he was on it for six weeks. The inmate talking to me believed the individual was now in a terminal stage and was receiving morphine. He was in his room at all times, very rarely lucid. Poor management of pain in prison, especially in cases of cancer, has been identified by the literature presented in the previous chapter.\textsuperscript{437}

Medication was problematic from another point of view. Certain medications had to be picked up in person every day or every week. For many this was a nuisance. Some seniors with mobility issues who moved very slowly mentioned having to choose between breakfast and medication because, with the waiting in line, they could not make both. They

\textsuperscript{437} See above p 78.
also complained about standing for long periods next to people with contagious diseases. For a number of inmates, picking up medication was, in particular, an excruciating task. No matter how sick, they had to go pick it up in person. Generally, those who took medication so strong that it required a daily pickup were in bad shape to begin with. Getting there and standing without being given priority was an ordeal for the nearly bedridden individuals or for those in extreme pain. In addition, in a couple of institutions the medication lines formed outside. Hence, the sick inmates had to line up, sometimes for over an hour, in rain, snow, freezing temperature, or heat to pick up their medication.

Death was, not surprisingly, a common thought on numerous inmates’ minds. In addition to the fears associated with their age, seeing their peers die in pain in prison, away from their loved ones, contributed to their suffering. As one of the inmates put it “We have memorials every month now. We never know who’s going to be next.” As it happens, there is a palliative care unit in Peterborough (not administered by the CSC), but it is the only one available in the area and the process of getting in is very long and complicated. The prisoners said they can count on their fingers the number of people transferred to the palliative care institution, while the number of people dying in prison without significant palliative management is increasing. This appears to be very different than the end-of-life care generally available in the community.  

Finally, a medical issue that I did not anticipate, and therefore I did not include in my protocol, was that of chemical castration. It appears that Lupo, or “the sex offenders’ drug,” is largely employed in Canadian corrections in an arguably coercive manner. In

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438 See above p 78 – 82.
439 Inmates referred to it as “Lupo” and I will continue using this term when referring to this drug. Lupo might be short for Leuprolide. Leuprolide is classified as a luteinizing hormone-releasing hormone (LHRH)
three institutions, I had extensive discussions with more than a few inmates regarding their concerns with Lupo. All of them said they agreed to take it and they were not forced into doing it. When I asked why they were taking it, most of them said that they were told that it was the only way they will be transferred to minimum security. People in minimum security said they were taking it because otherwise they would be transferred to medium security, and that they had seen that happen many times before. All of them were hoping that being compliant with the medication would increase their release chances but they agreed that they also saw many inmates taking the drug for years and not being paroled. A number of the inmates believed that this drug interfered with their other medications and reported symptoms that their doctor believed could be polypharmacy. One of the inmates reported an increase in his breasts while using this drug. He was diagnosed with breast cancer after a few years and underwent a full mastectomy. A few inmates also complained that they were supposed to have blood tests done every month while on this medication, but that often they were ignored for months in a row. There is no doubt that this drug has serious medical side effects. The manner in which it is administered is also of concern. I am not sure if there is solid evidence of effectiveness in reducing sexual libido. Some of the prisoners had been on this drug for a very long time. Others entered prison early in life, grew old in prison, and in order to be moved to a lower security level agreed, in their 60s, to take the drug. Finally, many first time offenders incarcerated after 50 were sentenced for sexual crimes committed 20 or 30 years ago. Hence, while there may be successful

agonist, which means that it resembles a chemical produced by the hypothalamus (a gland located in the brain) that lowers the level of testosterone in the bloodstream (See Medical Dictionary online: http://medical-dictionary.thefreedictionary.com). Nonetheless, I was not able to confirm the actual product used with any prison medical staff. Hence, it is possible that other anti-androgen products are also used for sex offenders.
administration of this drug in sexually active individuals, I think the purpose of its administration among the participants in this study is, at best, questionable. It might be the case that the side effects of this drug trump its benefits.

Though there have been numerous discussions about the need to improve senior care in the community, far more options for care are available there than in prison. Primary care is fully covered by OHIP and gives the individual a choice in the medical practitioner he sees, the drugs he takes, and the hospitals he goes to. Extended care is covered by private insurance, but sometimes government supplements are available. Even if they have the money, inmates never have access to extended care that is comparable to what is available in the community.

Programming and Exercise

A recurring complaint of older offenders was the lack of a place to exercise. Numerous offenders felt that the gym or the weight pit were inaccessible because of the presence of younger offenders who would ridicule them. In one institution, an inmate described the gym as a dangerous place, “that is where things go down.” The majority of seniors were using the court yard. However, in winter it was always a problem. In some institutions the yard was not shoveled, and it could not be used after dark. Not surprisingly considering the number of people with cardiac problems, a number of offenders complained about the lack of cardio machines or walking/jogging tracks.

440 See above the description of the three levels of care and the options available in the community p 86 – 87.
I also had a substantial number of complaints regarding access to computers. Computers had been banned in penitentiaries some years ago. In only one institution were a small number of inmates allowed to use the computers they owned at the time of the ban. The seniors mentioned the importance letters play in their lives. A number of them had problems writing by hand, mostly because of rheumatic problems. Hence they would have been very happy with a computer with no internet access or with access to a couple of computers in the library. Other people mentioned that they did not have access to distance courses (which are now all online) provided by outside institutions because of the lack of internet access. Finally, the greatest number of concerns were related to the fact that many inmates were technologically illiterate. Some of them had been incarcerated before computers were widespread. Others, incarcerated more recently, only knew how to use 10-15 year old programs. So it was not surprising that the offenders thought that computer literacy programs should be either available during incarceration or as part of their release plan.

A different complaint related to access to programs. A number of inmates had to waive their parole hearings because they did not complete the programs prescribed to them due to lack of space in those programs. I met a person that had been in prison for 14 years and was still not given a spot in his mandatory program. He said that it often happened that lifers and dangerous offenders had to “take a back seat.” They were told that because they will not get out anytime soon, they were at the bottom of the waiting list. However, I also met numerous offenders who received sentences of up to five years who did not apply for parole for the same reasons. They said that “it was known that if you come in with a short sentence, they will not give you your program in time for the first parole date.” Needless
to say, more space in mandatory programs was one of the main requests regarding programming. In addition, four inmates that I interviewed did not speak English. They mentioned the importance of having a language course available for foreigners. Many inmates also wished there were programs or activities specifically for older inmates, especially in the institutions where the seniors were outnumbered by the younger offenders. Yoga, Thai Chi and arts and crafts activities were the most desired programs. Two institutions offered yoga or seniors’ fitness classes but the classes were comprised of 8 people that could participate for 8 weeks at a time. The yoga classes were open to any age, and there were 200 inmates in one institution, and over 600 in the other. In maximum security, these activities were available only to the mental health unit inmates.

Finally, the people I talked to could be placed into two categories. The first were the ones that were hoping to be released someday. They were concerned about their parole and complained about the limited release preparation and life skills classes such as cooking, financing, banking, etc. One of the inmates correctly observed that a large number of seniors grew old in prison. Society has changed and they were not part of it. They have no identity on the outside, and no ability to work with technology. They believed receiving help to create an identity (SSN, bank account, identity card) should be part of their release package. In the second category were those people who were resigned to the idea that they will die in prison. They felt that there should be programs and activities that could make their existence meaningful in prison.
Safety, Discipline and Relationships

Every second person I talked to specifically complained about the difficulties they encountered on a daily basis in dealing with younger offenders. The most serious allegations were those of sexual abuse, physical bullying, and food and medication stealing. However, the majority mentioned being regularly insulted, threatened, and cut ahead of in line by younger prisoners. A large number reported not using the gym because of fear of those inmates. They also mentioned that complaining to staff is not an option because that would make them “rats,” which would only increase the bullying. Many inmates believed the bullying was due both to the need of the younger inmates to validate themselves and because of the stigma associated with old age. My participants often complained of being called “pedo,” “kiddie diddler,” “rapist,” even though their crime was not of a sexual nature.

The conflictual relationship with the younger offenders was also perpetuated by the clash between generations. A number of the participants complained that the younger offenders were noisy and listened to loud music at night. This is a concern, considering the high rates of sleep problems among older offenders revealed by the data. One of the older inmates mentioned that in addition to having a hard time falling asleep because of the music, he often got in trouble in the morning. Because he was on medication, he needed to get up at 6 to pick it up. If it happened that he woke the younger inmates on the range, he got screamed at and pushed, because many of them slept through breakfast. Another offender complained about the fact that his 20-year old cellmate worked out all the time and he needed the window open afterwards, even in the dead of winter. As already mentioned, the community literature emphasized the importance of addressing the
environmental risk factors that compromise sleep, in order to address and prevent a multitude of other conditions associated in seniors with lack of proper rest.\footnote{See above \textit{p 72-73.}}

Double bunking was mentioned as a huge accommodation issue with repercussions on the relationships between younger and older offenders. Many of the participants I talked to had a lower bunk. However a fair number had to take the top bunk. That generally occurred in three circumstances. First, I was told “everyone has to go on top when they get in.” Second, the senior might not be allowed by his younger “bunkie” to take the lower bed. And finally, most inmates preferred being hosted with a person their own age. However, that meant that one of them would take the top bunk, regardless of the age. Shared accommodation in general was very hard on incontinent inmates. One inmate mentioned being ridiculed both by officers and his cellmate when “accidents” happened. A few others mentioned that the lack of privacy contributed to the stress of frequently having to clean themselves up.

The younger offenders are not the only ones that ridiculed older offenders. While the older offenders appeared to have good relationship with staff members overall, some of the inmates described specific situations in which they were \textit{humiliated by correctional officers}. In one instance I was not able to see my scheduled participant because “they were not able to find a wheelchair.” As it turns out, it was common practice for some correctional officers in the institution to take the wheelchairs of disabled offenders and put them in other people’s cells. This sometimes led to altercations because the prisoners that found the wheelchairs in their cells grew frustrated and took out their frustration on the inmates to whom the chairs belonged. Some offenders also complained that a small number of officers
were “making life hard for everyone.” They discussed other inmates’ offences and instigated prisoners to take action against each other. One inmate recalled an officer stopping regularly in front of his cell and saying out loud “here is the guy I told you about.”

It is of course difficult to confirm the accuracy of the inmates’ claims. Nonetheless I witnessed instances of mishandling of older offenders. For example, in maximum security an officer closed the metal door over the face of one of my very slow moving participants, as he was making his way towards me. Had there not been laughing about it, I might have thought it was an accident.

A large number of older prisoners complained about the way their families were treated. I was told that generally if an inmate was not well liked, his family was treated badly. Older inmates took issue with that especially if the family members were older relatives or small children. One inmate reported that every time his two young sons came to visit, the officer let the dog jump on them, despite the fact that one of the boys was very afraid. The inmates complained that these behaviors acted as a deterrent for many family members to come and visit. This might explain the low number of visits reported in the study.

As a conclusion to their stories, some of the inmates believed there should be more training for correctional officers that should focus on sensitivity, mental illness and aging.

Finally, a number of the inmates interviewed had lost a close family member in the recent past. A few complained about the fact they were not allowed to visit them on their death bed, and one mentioned not being allowed to attend the funeral. An offender whose mother died stated that, despite his father calling and leaving a message for him, the message was never delivered. He found out about his mother’s death the next week when
he called home. Some of these inmates were offered therapy after losing their relatives. However, most of them believed this was only to ensure they would not commit suicide. They felt that a grief and loss group would be of more benefit.

7.2.2 Main issues per institution

The institutions I visited had between 15 older inmates and almost 200. While all institutions are bound by legislation and by the CSC directives and legislation, their practices differ depending on the demographics, the security level, staff, warden, physical infrastructure, resources etc. Hence, it is not surprising that some institutions were responding better to older people’s needs than others.

Institution 1 – medium security

In general, a good number of the participants from this institution were repeat offenders. The institution provided two types of accommodations: one was cell style housing, with ranges, and the other was independent living, for the better behaved prisoners. In the independent living arrangement, inmates were cooking for themselves and enjoyed a bit more freedom. Not surprisingly, a fair number of the older offenders were housed there.

The biggest complaint in this institution was safety. Regardless of their living arrangements, most people complained that the younger offenders were violent and noisy, and that officers did little to control them. It appeared that bullying, threats, and stealing were very common. Nearly the entire sample in this institution mentioned that having an older prisoners’ unit would improve their quality of life. It would improve their stress level, and they would be able to sleep better.
The second most common complaint was the lack of access to medical supplies and pain medication. I was told that many of the prisoners incarcerated here were very violent and there had been incidents of drug stealing or faking diseases to get a better mattress. Hence, the administration introduced a ban on supplies. The older prisoners believed they were the ones who had to suffer the consequences of the younger inmates’ behavior.

*Institution 2 – minimum security*

Most participants in this institution were first time offenders, a good part of whom were lifers. Numerous inmates spent years in this institution and did not believe they would be released any time soon. Though inmates had relative freedom, with some working on the outside, and others receiving regular community passes, there was no independent living accommodation available.

The main complaint was about the number and the quality of programs. I had numerous complaints mentioning that there were no support groups, preparation for release or anything else with rehabilitative value. There was a Lifers’ Group but most members were young, so the seniors would not attend. Many people were too disabled to work, and nothing was offered to them instead. A small number of people worked on the outside, and they mentioned that this was a great advantage.

Another complaint was double bunking which existed in 80% of the institution. This appeared to be very hard on seniors, especially since the rest of the infrastructure was not old age-friendly. Most cells were upstairs, the food was served downstairs, and there were no wheelchair ramps, and no handrails in the showers.
On the bright side, there were considerable fewer complaints regarding medical care than in other institutions. Some even mentioned that they were treated well medically, and that the medication was readily available. One of the inmates described a heart surgery which he said saved his life. He believed he would not have been able to receive this medical care on the outside. It also appeared that mental health services were available, and a couple of inmates mentioned receiving regular psychological counselling.

*Institution 3 – maximum security*

The majority of my participants were either lifers or dangerous offenders. There was a high incidence of mental illness. A good part of my participants were from the “mental health” range which was considered the “quieter” unit. Others were in “protective custody” (PC) either because they were afraid of being victimized or because they did not want “to get in trouble.” However, in exchange for this protection, they were locked up for 23 hours every day and they accepted the stigma associated with being in protective custody. One inmate told me that those released from PC into the general population “have a target on their back.” Everyone agreed that despite the strict security, it was an extremely dangerous institution. Many of the participants appeared heavily medicated when I saw them. They reported taking a very long list of mental health medication. I was also told that they had been warned not to come to see me, but they did not say by whom. A couple suggested that this was the reason many inmates did not sign up for an interview.

Many people complained about the way they were treated by officers, as if they “were sub-human.” They reported being ridiculed, hit, ignored, and threatened. Considering that this is a more violent prison population, I would expect a tougher attitude
from guards. But as I already mentioned elsewhere, I myself witnessed an act of unwarranted violence, when the officer let the metal door slam the slow moving prisoner on his head.

There appeared to be a lot of idleness. When asked if they had problems with daily activities, they inevitably replied “what activities?” The inmates in the general population said they had time on the range but because there were no chairs to sit and socialize, the majority of the senior inmates chose to sit alone in their cells.

It appeared that the mental health unit had a variety of programs: yoga, meditation, counselling. The inmates appeared to be treated considerably better. The PC population had access to absolutely nothing, aside from 1 hour in an outside cage. Most of them were not working. The general population had access to certain programs that were in their correctional plan, but said that spots were limited. The rule was that the programs were to be completed at a lower security level. No support groups with regular meetings were available.

The biggest problem aside from idleness appeared to be the medical care. The waiting time and the lack of responses to their medical requests appeared to be worse than in any other institution. It was here that two prisoners with tooth abscesses had to wait for two weeks to be seen by a dentist. Most of the inmates talked endlessly about what they saw in the institution, and they seemed particularly traumatized by the violence they encountered. Some had PTSD diagnoses. None was seeing a psychologist on a regular basis. They said that each inmate in need was entitled to three sessions if they were not on the mental health range. One of the participants had been recently diagnosed with stage 1
dementia. This should not come as a surprise considering how little mental stimulation these inmates were exposed to.

_Institution 4 – medium security_

A large proportion of this prison’s population was comprised of people over 50, many sentenced for sex offences. There were two range units and one independent living unit, with houses. The inmates had more freedom than in other medium security institutions. They were described by staff members as a rather calm population, with very few incidents occurring in that institution.

Many programs and support groups were available and the attendance of older prisoners was high: lifers’, seniors’, oriental, French, Spanish, Toastmasters, Maritimers, Native Brotherhood etc. This was the only institution that had a Seniors’ Representative to mediate the relationship between seniors and authorities. Yoga and meditation were very popular; they also used to have fitness classes for seniors and bike trails outside. Many people were disabled, and there were peer caregivers available. For the most part, participants said they felt safe in this institution and that it was the best they have been in. It appeared that psychological services were readily available and many participants were seeing a therapist. Nonetheless I did get regular complaints about lack of space in mandatory programs.

The biggest concern was healthcare, other than psychiatric. A number of prisoners told me that the doctor prescribed medication without seeing the patient. There was no 24h staff and one of the inmates described a terrifying heart attack that happened outside working hours. It took over an hour before an ambulance was called for. Another inmate
had an aneurysm rupture in his leg. He was transported in a CSC van and had to wait until they switched the shift. Finally, one of the inmates had a year old leg infection that smelled terrible, and was obviously very badly attended to. Many people were on serious medication for their conditions. They had to wait outside for an hour every day to pick them up in person. This was why some of them just skipped taking them days in a row when the weather was bad.

Finally, the use of Lupo – “the sex offenders’ drug” - appeared to be widespread in this institution. Inmates told me that they had to take it because if they did not, they would be transferred to a “serious” institution, where they would not do well. Everybody seemed to know that if they were sex offenders they needed to do everything they could to stay away from institutions with a different demographic, where sexual predators were targeted.

_Institution 5 – medium security_

In this institution there was also a very large number of older people, most of them being lifers and dangerous offenders. Most of them had substantial experience with being in prison. Because of overcrowding, the segregation rooms were used at times to house prisoners with no disciplinary or administrative issues.

One unit was used to house mostly disabled prisoners. I was told that it started as an older people’s unit, but now there were many young prisoners as well. Some people were placed there for protection, because there was no protective custody unit. A good part of my participants were not in that unit.

There was a wide variety of support groups and groups run by volunteers. I was told there used to be many more programs but they were cut. The programs missed the
most were the craft and hobbies, the grief group, health prevention group, and the personal support person. However, many prisoners complained of not getting a spot in their mandatory programs. For example, one prisoner told me he had been waiting for 10 years to get a spot.

The medical items system was particularly strict. The doctor was not allowed to prescribe any items, such as medical bedding, braces, etc., even if the prisoner was willing to purchase them himself.

The main concerns here were the food and diets. Many of the prisoners had been incarcerated for a long time, sometime as much as 40 years. They were in a very bad shape, with high rates of diabetes. They complained about the budget cuts which made it even more difficult for them to supplement their food.

There were also numerous complaints about the long waiting times to see the doctor. The line for medication formed outside, and the pills had to be picked up in person. There was one psychologist for 600 people. Some were told that if they were not suicidal they had no business asking to see a psychologist. A few people with suicidal ideation, when seeking help had been sent to segregation. Other specialists were also close to non-existent. There was no toe nurse and the physiotherapist was only available for three sessions per person. A few people had asked for physicals and they were told these were not available in prison.

Lock-downs were frequent and unpredictable in this institution. I was told that if someone was found with a handmade weapon the whole institution would be locked down for as long as it took to search 600 people. Sometimes it took weeks. Showers were on the range, so inmates did not have access to them for days during lock downs. They also did
not have access to permanent medical care. A nurse would bring them the pills during daytime. It appeared that the lockdowns contributed to the stress levels of most of the seniors.

Institution 6 – minimum security

A large part of this prison’s population was over the age of 50. There was an independent living system, where inmates were grouped in houses. Each house received a food budget and cooking took place in each house. Two houses contained the very sick and disabled, and the inmates there had a cook and caregivers. The institution was called “the death camp.” I was told that many of the very sick prisoners were brought there to die.

It did indeed appear that this was an age-friendly institution. Staff were considerably nicer than anywhere else. Inmates reported never having an issue with receiving the extra medical items they needed, such as blankets, bedding, props etc. Work was available for nearly everyone, and the jobs were adapted to the capacity of individuals. Numerous inmates received regular escorted or unescorted passes in the community, though working in the community was not available.

Health care was the biggest complaint, though it did appear to be better than in other institutions. Specialists appeared to be available, though the waiting times varied. Inmates confirmed that psychological services were available on a regular basis.

Issues were raised by the lack of 24/7 medical staff on the premises. It also appeared that the institution, not unlike the rest of the penitentiaries, was poorly equipped to respond to emergencies. Again, I was told stories about people suffering strokes and heart attacks outside the nurses’ working hours, which were severely mishandled. It was also here that
the inmates raised money to purchase Tylenol for an inmate in excruciating pain from cancer. Most of the prisoners were in need of outside medical care because of the severity of their conditions. However, I was told that there were only 3 escorts available per week. It appeared that this might be a contributing factor to why people brought here for better access to chemotherapy only received a small number of treatment sessions at different time intervals. Hospital transportation was done in the CSC vans and the inmates were shackled. One of the inmates reported refusing to attend his outside doctor appointments because it was very difficult for him to kneel in order to be shackled. In addition, the procedure was such that inmates also needed to be handcuffed during surgery and chemotherapy.

Finally, a high percentage of this prison’s population were sex offenders. As a result, it was not surprising that treatment with Lupo, “the sex offenders’ drug,” was a reoccurring source of concern. I was informed of the same medical issues raised by inmates in other institutions. Again, because this was one of the better penitentiaries, the fear that they would be transferred elsewhere was persuasive enough for inmates to keep to the treatment despite its side effects and negative interactions with their other medication. One of the inmates told me that he has been in for a very long time and he did not expect to get out at all. Hence, he needed to be in a better institution since that was his home. In these circumstances, not taking the medication was not an option. Again, it is questionable why somebody with little chance of release would be treated with this drug, 30 years after the commission of his offence.
Institution 7 - medium security

The last institution visited was also the most difficult. There were only a small number of older offenders incarcerated here and the institution was not in any way prepared to deal with their needs. There had been recent drastic modifications to the infrastructure and demographics of this institution, and services had not yet been adjusted to the changes. There was a general sense of disorganization, and staff were apprehensive regarding my presence in the institution.

The participants in this institution were generally in their 50s or early 60s, and appeared physically stronger than my average interviewee. They still had numerous conditions that were treated by the use of heavy medication. The institution was described as “the gladiator school,” a very violent place worse than maximum security. As one of the inmates put it “at least in max [maximum security] you are locked up most of the time, so that offers some protection.” I was told that staff were very abusive, both physically and mentally. Though the demographics were those of inmates of a more violent kind and probably required a tougher approach, I do not doubt the claim. It was the only institution where I myself felt mistreated by the officers. An inmate also complained about how his children are treated when they come to visit. He believed that because he was not well-liked, the staff took it out on his visitors.

Health care was not a big concern because most of the participants did not think they were “entitled” to it. I was told that putting in a request was useless, and that seeing a specialist was rare. They said “since the assessment unit opened in this building we are not getting anything. They [staff] say that resources need to be split with the assessment unit.”
Ramps and handrails were not available. The population did not appear to need it. However, they did complain about double-bunking. Most of the inmates were living on a sick and disabled range, hence they were bunked with people sometimes feeble-er than themselves. Thus, they had to take the top bunk. They complained about the fact that the bunk did not have ladders to climb, so they had to push themselves up and jump down. Needless to say, this was not an easy task for a man in his late 50s or early 60s. However, they did not want to be moved off that range, because they said it was a bit quieter than the rest.

Finally, a common complaint was the lack of predictability of the schedule. About half of the sample worked but they said that sometimes they were called for work, sometimes not. It appeared to be the same with programs and meetings of different groups. Lockdowns were frequent and lasted for days or weeks.

7.2.3 Particularities of the Assessment Unit Participants

The assessment unit is comprised of transitory prison population. It is very different from the rest of the institutions and it is difficult to assess by the same criteria. Unfortunately, however, I did not have enough participants from this unit to quantify data. It is still relevant to look into the qualitative findings, with an exploratory mindset.

The assessment unit is the first federal institution an inmate enters when sentenced. This is the first contact of an individual with the federal correctional system. It is here that his security level is determined. Because it is a transitional place with no rehabilitative value, an inmate should not be there for more than 90 days. Some of the inmates there were either approaching this limit or have surpassed it.
With two exceptions, the participants were from the protective custody range, meaning that a number of them were sex offenders. Except one, all of these individuals were first time offenders, facing the system at an old age. Many of them were incarcerated for crimes committed up to 30 years ago. They were more scared and confused than any other participants I interviewed. Some of them had been in the unit for two months and they had not met with a parole officer and did not receive any orientation. I was the first person they were talking to outside their peers. They only had access to rumors and gossip, so did not know what would happen to them. Most of them had problems sleeping and their level of anxiety was very high. Communication with staff, or the lack thereof, was by far the number one source of concern for these participants.

The participants did not seem to have access to anything. There were no jobs, no programs, and no support groups available. They had limited access to their families. They complained that it took months to get a phone card or to get their visitors’ list approved, which contributed to their stress. They were not allowed with any personal items and there were serious delays in receiving some from the institution. Most people were un-groomed because they had not seen a razor or clippers in months. Some could not read because their eye glasses were confiscated and they did not receive another pair. As well, some people did not have dentures, hence they had a very hard time eating.

Medical care was problematic and very limited. They were told that resources were limited since they had to share them with the medium security population. When asking for a doctor or a consult, they were told that will only happen once classified and sent to their mother institution. The issue with health care in the assessment unit was recently identified in a not yet released investigation of the Office of the Correctional Investigator.
The document reports that people in the AU are abruptly discontinued the medication they were on in the community and are left without any for 30 days or more. Of particular concern was the discontinuance of pain and mental health medication.\textsuperscript{442}

Fortunately, this population was in better health than the other participants. They had just entered prison and they had a smaller number of conditions. As well, the data showed that mental illnesses were much reduced compared to those among classified inmates who had been incarcerated for a longer time.

7.2.4 Summary of Qualitative Findings

The qualitative findings are meant to complement the statistical data, especially in regard to the responses offered by institutions to seniors’ needs. They are confirmation of the fact that what is particular about older offenders is not their health status, which to a certain extent could be attributed to aging (even if perhaps accelerated). The particularity is that they are facing the challenges of aging in an environment often inadequately equipped to deal with them, and they lack almost any control over their own well-being.

Both the quantitative and the qualitative data point to a series of risk factors that could enhance the natural degradation of health in old age, or at least make it difficult to manage. These risk factors include: limited access to medical personnel in some institutions, improper emergency care, inadequate psychiatric care in certain prisons, segregation in response to mental illness, little mental stimulation in higher security, challenging infrastructure, top bunks, ineffective pain management options, tense relationships with younger offenders, harassment and ridicule by certain staff members,

alteration of family relationships because of the challenges associated with visiting, limited assisted living opportunities, partial or complete lack of medical props and non-medication interventions such as diets, the quasi-obligation of some to take the potentially harmful sex offenders’ drug, inappropriate exercise space, long term incarceration burn out, the idea of dying in prison, the pressure of putting their affairs in order from behind bars, the burden of guilt, shame and stigma associated with crime, and are all factors that a senior in the community does not encounter. In fact, comparing the data in this chapter with the one revealed by the community literature, we can see that while the needs are similar, or enhanced in prison, the options available are not. In some cases, the options senior inmates have are so limited that it might raise not only moral issues, but also legal ones.

Because of security considerations and the general nature of prison, we cannot reasonably expect that aging in prison could be the same as aging in the community. We expect that aging in prison will be more challenging than on the outside. However that is not to say that older offenders should expect to be deprived of the necessaries of a decent life in old age. Because the needs that sustain a decent life are enhanced in old age, both on the inside and on the outside, more has to be provided for older offenders than is currently available.

I do appreciate the burden this places on the CSC, for both the budget and the organization. I do not expect that this challenge will be dealt with overnight. It will require an adjustment process. However, ignoring the problem will not make it go away. On the contrary, it will raise numerous legal issues that the CSC will be exposed to by not addressing a situation that will only get more serious in the next decades, as the older population is expected to increase.
Chapter 8

Data Interpretation

As the prison population ages, it appears that there is a gap between senior inmates’ needs and the treatment available to meet these needs. The previous chapter dealt with establishing the main issues facing the Canadian correctional system in managing older offenders. This chapter is meant to assess and articulate the consequences of these findings. What happens when the needs of an increasing prison group are only partially met? Does the correctional system have an obligation to meet these needs? What are the institutional and legal effects on the correctional system? Can the goals of incarceration be met when the system is falling short of answering basic human needs? What are the legal tools that the inmates have to claim their rights? Is the current legal and policy framework sufficient to support such claims? If not, is there a need for the refinement of this framework?

In this chapter I argue that, based on the findings of this study, the correctional system is not yet prepared to manage aging in an appropriate manner. Because of that, there is a gap between what these people physically, mentally, and emotionally need, and what CSC is equipped to give them. The issues identified in this study are emerging problems, and thus, there is virtually no case law dealing with them. I maintain, however, that both the Charter and the current legislation are sufficient for protecting the enhanced needs of older prisoners. Nonetheless, the application of legal provisions might need to be refined in order to reflect the new realities our aging society is facing. The possibility, and indeed the obligation, to adapt the Charter’s application to changing realities is one of its greater
benefits, deemed as such nearly since its inception.\textsuperscript{443} Hence, the following arguments are an attempt to fit the issues identified in this study under the protection of the Charter and other legislation. They are also an attempt to close the need – response gap itself, by discussing the institutional and policy implications older offenders bring about. Adapting to new realities means first and foremost changing policies and institutional approaches. As crucial as it is, a proper legal framework is not the change we seek, but only an incentive for that change and a remedial tool.

For these reasons, the first subchapter will explore the institutional changes required by the needs of an older population. If these adaptations fail to occur or will be insufficient to meet basic needs, then the law should step in, allowing individuals to claim well-articulated rights. This will be explored in the second subchapter. Finally, the last subchapter will provide reflections on the purpose of incarceration in the context of this study. While rehabilitation is not the only goal of sentencing and imprisonment, it should be an important one considering that most individuals will be released at some point. Arguably, rehabilitation means offering opportunities for growth. These opportunities need to be based on needs and capabilities. When they are lacking, the possibility of rehabilitation itself is threatened. Such a threat weakens the very mandate of the CSC:

\begin{quote}
3. The purpose of the federal correctional system is to contribute to the maintenance of a just, peaceful and safe society by
\begin{itemize}
\item[(a)] carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders; and
\end{itemize}
\end{quote}

\textsuperscript{443} The metaphor of “a living tree capable of growth and expansion within its natural limits” (\textit{Edwards v A-G Can}, [1930] AC 124, 136) has been deemed applicable to the Canadian Charter. See Peter Hogg, \textit{Constitutional Law of Canada} (Carswell: Toronto, 2013) at 36 -25 [Hogg].
(b) assisting the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of programs in penitentiaries and in the community.\textsuperscript{444}

8.1 Institutional Implications of the Findings

In chapter II I presented a number of challenges that the CSC is currently facing due to an increase in its prison population. The CSC has been criticized in the last decade for its budgetary distribution, for inappropriate responses to mental health needs, for the increase in the use of force as opposed to other correctional intervention methods, and for insufficient programming.\textsuperscript{445} Statistical information available after 2010 shows that the number of incarcerated people in general is increasing. There is also a significant increase in the number of people incarcerated after the age of 45, and of the number of people growing old in prison.\textsuperscript{446} However, the CSC budget is decreasing, and the allocation of the money appears to stay the same, with little dedicated to health care and programming.\textsuperscript{447}

This study shows that in addition to the already known challenges, the shift in the demographics of the prison population and the increase of the number of older prisoners adds a new layer of problems. As it appears, this growing age groups has extremely high rates of mental and physical problems, as well as chronic, acute, and terminal diseases. Their well-being and health appears to be sensitive to programming availability, disciplinary means used, family relations, and their predisposition to abuse by peers and staff. It is clear that maintaining the present status-quo in corrections, under the new circumstances, raises numerous ethical and legal problems.\textsuperscript{448}

\textsuperscript{444} CCRA, supra note 8, s. 3. For a discussion on CCRA see above p 23–24.
\textsuperscript{445} See above Chapters 3 and 5.
\textsuperscript{446} See above p 45
\textsuperscript{447} See above p 47.
\textsuperscript{448} See below subchapters 8.2 and 8.3.
As a result, a new CSC management plan that takes into account all these realities is required. More specifically, a strategy that considers the issues raised by the aging population is mandatory. The increasing number of this age group, coupled with their high needs, appears to have an impact on all aspect of the correctional system, from its physical infrastructure to the services delivered and staff training. While a budget increase would be ideal, rethinking the allocation of resources, in accordance with new findings, might be just as efficient. Even an increase in the CSC budget, without a proper spending strategy oriented towards inmates’ needs would not bring the change needed.

A shift in priorities must start with a recognition of older prisoners as one of the CSC vulnerable groups. This study brings evidence that:

a. Elsewhere in the common law world, as well as continental Europe, there have been substantial studies done that show that older prisoners have enhanced needs, that require special correctional responses. Some of these countries, in particular the US, have developed strategies to deal with the challenges, from palliative care units, to compassionate release opportunities.

b. Seniors in the community, according to the literature, have increased needs compared to the rest of the population.

c. The number of older prisoners in Canada is increasing, according to statistical data from leading Canadian authorities.

d. The older prisoners in Canada, according to this study, have particular and diverse needs associated with aging, comparable to those of senior offenders in other jurisdictions, and often enhanced compared to those of seniors in the community.
Just as women, mentally ill, and native prisoners have been acknowledged as having different and enhanced needs from the general population, it is time to accept that this as a reality for older prisoners as well, and act in consequence.

Once the issue of older prisoners is accepted as a significant problem, a differentiated strategy for dealing with them can be created. The best managerial way to do it is to acknowledge older people as a vulnerable prison group in the CCRA, and implement a strategy to deal with them through a Commissioner’s directive and standing operating procedures that would ensure that all institutions apply the same treatment to their older inmates. Now there are great variations in the way institutions are facing this challenge, based on nothing else but their own understating of how to deal with seniors.

Older prisoners have a number of very serious conditions. Often they are chronic, hence they need lifelong management. That means more infirmary visits, an increased need to have medical appointments, an impressive number of pills taken daily, better monitoring of drug interactions, specialists and medical bolsters and devices available, as well as more focused preventive measures. This means that the health care for seniors needs to be enhanced. It will require a policy-based intervention that would prioritize health care for seniors based on need, in order to respond to humane and legal concerns. Failing to do so could amount to equality challenges based on the failure to accommodate people with enhanced needs, as well as challenges based on the right to security of the person and the right to be free from outrageous treatment.

The overwhelming majority of the participants in this study would have welcomed a range, unit or institution specifically dedicated to older offenders. This would be the most
systematic manner to deal with enhanced needs without having to dramatically increase the overall correctional budget. This would allow for targeted medical and social interventions, similar to the initiatives in the community,\textsuperscript{449} based on the principle of equivalence of care.

A number of institutions have attempted a unit or a range for seniors, depending on the number of older prisoners, but they have not succeeded. Eventually they began placing younger prisoners in such units because of health problems, in lieu of a protective custody unit, or due to lack of space. In maximum security, older prisoners were simply placed in a protective custody system, which is far from responding to any needs other than safety. I believe this is proof that the officials of institutions have realized the need to deal with seniors in a differentiated manner. However, the lack of a centralized policy has caused their attempts to fail under the pressure of other challenges.

Seniors have high rates of disabilities. Under these circumstances, not having ramps, handrails, and using double bunking is not legally sound in an institution where there are older people. While some modifications have been made in a number of CSC institutions, they are far from being complete. There are still institutions where all cells are upstairs, where seniors sleep in top bunks, and where they have to walk long distances to get from their cells to the kitchen, program rooms or to receive medication. It might be extremely expensive to renovate all buildings, but failing to do so presents significant issues for seniors. The alternative is to create a senior friendly unit, equipped with the proper physical infrastructure. The buildings that cannot provide for that should not be

\textsuperscript{449} See above Chapter 4.
housing seniors at all. While no person with physical disability should be confined in such circumstances, older people, even when not necessarily in wheelchairs, still have high rates of rheumatologic and balance problems that require an adapted physical structure. This situation continues in federal corrections despite the 2012-2013 report of the Office of the Correctional Investigator reporting on the general unsafety of double-bunking for example and the correlation between such crowding and incidents of violence.450

A special unit or range would allow for a shift in budget priorities without compromising security in a penitentiary. This study shows that older prisoners, even those who used to be particularly violent in their youth, have very low rates of disciplinary problems. From those who have had a history of disciplinary issues, most of them were non-violent. There should be little doubt that at any level of security, an older prisoners’ range would be the quietest, safest range in the institution. Hence, for that particular range or unit a shift of money allocation from security to health care and programming would come not as a compromise, but rather as a natural cost-benefit outcome. The number of correctional officers on the unit could be reduced in favour of a 24/7 nurse, an extra doctor who could take appointments, or more escorts for trips to community specialists.

Strict correctional policies regarding appointments and dispensing of medication is based on an assumption of attempts by inmates to fake diseases in order to get a trip to the infirmary or drugs in order to get high. Stealing of medication is also common, which endangers not only attempts to keep prison drug and contraband free, but also the health of people who really need that medication. No doubt, there may be examples of older

450 Sapers, Report 2012 – 2013, supra note 77 at 22-23.
prisoners faking illnesses and using drugs for other purposes as well. However, this study shows that they are extremely likely to be in need of care because of their high number of conditions. A special unit for older inmates would allow for a prioritized system for medical appointments for seniors, as well as more readily available and diverse pain medication with less concerns for fraud or stealing. In addition, it would be easier to create a better system for medication dispensing that would not involve outdoor hours-long lines which deter people from claiming their needed pills. It would also be easier for medical personnel to check that the individuals for whom those pills were prescribed are actually taking them because the number of people would be reduced.

In a seniors’ unit it would be easier to provide systematic preventive health care, which would in turn be cheaper than treating consequential conditions. The participants in this study were very compliant with their medical prescriptions. One of the popular requests was for health care programs and more preventive interventions such as physicals and vaccinations. Some were even willing to pay for things such as shingles vaccinations, since it was not available in most instances. Having the people over a certain age grouped together would make it easier to organize self-care group programs or discussions, regular checkups and to approve less common demands for vaccinations – sometimes for a cost-based on the individual’s personal and family medical history. Providing seniors with physicals every second year would dramatically reduce the costs of health care by allowing for the early discovery of diseases. Proper self-care education and administration of vitamins and proper diets would also prevent a serious number of conditions. Providing for
these would also align prison practices with the ones in the community. There are numerous community studies that show that diets, even for healthy people, need to have different nutritional value based on the age of the individual. While this might appear pretentious in a prison setting, it is in fact a matter of practicality. A healthier, appropriate diet is what keeps individuals healthy. It is cheaper to modify diets than to treat heart conditions, high blood pressure, cancer, and diabetes, which may all be caused by too much fat and starchy foods. In addition, in a seniors unit it would be easier to organize more frequent vegetable and pastry “drives.” This would be true especially at higher levels of security where such drives are seldom because of security concerns.

A high number of the participants in my study underwent surgeries in prison, while very few of them spent the night after surgery in hospital. This is not surprising considering the expense of security. However, transferring people to their unmonitored cells only increases the risk of complications and infections post-surgery, which in turn requires new expenses. Transferring them to a seniors’ unit, where there would be 24/7 health care supervision would solve both issues.

There is also a concern with people dying in prison, which is a natural and inevitable process considering the increase in the older population. These people require end-of-life care. They have not been sentenced to physical punishment for their crimes, so it is mandatory that they are kept relatively comfortable and pain free during their last months of life. This does not appear to always be the case, which is not surprising considering the strict pain medication policies and the lack of actual prison palliative care. There is an

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451 See above p 70.
absolute need to create a palliative care unit in some institutions, where all dying prisoners can be sent. There is no ethical or legal reason to hold a terminally ill prisoner at the same level of security he was assigned when he was healthy. A palliative care unit, that has sufficient space for dying prisoners, would require relaxed security, enhanced visit possibilities, and need-based dispensing of medication. This indeed would not be cheap. The cheaper option, the compassionate release, is not widely available in Canada. Parole by exception (which could be applied for by terminally ill prisoners) is available only for prisoners with fix sentences (non-lifers). 452 There is no data pertaining to the extent of the use of this form of parole.

The concerns expressed by participants in this regard are consonant with the ones found by the Office of the Correctional Investigator not long ago. His office found that “natural” death is on the rise in prisons because of the aging process and longer sentences. He criticized the approach of the CSC in dealing with such deaths, the small number of compassionate releases, and the fact that their “dying” conditions are far from being dignified. 453 The fear of dying in prison, rated as the number one fear by many of the participants, appears justified in the context of the OCI’s report on CSC’s handling of dying prisoners. The OCI found that for half of the dead inmates whose files they reviewed, the procedure used to deal with their illness was affected by tardiness, or was incomplete, or their medical files simply did not elaborate on that procedure. While this report dealt with death in general, not just that of older offenders, this category of prisoners will be the most

452 CCRA, supra note 8, s. 121.
affected by CSC’s incapability of dealing with terminally ill.\textsuperscript{454} This could be even truer now in light of the new governmental initiatives to introduce life sentences without parole for certain crimes.\textsuperscript{455}

Mental illnesses are a general prison concern, but they appear to be even more critical among the older population. The fact that the elderly are predisposed to mental illnesses and suicidal ideation was confirmed by the medical community literature.\textsuperscript{456} Lifers and dangerous offenders are required to see a psychiatrist every year because of their prolonged incarceration.\textsuperscript{457} However, I was told that that the consultation is a mere formality that usually takes five minutes. Mental health was shown to be negatively associated with disciplinary programs, use of segregation, and overall dissatisfaction with life, in addition to suicidal ideation. Also, mental health appears to be influenced by incarceration, because there was a statically relevant difference in psychiatric problem rates between people freshly incarcerated and the rest of the sample. It is only natural to make preventive psychiatric care and therapy readily and substantially available to a category of prisoners severely predisposed to mental illness and suicide.\textsuperscript{458}

\textsuperscript{456} See above p 73 - 74.
\textsuperscript{457} This is an assertion of the inmates. I could not find any internal regulations that support this requirement.
\textsuperscript{458} See also the Chapter 5, Literature Review.
It appears that there is a strong connection between the use of segregation – both disciplinary and administrative - and people reporting mental illnesses. Hence, people with mental illnesses tend to be less obedient. On the other hand, it appears that segregation is used in response to mental illness and suicidal tendencies. This was one of the big concerns of the Correctional Investigator, who invoked literature to show not only that segregation has no therapeutic values, but rather it perpetuates and enhances mental illness.\textsuperscript{459} As a result, not only should segregation not be a response to psychiatric conditions, but mentally ill prisoners should be disciplined in a different way, more conducive to healing and rehabilitation. From the numbers, it appears that using segregation with this category of prisoners and thus increasing the mental issues not only raises ethical and legal issues, but does not deter disobedience in the future. In this context, Canada’s history of abusing the use of segregation\textsuperscript{460} is even less reassuring, and the need for a sound policy regarding the employment of segregation for seniors is even more stringent. On a similar note, the Office of the Correctional Investigator warned against the use of segregation and force for “treating” mental illness, which he also found were excessively used. This was a particular concern in his report on inmates’ suicides, where the OCI found that half of the suicides were committed in segregation by people with known mental illnesses. He also found that half of the inmates that committed suicide during the investigated period of time were over 45 of age.\textsuperscript{461} This confirms my findings that correlate mental illness with suicidal ideation and with the use of segregation for older prisoners.

\textsuperscript{459} See above p 59-60.
\textsuperscript{460} See above p 45-46.
\textsuperscript{461} OCI 2014, supra note 126 at 30 -31.
The Correctional Investigator also mentioned the high rates of vacancy for mental health professionals in prison, which would support the claims of participants that they do not receive timely and proper care.\(^{462}\)

Programming and exercise is a very important area for the well-being of seniors, and it is the main source for rehabilitation, which ought to be the guiding principle in Canadian imprisonment. In this context, the 17% of the budget that is invested in correctional programs is extremely low.\(^{463}\) While programs included in correctional plans are available, there are often insufficient spots, which lead to people spending more time in prison, independently of their behavior. This is not a cost-efficient approach. In addition, numerous programs that are available and required have very little value for seniors. There is little practical reason in requiring a seventy year old to take grade 12. The drug programs, while important, are of little therapeutic value. These programs offer peer support and guidance in how to avoid temptation. However, the organic effects of drug abuse are seldom addressed. There are no supervised detoxification programs available. This is of concern considering the high rates of addictions among prisoners in general, and seniors in particular. Moreover, programs delivered by volunteers are not always available. There are some religious programs run by volunteer groups, but there are not any age specific programs. For example, many seniors I talked to have lost somebody in the recent past. For them, grief groups would have been very useful. Also, seniors are at an age when they are dealing with aging bodies and memory loss, and are facing their own mortality. They grow stressed and anxious and this increases their mental instability, and thus the potential for

\(^{462}\) Sapers, Report 2012 – 2013, \textit{supra} note 77 at 17 – 19.
\(^{463}\) See above p 47.
disciplinary problems. Programs that teach people about growing old, dealing with death, making amends with people in their lives are crucial. It is said in the literature that many institutions that have dedicated units for older people deprive them of access to programs. This does not need to be the case. In fact, in most institutions, the number of seniors is so high that programs organized for people in those units, whether from the correctional plan or on a volunteer basis would be worth it. It would free space in the classes for the general population, while it would bring an age appropriate dimension to the correctional programs for seniors.

This study also shows that mentally ill seniors are in pressing need of exercise. They are trying to keep active in their cells or range or yards when available. A unit for older people would allow for an exercise room destined to meet the needs of aging bodies. It would not need to be large and it would not be crowded. It would protect seniors from the ridicule of younger inmates. It would be a safe place where they could use cardio machines, regardless of the weather, socialize with people their own age, and in general, be more comfortable in keeping active. Physical activity is known to be the cheapest preventive factor for physical and mental conditions. Once again, it is a cost-effective approach aligned with community initiatives for seniors.

A compelling argument in favour of age segregation is brought forward by an American scholar, Jonathan Turley who said “We all know grandparents who complain they’re afraid of walking at night because of crime. Imagine being geriatric in a neighborhood where everyone is certifiably violent.”\[^{464}\] The numbers resulting from this

\[^{464}\] Cited in Blowers, \textit{supra} note 305.
study show that older people are extremely vulnerable to both peer and staff victimization. Because of the sensitive nature of this issue, it is also likely that incidents of abuse have been underreported. Seniors are more physically and mentally frail, which makes them easy targets for inmates or staff members who want to assert their dominance. They are bullied out of the gym, they are at risk of having food and medication stolen, and they are ridiculed on account of certain medical conditions such as incontinence. This is the main reason why many seniors requested a segregated unit or range. Such a place would indeed offer physical safety, in addition to other benefits. Being with people of similar age, who encounter the same physical and mental transformations, would allow for more peer compassion, and enhanced social opportunities. It is likely that because of reduced security needs, the correctional officers would also have a more laidback and understanding attitude towards the inmates.

However, with or without a separate unit, the need for better staff training is mandatory. Indeed, prisons are not nursing homes and correctional officers are not caregivers. Nonetheless, they are increasingly faced with dealing with people in need of care, and officers, as first responders, are responsible for these people. Training that teaches staff about the transformation that occurs with age, sensitive approaches towards seniors, and attitudes that would contribute to the rehabilitation of elders, would not only be desirable but are mandatory from an ethical and rehabilitative point of view. In the literature there were accounts of officers treating prisoners as disobedient when in fact they suffered severe memory losses, hearing problems, slowness of movement etc.

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465 See above the Chapter 5, Literature Review.
Participants told me repeatedly that while only a small number of officers in each institution are physically abusive, many of them are negligent, indifferent, and rude. It only makes sense that if we want to rehabilitate people, the ones in charge should lead by example, with care and compassion. Maybe it would be easier to accomplish this in a smaller unit, where keeping young, strong inmates under control would not be an issue.

Training should also extend to parole officers (PO). They are being faced with numerous offenders in late stages of life, after a long time spent in prison. The parole officer’s support is crucial in the release of offenders. Most participants put all their hope and trust in their POs. Many had good relations with them, others were disappointed. A framework that would allow POs to put more weight on the physical capacity of an individual to be a risk to society when recommending parole would be more in accordance with the realities seniors are facing. Also, judging a 70 year old as uncooperative because he refused to go to school with 20 year olds, when appropriate programs are not available, might not be the best assessment tool.466

It is also likely that a segregated approach towards older offenders would be more conducive to extensive family visits. This study shows that people with increased family contact tend to have less disciplinary problems. Family connections provide inmates with purpose and an incentive to behave better so that they do not lose privileges and may have a chance at parole. Many of the participants confessed that they loved their families but their relations grew distant, especially because of the long time spent in prison. An alarming number of prisoners have never been visited in prison because of long distances

466 For an extensive discussion on release opportunities for seniors see below Chapter 9, Recommendations.
and old relatives. Others have family members who stopped visiting them because of the way officers treated them. This attitude must change. There needs to be training on how visitors should be treated, especially the frail ones. Not surprising, older people visit older offenders. The need for patting down an 80 year old lady who visits her son is questionable. Officers, as the primary contact of an inmate, should struggle to encourage family relationships. Each inmate has a parole officer and a correctional officer (CO) who should be in touch with them often. The inmates complained that often POs are not interested in the inmate’s well-being and that they rarely have any contact with their COs. These people should be trained to focus on the issues that appear to have a positive influence on senior inmates. They should encourage program participation, socializing, and most of all, contact with family. In the American literature, there is a particular emphasis on the need for institutions and officials to stimulate family relationships. It was maintained that is not just a moral obligation, but a legal duty of individuals in charge of inmates.467

In addition, it appears sensible that older prisoners, who are low risk, should be entitled to more family visits, escorted or unescorted passes, and “trailer time”468 with their families. Especially for terminally ill prisoners, there should be a program that would allow their families to visit them often, in decent conditions. Surely, this has nothing to do with security, because terminally ill prisoners are already very obedient. This is a matter of human decency.

467 See above Chapter 5, Literature Review.
468 Prisoners who meet certain criteria are allowed to receive, at certain intervals, a weekend-long visit with their families. This family visit takes place in a house on the compound of the prison.
Finally, many prisoners cannot be in touch with their families because they are living in other parts of the country and they cannot afford the costs of travelling. As one inmate suggested to me, installing a Skype system that would allow even supervised online visits for inmates whose families have objective reasons not to visit, would make a world of difference. Skype is cheap and more secure than in-person visits. It gives older prisoners a chance to see their children and grandchildren from the other side of the country or from other countries. Similarly, older relatives would not be subjected to body checks and mistreatment in prison. There would be no worries regarding contraband, and other safety issues. On the other hand however, regular skyping opportunities would keep inmates, especially the ones incarcerated for long periods of time, connected to their families. It would give prisoners a chance to work on fixing their relationships that might have been broken by the sentence and the crime. Hence, at the end of the sentence or upon parole they might have someone to go back to. Most of all, it would be a cheap, risk free incentive for prisoners to behave.

Enhancing family relationships would be of particular importance for lifers. Over half of the participants were either people sentenced to life in prison or with an indeterminate sentence. For these people, incarceration has a particularly devastating effect on family relationships. Also, some of them will never be released so there is very little incentive for maintaining relationships. However, the value of such connections cannot be disputed. Encouraging such relations, either by facilitating in person visits or Skype conversations should be a correctional focus.

Lifers tend to have other particular needs. Because of the possibility that they might not be released, the fear of getting sick and dying in prison is stronger than among other
category of prisoners. Sometimes this contributes to anger and frustration, in addition to getting burned out because of prolonged incarceration. It is why being on a quieter range, with age appropriate programs and opportunities for work, exercise, and socializing is even more important for people who call the prison cell “home.” In addition, as individuals approach the end of their life, they should be encouraged to put their things in order, and be given fair opportunity to do so. They should be encouraged to think about their wills, as well as advance directives (such Do-Not-Resuscitate orders and types of medical interventions). They should have the opportunity to seek legal counseling. Very few prisoners can afford extremely high legal fees. Even when they can, it is not easy to reach a lawyer from behind bars and convince her to help with a will. This is of particular importance considering that some prisoners are illiterate and many are undereducated. As an alternative, law students would be a cheap choice for legal advice, in exchange for practical experience. Some sort of understanding between the CSC and the universities across Canada can surely be reached. As it is, Queen’s University is the only one that provides student legal advice to inmates. However the program is limited, and it generally covers disciplinary prison matters, parole and grievances, rather than other specialized areas of private law.

To conclude, transformation is needed and must be synchronized with the enhanced needs of older offenders and the community initiatives for seniors. The first step should be setting up some form of age sensitive living arrangements. While age segregation is an ongoing debate, the side effects of not having separate ranges for older people, especially where they constitute a considerable group, are very serious. The main argument of dissenters is that older people have a calming effect on the general population. This is
neither confirmed nor denied by this study. However, as one author points out: “Correctional officers and staff (not inmates) are charged with and equipped for the responsibility of maintaining social order; hence it seems inappropriate to saddle aging inmates with the dubious responsibility of calming younger inmates in age-integrated settings.”

8.2 Legal Implications of the Findings

Prisons are called “total institutions.” That means that the individual is completely separated from the outside world and is under the control of his incarcerators. Except for legal safeguards, he is de facto at the mercy of the state. Prisoners are not covered by OHIP. They do not have the freedom to choose their doctors, to take the medication they want or their outside doctor prescribed, or to take the tests they wish. While not prohibited from requesting a specific doctor, they need to pay for this from personal funds, as well as for transportation and security. The sum generally costs thousands of dollars, oftentimes an unreasonable amount. Even the wealthy ones have serious hurdles in accessing a chosen doctor or specialist because of bureaucratic delays.

Under these circumstances, the health and well-being of the prisoner is to a certain degree outside his control. The fact that numerous older offenders are undereducated or burned out by prolonged incarceration also makes them less likely to be assertive when demanding health care. Hence, this increases the chances of them falling through the cracks of the bureaucracy and not receiving the healthcare they need. This is why a solid legal framework that can effectively ensure the protection of inmates’ rights is mandatory.

469 Blowers, supra note 305 at 149.
8.2.1 Charter Implications

Enacted in 1982, the Canadian Charter of Rights and Freedoms has since been part of the Canadian Constitution. Hence, all federal and provincial statutes and regulations, as well as governmental policies, need to conform to the Charter. A law or an act of the government may be challenged in court for non-compliance with a right or freedom. If the claimant proves the breach of the Charter, various sanctions are open to courts. In certain cases however, the government may prove that its act of non-compliance reasonably limits the individual rights in accordance with s. 1 of the Charter. The test applied by courts to determine if s. 1 applies to a breach is known as the *Oakes* test.470

The Charter allows for expanded judicial review. Since its entrenchment in the Constitution, it has been creatively applied by courts in order to enhance the protection given to individual rights. Hence, the Charter and its application have been important in defining the scope of individual rights. The Charter has also played an important role in promoting democracy, ensuring the separation of powers, and keeping legislative and governmental action in line with constitutional principles and rights.471 Below, I argue that three Charter sections are potentially breached by certain governmental actions that impact older offenders. While the possibility of applying some sections – like s. 7 - to issues raised in this study is rather obvious, the application of others - like s. 12 and perhaps even s. 15 - requires an extension of the current jurisprudence. I argue nonetheless, that such extensions are logical consequences of the development of the Charter protections in the

470 *R v Oakes*, [1986] 1 SCR 103. The court will assess if the law or act in breach of a right is of sufficient importance, if it has a rational connection to its objective, if it is the least drastic mean to reach that objective, and if it has a disproportionate effect on the persons to whom it applies.

471 For a description of the purpose of the Charter see Hogg, *supra* note 443 at 36 -3.
area of those rights. Their application could prove crucial: it might be the only way of outlawing certain governmental prison practices when reasons such as security and budgetary restraints are invoked in defense of the current *status-quo*.

Section 12

Section 12 of the Charter provides that “everyone has the right to be free from cruel and unusual treatment or punishment.” This section encompasses various types of situations. “Barbaric acts” such as torture and corporal punishment would fall uncontroversially under this section. Another category has been interpreted as grossly disproportionate sentences. For this category, the threshold is very high, defined as an action that amounts to treatment or punishment so excessive that it “outrages the standard of decency.” The majority of section 12 cases have dealt with challenges to the constitutionality of minimum sentences. In a 2015 case, *R v Nur*, the SCC refined the test applied to determine when a piece of legislation (here imposing mandatory minimum sentence) would trigger the application of s. 12. This was a refinement of the reasonable hypothetical test previously used. The court maintained the “grossly disproportionate” threshold. A law would be in violation of s.12 when the measures it imposes are grossly disproportionate on the individual challenging them, or when it is reasonable foreseeable that it will be grossly disproportionate on other persons.

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472 Charter, *supra* note 13, s. 12.
474 This is a pre-charter definition originating in *R v Miller and Cockriell*, [1977] 2 SCR 689, and was later accepted in *R v Smith*, [1987] 1 SCR 1054 [Smith].
There is no question that how sentences are served can amount to cruel or unusual punishment if they meet the “grossly disproportionate” standard or are so excessive as to outrage the standard of decency:

“One must also measure the effect of the sentence actually imposed. If it is grossly disproportionate to what would have been appropriate, then it infringes s. 12. The effect of the sentence is often a composite of many factors and is not limited to the quantum or duration of the sentence but includes its nature and the conditions under which it is applied. Sometimes by its length alone or by its very nature will the sentence be grossly disproportionate to the purpose sought. Sometimes it will be the result of the combination of factors which, when considered in isolation, would not in and of themselves amount to gross disproportionality. For example, twenty years for a first offence against property would be grossly disproportionate, but so would three months of imprisonment if the prison authorities decide it should be served in solitary confinement. Finally, I should add that some punishments or treatments will always be grossly disproportionate and will always outrage our standards of decency: for example, the infliction of corporal punishment, such as the lash, irrespective of the number of lashes imposed, or, to give examples of treatment, the lobotomisation of certain dangerous offenders or the castration of sexual offenders.”

In Munoz it was held that conditions that shock the conscience of the community are a violation of s. 12; the particular circumstances of the individual and the institution must be taken into account. The issue in this case was the awarding of pre-trial credits for prisoners who endured bad conditions in pre-trial detention. Applying a similar analysis, the Alberta Queen’s Bench found a breach of s. 12 on two grounds with respect to the Edmonton Remand Centre in the case of Trang. The court concluded that forcing inmates to wear underwear badly stained by human waste was “grossly disproportionate in that it does not accord with public standards of decency and propriety, and shocks the general conscience. It is degrading to human dignity and worth.” The court also found that the cumulative effect of the inmates being double-bunked, locked-up for 18 to 23 hours

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477 Smith, supra note 474 at para 56.  
479 Trang v Alberta (Edmonton Remand Centre), 2010 ABQB 6 at para 1046.
daily with little recreational activities available was also grossly disproportionate. However, other conditions (such as prolonged segregation, the use of baby-dolls, limitation to visits, forcible cell extraction, exposure to racist taunts and comments, long waiting time for dental care and transportation to medical facilities, and even the cumulative effects of all of these) were found not to raise to the level of severity required by s. 12.480

Claims of breach of s. 12 based on conditions of confinement have been brought in a number of other cases but they have been largely unsuccessful. For example, irrespective of the circumstances (including when it involved untried prisoners), double-bunking has consistently been found not to raise to the threshold needed for a finding of a breach of s. 12.481 Claims of a breach based on the fact that inmates were allowed very little time out of the cell (sometime as little as 40 minutes per day) were also found not severe enough to engage s. 12.482 Lengthy periods in disciplinary or administrative segregation have also been found not grossly disproportionante, even if they were “hard time”.483 The use of “Baby-dolls” (restrictive body suit) in segregation was considered serious but justifiable.484 Serious restrictions to visits were also deemed acceptable.485 Thus, while findings of cruel or unusual conditions of confinement are within the scope of s. 12, they are currently unlikely in Canada. For s. 12 to be a useful mechanism of protecting inmates against destructive conditions of confinement, the threshold might need to be lowered.

480 Ibid at paras 1036, 1037, 1041, 1053, 1055, 1060.
481 Trang v Alberta (Director of the Alberta Remand Centre), 2001 ABQB 659, para 29; Collin et al v Kaplan et al (1982), 2 CRR 352 (FCTD); Piche v Solicitor General of Canada (1984), 17 CCC (3d) 1 (FCTD) aff’d (1989) 47 CCC (3d) 495 (FCA); R v KRP, [1994] BCJ No 2405 (Prov Ct).
482 Soenen v Edmonton Remand Centre (1983), 48 A.R. 31 (Q.B.); Maltby v. AG (Saskatchewan), 2 CCC (3d) 153 (Sask QB).
485 R. v Chan, 2005 ABQB 615.
In other jurisdictions prison conditions have more often been found to amount to cruel and unusual punishment. The US has acknowledged that prison practices can amount to breaches of the Eighth Amendment, the equivalent of s. 12.\textsuperscript{486} The leading case is \textit{Estelle v Gamble},\textsuperscript{487} which established that “deliberate indifference to serious medical needs of prisoners are a violation of the Eighth Amendment.” The “deliberate indifference” test has become the legal standard. In \textit{Hayes v Snyder}\textsuperscript{488} the court stated that refusing prescription-strength painkillers to a person suffering from a testicular cyst and delaying a visit to a specialist might amount to a breach of the Eighth Amendment. The same two claims (lack of a timely surgery and lack of proper painkillers) were successful in \textit{Brown v Englander},\textsuperscript{489} where the complainant was a 72 year old individual. A similar finding was reached in the case of an older offender who complained of the lack of medical staff at night and of the fact that he fell from a top bunk without a ladder (\textit{Guzman v Cockrell}).\textsuperscript{490} An inmate with numerous medical conditions was successful in his Eighth Amendment claim concerning the failure of officers to implement the physician’s recommendations.\textsuperscript{491} Successful Eighth Amendment claims were also brought in regards to physical prison conditions. In \textit{Goodman v Georgia}\textsuperscript{492} it was found that infrastructure not fit for people with disabilities amounted to inhumane treatment. Lower courts have also decided favorably in similar cases based on

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\textsuperscript{487} \textit{Estelle v Gamble}, 429 US 97, 102 (1976).


\textsuperscript{489} \textit{Brown v Englander} (2010), US dist LEXIS 126245 (DNH).

\textsuperscript{490} \textit{Guzman v Cockrell} (2011), US Dist LEXIS 41646 (ED Tex).

\textsuperscript{491} \textit{Woods v Goord} (2002), US Dist LEXIS 7157 (SD NY).

\textsuperscript{492} \textit{Goodman v Georgia (United States v Georgia)} (2006), 546 US 151.
breaches of the American Disability Act. These claims were brought forward by older people with different disabilities or mobility problems, many in regards to accessibility.493

Article 3 of the European Convention for Human Rights and Fundamental Freedoms includes an almost identical provision to s. 12.494 The European Court has been more open to applying this provision to incarceration.495 The standard used has also been more generous than both the Canadian and the American ones. The threshold employed has been defined as “minimum level of severity,” which is to be established by looking at all circumstances of a case including duration of treatment, its physical and mental effects, as well as the sex, age, and state of health of the victim.496 Generally a treatment in breach of art. 3 goes beyond “the inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment.”497 While the standard is flexible and perhaps less predictable than the US and Canadian ones, European scholars have noted that this may be an advantage, because “it allows the courts to play a much more interventionist role than the American courts, which have insisted on a finding of ‘deliberate indifference’ on the part of authorities before holding that prison conditions are cruel and unusual and thus in contravention of the Eighth Amendment of the US Constitution.”498 Due to this generous threshold, the European Court has developed a whole line of prison jurisprudence


494 European Convention, supra note 53, s. 3.

495 See for example Vincent v France, no. 6253/03, § 103 [2006] (ECHR), Henaf, supra note 57, Mayzit v Russia, No 63378/00 [2005] (ECHR), GB v Bulgaria, No 42346/98 [2004] (ECHR).

496 Valasinas v Lithuania, no. 44558/98, ECHR 2001-VIII at paras 100-101.

497 Dougoz v Greece, no. 40907/98, ECHR 2001-II at paras 46.

498 Van Zyl Smit & Snacken, supra note 337 at 128.
based on article 3, often referred to as “the unwritten article 3 pertaining to inmates.”

The European documents regarding the treatment of prisoners and prisoners’ rights are probably the most developed in the world at this moment. They provide for clear standards to be met, while allowing for an expansive jurisprudence that protects prisoners from abusive prison practices and inappropriate living conditions.

Canadian courts have so far been deferential towards the government where prison treatment and policies are concerned. The “grossly disproportionate” standard allows for a breach of s. 12 finding only occasionally in sentencing matters and rarely in prison condition challenges. While this standard might be appropriate in sentencing, in the context of the conditions of a total institution, it might be too high. Prisoners are placed under the full control of the government, whose policies and decisions are administrative rather than legislative. There is little external oversight of decisions that irreversibly affect inmates’ lives. In such cases courts should be able to use a lower threshold to evaluate the constitutionality of these practices. This study has shown some of the effects and practices that fail to meet the needs of the senior prison population. While not all of them are cruel and unusual, many of them disproportionately harshen the sentence. When certain practices are systemic, or create with regularity more hardship on a certain group of people than on others, those people are suffering punishment that should be covered by s.12, whether disproportionate or grossly disproportionate.


500 See e.g. Rec (2006) 2, supra note 59.

Reiterating the goals of punishment, an individual is sent to prison in order to protect society from him, to make a statement regarding the community’s attitude towards such behavior, and to help the offender to eventually reintegrate into the society, as a better version of himself. In order for this to be accomplished the individual must be segregated from free society, in a stricter or looser environment, depending on the level of risk he presents. He cannot be with his family and friends, he cannot raise his children, he cannot have romantic relationships, he cannot go to work, and he cannot choose the activities he will perform and his company. He rarely decides what he will eat and what he will wear. He cannot choose when he will bath, when he will shave, when he will exercise, when he will go to bed or wake up. He cannot choose his doctors, and has limited choice over the medical services he will receive. He must work hard to fulfill his correctional plan and to display restrained behavior in order for a chance at release. He must watch his back at all times because prisons are dangerous places. He will have to put up with strict authority and often be humiliated by it. He will always fear physical harm, the possibility of not getting paroled, and the potential that his family will reject him. Simply put, he loses his freedom and all that is associated with it. This is his punishment. Its length will depend on the offence he has committed. That’s where proportionality in sentencing comes in. The loss of freedom is not a death penalty. It is also not a slow and agonizing death. It is not a sentence to physical pain caused by physical violence or untreated conditions. It is not a sentence to mental degradation. It is not an identity extraction, a brainwash experiment, or a survival exercise. It is not a sentence to prove one’s virility. It is also not a sentence to contamination with infectious diseases that will last a lifetime. Prisons are not martial arts schools, or gladiators’ arenas. Any environment that is systematically conducive to these
conditions is generating an inhumane and unusual punishment. It is more than what the individual’s sentence presupposes; it is often disproportionate and sometimes grossly disproportionate.

The situation of older offenders is bound to engage Canadian courts with a s 12 challenge at some point. This study shows that these prisoners are indisputably at physical, mental, and social disadvantage due to the natural aging process. It is not difficult to point out situations where their sentences are experientially harsher than that of similarly situated younger peers. The rates of people complaining of improperly treated pain while in prison, as well as the horrific stories told by some of participants, surely place these sentences above what the judge has intended. The lack of special diets for people who need them to survive, the slow response to emergencies such as heart attacks, the segregation of individuals with already serious mental problems, the lack of palliative care for terminally ill prisoners, could all become sentences to physical and mental degradation or even to death in some cases.

If any of the above examples of older offenders’ treatment would occur in a hospital, nursing home, or shelter, these would no doubt be considered to be breach of the “standards of decency” referred to in Smith. Prisons are not facilities created to care and treat individuals. However, care and treatment is intrinsically connected to complete control over the prisoner’s life. And it has to be done according to our society’s standard of decency. For such types of situations, courts should follow the example of other jurisdictions and be prepared to find such excessive treatments as “cruel and unusual.” Lowering the threshold used to analyze s.12 breaches from “grossly disproportionate” to

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502 Smith, supra note 474.
“disproportionate,” “deliberate indifference,” or “minimum level of severity” would be fully justified in the context of conditions in a total institution, and would allow for a better protection of prisoners against cruel or unusual treatment or punishment.

As a final note, where a practice or a law has been found to be cruel and unusual by a court, it has never been deemed justified under s. 1. While s. 1 can be invoked by the government in any situation, it is unlikely to succeed where the right breached affects the very existence and health of a group of people, absent some unpredictable natural emergency or war.

Section 15

Section 15 states that “every individual is equal before the law and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular without discrimination based on race, national or ethnic origin, religion, sex, age or mental or physical disability.”

The initial application of this section was ambiguous. It has, however, developed over time, and, in law, the SCC held that s. 15 prohibits actions that amount to discrimination following this definition:

a. The challenged law or action places the claimant at a disadvantage in comparison to others,

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503 Charter, supra note 13, s 15.
b. The disadvantage is based on a ground listed in or analogous to a ground listed in s. 15, and

c. The disadvantage also constitutes an impairment of the human dignity of the claimant.

The human dignity criterion was to be analyzed based on four contextual factors: the existence of a pre-disadvantage or vulnerability, the correspondence between the difference in treatment and the claimant’s vulnerability, the existence of ameliorative purposes or effects on other groups, and the nature of the interest affected. *R v Kapp* 505 subsequently replaced the impairment of human dignity criterion with the requirement that the disadvantage created have discriminatory effects. The analysis leading to the establishment of this element is similar to the one previously used for the impairment of human dignity. Because of the discriminatory effects criterion, s. 1 can rarely be successfully invoked by the government once the court found a violation. It was argued that “in the great majority of cases, the inquiry [into discriminatory effects] is really a loose form of the inquiry into the justification under s.1.” 506

Discussions regarding the need for differential correctional approaches in order to attain equal results have emerged in Canada and elsewhere in the context of feminist analysis. Its importance cannot be overstated. The differential approach was based on the idea that indirect discrimination can occur when an apparent neutral rule unfairly affects a particular group. The approach was used to claim gender sensitive programs for female offenders. In this context it was said that:

505 *R v Kapp*, [2008] 2 SCR 483 [*Kapp*].

“Gender-specific policies raise the question of reconciling differential treatment with principles of equality, as well as the risk of scriboring inherent characteristics of women, that is, the problem of essentialism. The Committee on Women’s Imprisonment, chaired by Dorothy Wedderburn, which visited 14 prisons, emphasized that applying principles of punishment in an equitable and non-discriminatory way does not entail equal treatment, but rather treatment as an equal (emphasize added) (Prisons Reform Trust, 2000). It should take account of the fact that women are less dangerous than men, that the social costs of women’s imprisonment are higher than of men’s and that different treatment for men and women within the penal system is justifiable. ‘Equal treatment... does not mean identical treatment whether for women or members of cultural or ethnic minorities.’ (Prison Reform Trust 2000: par 7.2).”

According to my study, as well as the American literature and the report of the Office of the Correctional Investigator, older offenders have a very high number of physical and mental conditions. As well, because of prolonged incarceration, they are more likely to lose family contact and to die in prison. All these make older individuals more prone to mental instability, victimization, risk of injury, higher needs of medical and social services, and an overall dissatisfaction with life. Older offenders have problems similar to those of seniors in the community, most likely enhanced because of their particular life circumstances, and probably higher than those of their younger peers. Once we acknowledge the vulnerabilities of older offenders as a growing group of inmates, we could and should adopt feminist analysis that would allow for the principles of differential treatment to be applied in the case of older offenders.

Similar to other recognized groups, older offenders have distinct characteristics as highlighted by this study and by the literature. They have low rates of violent behavior, and short histories of disciplinary sentences. They tend to get along very well with staff, and cause few problems. They are sociable and compliant with their correctional plans. On the

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other hand, they tend to have spent a long time in prison. They are physically and mentally degraded and require a large amount of services. Because the services are either equally distributed among offenders, or given with priority to those who are vocal about it (and those tend to be younger offenders), seniors tend to receive very little compared to their needs. This decreases their quality of life, their mental and physical well-being and makes them face hurdles that are not intrinsic to the deprivation of freedom. Very important, older offenders are predisposed to dying in prison. They face this possibility every day, and it takes a toll on their mental and emotional state. Finally, the combination of improper care and the natural course of life can lead to terminal illnesses. Hence, they face chronic and acute pain, while they have restricted access to the same amount and type of services and medication as all other prisoners. Seniors face the same infrastructural conditions as everyone else, including top bunks, stairs, long distances to walk, non-shoveled paths, lack of handrails, etc. This study shows that rheumatic problems are the number one cause of disability. The lack of proper aids, caregivers and physical accommodation (such as reduced stairs in some institutions or lower bunks) leads to increased hurdles for older offenders adjusting to the prison environment.

S. 15 of the Charter of Rights and Freedoms is an appropriate tool that would allow older offenders to claim their rights. While to date there have been no prison equality challenges based on age, there are other cases that clearly indicate that discrimination may occur on this basis.\textsuperscript{508}

\textsuperscript{508}McKinney \textit{v} University of Guelph, [1990] 3 SCR 229; Tetrault-Gadoury \textit{v} Canada (1991), [1991] 2 SCR 22
In order to amount to a Charter breach, discrimination does not need to be direct. Rather, the law is settled that identical treatment may lead to discriminatory results for a vulnerable group.\(^{509}\)

In the context at hand, all offenders have to climb the same flight of stairs and use the same top bunks, but those prone to severe arthritis and back problems (usually older offenders) will suffer incomparably more. Similarly, all offenders eat the same food. However, the diabetic ones for whom a proper diet is not available face increased health risks. In addition, the waiting time to see a nurse or doctor is the same for everybody. However, people who have up to 16 conditions and take over 20 pills daily may need better monitoring. There are no written rules or regulations to deal with these matters. In some institutions the staff is more attentive to the increased needs of the elderly, in others these needs are completely ignored. For example, I interviewed the same number of people (36) in two different minimum security institutions. In one of them, the older people tended to be grouped together, there were caregivers available, and an extra dentist was hired to respond to the demand. In the other institution, not only were these things not available, but almost all rooms were upstairs, no ramps existed, and no disability accommodations were made in the showers.

In order to counteract the effects of indirect discrimination, proper accommodation of the needs of the elderly should be made. The law requires that when a certain group of people is disproportionately affected by a measure, special accommodation should be made.

implemented for those people. For example, in the *Eldrige* case a hospital was found in breach of s. 15 for not providing sign language interpretation for the hearing impaired. Such services were not available for anybody, but their absence only affected the people with a hearing problem. This situation is no different than the numerous cases discussed in this study and presented as indirect discrimination. Clearly, people without rheumatologic problems will not be affected by the infrastructure of the prison in the same manner that those who face such problems. According to *Eldrige*, there is a duty on the institution to create the necessary conditions to meet the needs of the people disproportionately affected by its mainstream practices. This extends to diets, availability of pain medication, medical services, programing, release opportunities, and physical infrastructure.

Proper directives emanating from the CSC headquarters need to be drafted and a set of solid rules for the treatment of older offenders needs to be applied equally in all institutions. This would allow for a consistent course of action to ensure the protection of seniors against unwanted side effects of identical treatment. The enactment of such directives, together with their institutional enforcement, would be the CSC’s expression of affirmative action for the protection of older offenders. This would be similar to the course taken in regulating the treatment of women and other groups of offenders with special needs. However, for these particular groups there are also legislative sections that specifically protect their rights. Express statutory protection

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510 See e.g. *Ont Human Rights Comm v Simpson-Sears* [1985] 2 SCR 536; *Eldrige*, supra note 509.
511 *Eldrige*, supra note 509.
513 See e.g. *CCRA*, supra note 8, s 4 (h).
for seniors would be significant, supplemented by correctional directives and standing operating procedures that address this issue.

Section 15(2) allows for affirmative action to be taken and differentiated treatment to be applied to groups of people that are in a more vulnerable position. The SCC has interpreted s. 15 to grant a substantive rather than formal protection of equality. In such circumstances, different treatment in the service of equity for disadvantaged groups is “an expression of equality, not an exception from it.” The CSC should take advantage of this provision that is allowing the government to “proactively combat discrimination.” Arguably, it is more than an opportunity; it is an obligation in order to minimize the discriminatory effects that the rigors of incarceration have on older offenders.

It is true that challenges based on age discrimination have been less successful than on other grounds such as race, gender, and nationality. This however can be explained by the fact that most age-based challenges of laws or governmental practices occur in the employment context where it can be argued that different standards can be justified because there is some correlation between age and ability. This is the reason why, even when a discriminatory practice based on age is found, it is more likely that the court will save it under the ‘discrimination’ stage of a s. 15 analysis, than when other discriminatory grounds

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514 Charter, supra note 13, s 15(2): “Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged because of race, national or ethnic origin, colour, religion, sex or mental disability.”
515 S 15 (2) of Charter, supra note 13 states that: “Subsection 1 does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.” (emphasize added) For the application of this section see Kapp, supra note 502.
516 Hogg, supra note 443 at 55-54.
517 Kapp, supra note 505.
518 Hogg, supra note 443 at 55-66.
are invoked.\textsuperscript{519} However, this justification cannot stand if a s. 15 argument is brought in regard to discriminatory arguments based on age among the inmate population. In this case the correlation between age and ability only enforces the fact that older individuals with reduced abilities need increased protection and accommodation because they are more vulnerable. In addition, it would be difficult to dismiss a challenge based on age discrimination without breaching international obligations. The United Nations Principles for Older People\textsuperscript{520} require that older individuals, including those incarcerated be treated fairly without discrimination based on age or any other grounds. While the document does not contain enforceable legal obligations, it does raise issues of political and international integrity when it is not respected.\textsuperscript{521}

Finally, it can be argued that special accommodation for older people will cause considerable costs. Hence, budgetary restraints may be invoked to evade such obligations. So far, financial reasons brought by the government as a justification for failing to make necessary accommodations have not been largely successful. There has only been one s.15 case where a financial argument was accepted as a justification under s. 1. That was a collective agreement case where the court found discrimination based on sex. The discrimination was not however left unaddressed. Rather, the compensation was postponed for a limited duration due to the fiscal crisis.\textsuperscript{522} The second argument that may be raised is security as a concern for dispensing stronger medication. First, medication is only one


\textsuperscript{520} Older People, supra note 23.

\textsuperscript{521} See below the International Documents subchapter.

\textsuperscript{522} Newfoundland v N.A.P.E., [2004] 3 SCR 381 [N.A.P.E]. It should also be reiterated here that s.1 rarely plays any role in s. 15 claims anymore. As mentioned above in this chapter, the s. 15 test tends to leave no role for s. 1.
aspect of appropriate accommodation for older offenders. Second, even in this regard, it is
doubtful that such an argument would pass either a discriminatory effects argument or
would meet the s.1 test. Adapting the accommodation in the manner presented in the
“Institutional Impact” subchapter, would allow for the dispensing of medication to
seniors without compromising security. As long as such options exist, deprivations of
necessary treatment are unjustifiable.

Section 7

Section 7 of the Charter states that nobody can be deprived of the right to life, liberty, and security of the person except in accordance with the principles of fundamental justice. Section 7 has been interpreted to protect physical liberty, the right not to be exposed to health risks, to have control over one’s body, and to psychological integrity. However, such deprivations only violate s. 7 if they are not in accordance with the principles of fundamental justice. These principles have been defined as “the basic tenets of the legal system.” They must be legal principles which enjoy sufficient societal consensus and are sufficiently precise to yield manageable standards. Jurisprudentially, a number of situations that affect life, liberty, and security have been identified as not conforming with principles of fundamental justice when they are disproportionate, overbroad, vague.

523 See below the Institutional Impact subchapter.
524 Hogg, supra note 443 at 47-7 – 47-19.
527 Ibid
arbitrary or wrong. Finally, if the law or act is found in breach of this section after the principles of fundamental justice analysis, it is unlikely that a s. 1 argument will succeed. Similarly to s. 15, the test included in the s. 7 analysis, leaves little room for s. 1.

It has been established that lack of proper access to medical treatment which causes dangers to life, or unnecessary pain and stress is an infringement of s. 7. Morgentaler established that risks to health created by a law can be a deprivation of security of person. Three of the five judges believed that the right to security of person goes beyond the risks to health, but rather has a personal autonomy component – in that case the loss of control over the termination of a pregnancy. This was later confirmed in Rodriguez, where the court found that the fact that the terminally ill plaintiff could not choose when and how to end her life amounted to deprivation of control over one’s body, and hence of security of person under s. 7. However, the majority ruled that this breach did not offend the principles of fundamental justice, and thus the ban on assisted suicide was upheld. This position was reversed in 2015 in Carter v Canada. The SCC held that the law prohibiting assisted suicide impinged on the right to life as it forced individuals to prematurely commit suicide (because they are afraid they will reach a point when they will not be capable of ending their lives). It also impinged on personal autonomy because it denied people the right to make decisions regarding their bodies and their medical treatment. Finally, it affected the

532 It is worth noting however that some judges have found a s. 1 justification in cases where a s. 7 breach was made. These judges, however, never formed the majority in a decision. Hogg, supra note 443 at 47 –4
533 Morgentaler (no 2) [1988] 1 SCR 30.
536 Carter v Canada (Attorney General), 2015 SCC 5.
right to security because it left individuals to endure intolerable pain. These deprivations were found not in accordance with the principles of fundamental justice. The court held that “the law relating to the principles of overbreadth and gross disproportionality had materially advanced since Rodriguez.”

In Chaoulli the Court decided that long waiting times in the public health care system can cause unnecessary pain and stress to those awaiting medical procedures. This amounted to breaches of both the right to life (where death occurred due to prolong waiting times for medical treatment) and security of person. The SCC stroke down a provision which denied people the right to purchase private health insurance. The Quebec government argued that such a provision was justified in order to prevent the diversion of resources from the public health system to the private one. The SCC decided that this argument was arbitrary because there was no common sense connection between the prohibition and the maintenance of a high quality public health system. When a law affected the right to life and security of person and was arbitrary, it could not be said to be in accordance with the principles of fundamental justice. Thus “in the face of delays in treatment that cause psychological and physical suffering, the prohibition on private insurance jeopardizes the right to life, liberty and security of the person of Canadians in an arbitrary manner, and is therefore not in accordance with the principles of fundamental justice.” This case was not solved on a s. 7 basis, but rather on provisions of the Quebec Charter of Human Rights and Freedoms. Professor Hogg has argued that the reasoning in

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537 Ibid.
538 Chaoulli, supra note 530.
539 Ibid at para 153.
this case could easily be transferred to a section 7 case, though it will take another case to confirm that.\textsuperscript{540} This is easy to envision because the Quebec Charter, unlike other provincial human rights legislation, is similar in wording and application to the Canadian Charter.\textsuperscript{541}

All of the above cases challenged a piece of legislation as opposed to a governmental action. However, there are cases where it has been held that governmental action could potentially breach s. 7 if it affected the psychological integrity of the individual.\textsuperscript{542} In \textit{Blencoe}, the claimant was not successful in invoking a breach due to psychological stress, but the SCC mentioned that such claims could be successful where the state interferes, for example, with someone’s ability to make medical choices for themselves. As long as it is due to a state interference and it is serious, psychological stress could be a ground for a finding of a s. 7 violation.\textsuperscript{543}

The above examples, and in particular the landmark decision in \textit{Carter}, illustrate an expansion in the application of s.7 to breaches that occur in the area of health care and personal autonomy and a mitigation in courts’ willingness to allow such deprivations under the principles of fundamental justice argument. Budgetary constraints have not been invoked as a justification for an infringement of a right under s. 7. While SCC has never addressed the issue of costs in a s. 7 analysis, it has looked at it in the context of s. 1. As mentioned above, the s. 1 analysis is still applicable to s. 7 breaches, even though it is

\textsuperscript{540} Hogg, \textit{supra} note 443 at 47-13.
\textsuperscript{541} Historically, Quebec was the only province opposed to the Charter. This is one of the factors that determined them to craft a piece of legislation similar in scope to the Charter.
\textsuperscript{542} \textit{New Brunswick v G(J)}, [1999] 3 SCR 46; \textit{Blencoe v British Columbia}, [2000] 2 SCR 307 [\textit{Blencoe}].
\textsuperscript{543} \textit{Blencoe}, supra note 542 at paras 55 – 57.
unlikely it will be successful because of the similarity between this test and the fundamental principles of justice one.

In the context of a s. 1 analysis, SCC has upheld the breach of a Charter right based on a cost argument only in one labor law case. Even then, it was mentioned that “financial considerations would not normally suffice as the objective of a limit on a Charter right.”

544 Scholars have argued that “the cost may have an impact on the content of some Charter rights […] What is entailed by principles of fundamental justice may well vary from situation to situation, depending at least in part in the resources involved providing hearing and appeal rights of different extent.”

545 The argument is limited to legal rights as opposed to those affecting life and health. Transposing this logic to a s. 7 analysis, it might be very difficult to find a s. 1 limit in cases where the security of person is endangered on the basis of government’s limited financial resources.

The high number of physical and mental conditions among this population are challenging the correctional system. There is an insufficient number of specialists to deal in a timely manner with all the requests. People with tooth abscesses have to wait weeks to be seen by a dentist in some cases. In other institutions, chronic or terminally ill people receive very little palliative care and the access to escorts to take them to a community hospital is also limited because of resources. Diets are not readily available for people with chronic conditions such as diabetes. For these people, the lack of an adequate diet can not only aggravate their illness, but it can make the difference between life and death. Similar issues can be raised by the fact that medical devices are not available for people with

544 N.A.P.E., supra note 522.
545 Hogg, supra note 443 at 38-31.
disabilities or other mobility problems. In some institutions, the infrastructure is not
disability friendly which increases the risk of injury. The lack of pain medication has been
justified on security needs. Arguably however, it is not so much security as it is the failure
of correctional institutions to properly administer the dispensing of medication. Medication
is still being stolen, and drugs are still coming into institutions. While the effort to keep
prisons drug free is understandable, the solution is not to deprive people in chronic pain of
the needed medication, but rather a reform of the way drugs are administered. 546 In addition
to an acceleration in the decay of their physical bodies, older offenders’ fears of aging and
death are not alleviated by sufficient counselling, support groups or programs. This adds
to their sleeping problems, which in turns aggravates their mental condition. Confirming
my findings, the Office of the Correctional Investigation has found that there is an
insufficient number of mental health specialists to deal with the overwhelming number of
cases. 547 Thus, it can be argued that an environment that fosters mental problems as
opposed to treating them can potentially endanger life. In such circumstances the right to
life is breached, as well as the right to security of the person based on psychological
integrity. Security concerns may be raised as an argument in some cases for the use of
segregation for mentally ill prisoners but this is highly questionable. Even if theoretically
a breach of the right to psychological integrity might be trumped by the need for security
in an institution, this surely cannot be a systemic response for the “treatment” of mental
illness.

546 See below the Institutional Impact subchapter.
547 Sapers, Report 2011-2012, supra note 536; Sapers, Report 2012-2013, supra note 77.
All of these shortcomings pose serious risks to health. Some of these risks are arguably confirmed by the disproportionate number of people with physical and mental conditions, as well as their belief that their health has worsened since incarcerated. In addition, there is a clear statistical connection between physical conditions and the unmet requests for medical devices. To use the language in *Chaoulli*, these limitations of the system are causing “unnecessary pain and stress” on the older prison population. These can no doubt be translated into an unjustifiable breach of s. 7 based on the right to security of person, and in some cases to the right to life.

8.2.2 Corrections and Conditional Release Act Implications

The Corrections and Conditional Release Act\(^\text{548}\) in s. 4 (h) states that correctional policies, programs and practices respect gender, ethnic, cultural and linguistic differences and be responsive to special needs of women and aboriginal peoples, as well as to the needs of other groups of offenders with special requirements. As argued above,\(^\text{549}\) one issue is that older offenders are not yet recognized as a “group of offenders with special requirements.” Such recognition would be a step forward in improving the treatment of this group. Current legislation clearly encourages differential treatment for people with special needs. Section 70 provides that CSC must take reasonable steps to ensure that the prison environment, living and working conditions are safe, healthful and free of practices that undermine a person’s reintegration into the community. Section 76 directs the Service to provide a range of programs designed to address the needs of offenders and contribute

\(^{548}\) *CCRA, supra* note 8, s 4(h)

\(^{549}\) See above the discussion on section 15 of the Canadian Charter of Rights and Freedoms.
to their successful reintegration into the community. According to s. 86 the Service is under the obligation to provide every inmate with essential health care, and reasonable access to non-essential mental health care. As well, the provision of health care must conform to professionally accepted standards. Accordingly, the CCRA itself provides a framework for litigation.

The services available for older offenders, especially in the area of health care, do not seem to meet needs. Indeed it does appear that the treatment of mental illnesses, constant access to specialists, 24/7 nurses, and readily available health care tools are part of essential medical care. A substantial difference between the reported medical problems and the care received is worrisome. As well, it appears that a lack of a definition as to what are essential and non-essential medical services allows correctional facilities broad discretion. Some institutions will allow for medical devices, while others completely forbid them, even if purchased by the inmate. As well, some institutions will offer general dental service within a few weeks from the request, while others, in an emergency situation (an abscess) will take 2 weeks to a month. At the same time, the management of acute or chronic pain does not appear to be considered essential medical care in any institution. These limitations of the legislation make the care received by inmates in similar positions very different depending upon the institution where they are confined. It also makes it very difficult to make a legal claim if their rights are not clearly defined. “Professionally accepted standards” remains the legal yardstick. It is questionable whether medical services available in correctional settings reach acceptable standards of the profession at all times.550

550 For a discussion on the failure to meet the general standards, as well as a case law review see Adelina Iftene, Lynne Hansen, and Allan Manson, “Tort Based Actions in Canadian Prison Litigation” (spring 2014) 39:2 Queen’s Law Journal at 655.
While there are serious deficits in caring for seniors in the community, certain services are generally available in Canada for everyone on the outside, such as pain management, proper dental care, preventive medical care, cancer screening, etc. Similarly, some initiatives that exist in the community such as program integration, at-home support, treatment options, discussions about advance directives, self-care information sessions and brochures, palliative care options, diets and information about diets, extensive access to mental health services, environment adjustments also available, are nowhere to be found in prison. 551

We should not expect that care in prisons would be better than that in the community. However, failure to provide the same level of care available in the community is a breach of legal obligations. In the future, a more in depth review of the medical standards in the community compared to the ones applicable in prison is required with the purpose of creating a mechanism to synchronize the two. This is the only way to fulfill the legal requirement of the same level of care as found in different international declarations through which associations of medical prison professionals have committed themselves to delivering services according to the standards of their professions. 552

The CCRA requires that the services be directed to the reintegration of the offenders, based on needs and vulnerabilities. CSC does not have any specific regulations or directives for older offenders. Medical treatment is the same as for younger offenders. This study does not consider whether the care for younger offenders is sufficient or helpful for their reintegration. It does however show that the needs of older offenders are not met,

551 See above Chapter 4 for a description of the care available for seniors in the community.
552 See the Oath of Athens, supra note 26 and Principles of Medical Ethics, supra note 19.
and that segregation is most often the response to their behavior which appears to be influenced by both physical and mental conditions. This is hardly a practice conducive of reintegration in the community. Similarly, the lack of a prompt medical response may lead to an aggravation of the ailments these very vulnerable people already suffer. In this light, it is also difficult to see how offenders can be rehabilitated and come out as productive members of the society. On the contrary, lack of support produces anger and insubordination.553

8.2.3 Implications Regarding Commissioner’s Directives

In the second chapter of this dissertation I presented a set of internal CSC documents that are meant to regulate the application of the law in different specific correctional areas.554 These documents are mandatory for all institutions under the CSC’s administration. The directives (CD) and standing operating procedures (SOP) are not legislation but rather administrative tools. They cannot by themselves ground legal claims in court555 but they are important as aids in establishing what is reasonable.

The main medical related directive is CD 800.556 It is basically a reiteration of the legal requirements regarding medical services. Essential medical services should be readily available, and non-essential medical service should be reasonably available. The purpose of a directive should be to clarify and refine the legislation for a specific setting. The directive does not provide a definition of what are essential and non-essential medical services. This leaves the inmate with no clear legal basis to claim his rights when service

553 For a discussion regarding the rehabilitative effect of the incarceration of older offenders, see below “The Impact of Findings on Rehabilitation” subchapter.
554 See above p 26-34..
555 See Martineau, supra note 28.
556 CD 800, supra note 36.
is being refused. Even so, intuitively we can assume that emergency, mental health, dental, disability care should all be part of the essential service. For older offenders, these services are not available proportionate to the demand, and in some institutions they are extremely reduced.

A number of directives pertain to mental health. CD 850\textsuperscript{557} regulates the therapeutic and behavior program-based interventions that should be available to mentally ill prisoners. CD 840\textsuperscript{558} concerns the availability of psychologists during incarceration, as well as the need for an intake assessment upon incarceration, followed by re-assessments “during the treatment.” Unfortunately, this study confirms the critiques of the Office of the Correctional Investigator who identified the lack of sufficient and appropriate mental health care as one of the main current correctional issues. The number of people reporting mental illness is considerably higher than those reporting receiving therapeutic care on a regular basis. Moreover, a common response to mental illness appears to be segregation. This was identified by participants as the reason they avoid mentioning their suicidal ideation to medical staff. Hence the directives are probably insufficient for maintaining a high and uniform standard of health care among all CSC institutions.

Another directive that does not appear to be properly applied is CD 880\textsuperscript{559} pertaining to medical diets. The directive regulates the procedure according to which medical diets are to be prescribed. Once prescribed, they are mandatory. In addition, the standing operative procedures regarding food distribution\textsuperscript{560} require that prescribed medical diets,

\textsuperscript{557} CD 850, supra note 43, 
\textsuperscript{558} CD 840, supra note 42, 
\textsuperscript{559} CD 880, supra note 45, 
\textsuperscript{560} SOP 880-1, supra note 46; SOP 880-2, supra note 47.
or ingredients for them when inmates are housed in independent living arrangements, are available for those who need them. It is true, however, that neither the CD nor the SOP regulate the quality or the content of such medical diets. A number of participants mentioned that there is something called a medical diet in their institution, but if they were to follow it they would starve to death. They claimed it came in very small portions and was of little nutritional value. As well, almost all prisoners in institutions that provide some form of medical diet mentioned that there is only one for all conditions. This is like saying all surgical patients will get the same surgery regardless of ailment. This is an issue that needs to be better regulated in order to ensure not only that some food labeled “medical diet” is available but that it corresponds to the nutritional requirements for such a diet and the condition for which it is prescribed.

CD 300\textsuperscript{561} requires that institutions have the proper infrastructure in order to meet the needs of disabled individuals. As shown, this has turned out to be an issue in some institutions. The facilities that lack ramps, main level accommodations, single or lower bunking for older individuals, handrails, disability friendly showers, and appropriate gym and yard space can surely not be found to meet the exigencies of this directive.

Finally, CD 730\textsuperscript{562} directs that institutions should provide for programs based on the need of the individuals incarcerated in that institution. This study found that, indeed, institutions with a higher number of older offenders are better at providing more diverse programs and groups that are of interest to this category of people. However, not all of those institutions provided for regular fitness programs, grief groups, health care programs,

\textsuperscript{561} CD 300, supra note 49.
\textsuperscript{562} CD 730, supra note 51.
craft and arts, and senior peer support groups. In addition, I found that the institutions counting less than 20 older individuals tended to have almost no programs of interest for this group, being structured to cater entirely for a younger population. The complete lack of such programs in some institutions, and the insufficient existence in others, suggests that the age-related needs of older prisoners are often ignored. In addition, older offenders should never be placed in institutions that cater almost entirely to a younger population. It is not feasible to require that such an institution develop a diverse array of programs for 15 seniors, when the total population is 200. However, it is reasonable to ask that these 15 people be transferred, according to their security level to institutions where their needs can be met. This would be difficult to accomplish for people rated as maximum security, where the number of older offenders will always be low. In these institutions there will always be the need for extra monitoring of how their needs are being met. The fact that the number of older offenders is low, that there is nowhere else to transfer them, and that they are maximum security cannot serve as an excuse for disregarding the directives protecting their right to have their medical and programming needs met accordingly.

8.2.4 Implications Regarding International Documents

In Canada, an international document is generally not part of the national law. The ratification of a treaty is not sufficient to create domestic legal obligation and to offer support for legal claims. Once ratified, a national law needs to be enacted by Parliament, reiterating the international obligations Canada has committed itself to. Canada has signed and ratified all of the treaties and declarations described in Chapter 2.\textsuperscript{563} There are two

\textsuperscript{563} For a comprehensive description of Canada’s international obligations see above Chapter 2.
purposes for looking at international materials in this subchapter. On one hand, international documents have been sources of inspiration for the Canadian Charter.\textsuperscript{564} Some of the rights guaranteed in the Universal Declaration of Human Rights,\textsuperscript{565} the International Convention on Economic and Social Rights,\textsuperscript{566} and the International Convention on Civil and Political Rights\textsuperscript{567} find equivalences in the Charter of Rights. Hence, these treaties and conventions can help interpret Charter claims. On the other hand, the interpretation and application of international rights is progressing quickly. Canada is not always keeping the pace with these developments.

The international commitment brings an additional dimension to the protected rights. Canada is a rich, developed country that has always prided itself with being a human rights champion. Failing to stand by its commitments when it has the resources to do so, should be an international and political embarrassment. For example, Canada has never transposed the Minimum Standard Rules for the Protection of Prisoners\textsuperscript{568} into its national legislation. However, it has committed itself internationally to full compliance, and that has been considered sufficient.

Through the ICESR,\textsuperscript{569} Canada has committed itself to offer everyone the highest level attainable of physical and mental care medical services. As it was argued above, this is not the case in regard to prisoners, and in particular older prisoners. This convention is complemented in the correctional area by the “Principles of Medical Ethics Relevant to the

\textsuperscript{564} Charter, supra note 13.
\textsuperscript{565} UDHR, supra note 11.
\textsuperscript{566} ICESC, supra note 15.
\textsuperscript{567} ICCPR, supra note 16.
\textsuperscript{568} UNSMR, supra note 17.
\textsuperscript{569} ICESC, supra note 15.
Role of Health Personnel, Particularly Physicians in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,"570 as well as the Oath of Athens571 taken by the organization of Prison Medical Practitioners where Canada is represented. The Principles were adopted by the UN General Assembly. The international commitment to curb mistreatment of inmates due to insufficient, inappropriate or tardy response to medical needs should serve as an inspiration for a Canadian boost of its medical approach towards older offenders at the very least.

Canada has also recognized a series of very important declarations which it appears to have forgotten when dealing with older prisoners. The declarations regarding older people, people with mental illnesses, and people with disabilities are only a number of the ones relevant to this issue.572 All of them make a point of discussing the impact of incarceration on the category of people protected by the document. The Declaration for the Protection of Older People, adopted by the UN General Assembly, enforced the idea that individuals are not to be the object of discrimination based on age, that they are to be treated fairly and humanely, and that institutions will make their rehabilitation a priority. Surely these provisions should strongly resonate in creating a Canadian system of protection for the senior incarcerated offenders. The other two declarations require appropriate treatment and accommodation for people with mental illnesses and with physical disabilities. Their

570 Principles of Medical Ethics, supra note 19.
571 Oath of Athens, supra note 26.
572 Older People, supra note 23; Persons with Mental Illness, supra note 24; Persons with Disabilities, supra note 25.
vulnerability in a prison setting is recognized, as well as the need for actual institutional treatment.

While international commitments do not have the same legal force as national law, their existence is another argument for the direction Canada should take regarding the protection of its citizens. In addition, it has been recognized that the principles defined in international law may be used to inform national decisions and may have traction in Charter cases. In this context, the conventions and declarations affirming the need to protect vulnerable incarcerated individuals should inform a policy decision to create an articulated protection system for senior inmates and the courts’ readiness to enforce such protection if the case may be.

8.3 Implications of the Findings on Rehabilitation

Rehabilitation as a goal of sentencing and imprisonment has long been a part of penal philosophy. Its purpose is a preventive one, focused on changing the offenders’ habits. This model “is essentially a consequentialist rationale of compulsory social intervention: in its stronger form the claim is that this approach to the prevention of crime and the reduction of reoffending can benefit society in general, whereas in a weaker form the claim would merely be that although we cannot be confident in our abilities to change offenders for the better, we can at least avoid unnecessary harm resulting from excessive or damaging penalties.” Thus the aim of this approach is to address the physical, psychological, and social issues that the offender may be facing and to avoid damaging the individual through

the sentence applied. This type of social intervention presupposes an assessment of the individual and a correctional treatment that addresses potential cognitive-behavior problems, substance abuse, victimization etc. The purpose of this chapter is to review the impact of this study on the rehabilitative goal of incarceration. There is a gap between medical and social needs and their fulfillment. The question is, can an individual grow and improve when his basic needs are being frustrated?

Rehabilitation is one of the acknowledged goals in Canadian corrections. It is one of the reasons that explains the introduction in the ‘90s of correctional plan for all sentenced offenders. This presupposed an initial assessment and regular re-assessments that determine the individual programming and therapeutic needs. Correctional Service Canada posted on its site as its number one priority “safe transition to and management of eligible offenders in the community.” The CSC is extremely explicit in its goals:

“CSC’s goal is to assist inmates to become law-abiding citizens. The correctional process begins at sentencing. From the time an offender is initially assessed, through case management and to supervision in the community, there is a team of dedicated professionals working closely with the offender. Correctional programs are offered to help offenders take responsibility for their actions. They are encouraged to learn the skills necessary to help them return safely to the community. A range of motivational strategies are used to help offenders see the value of participating in these programs. The correctional process does not end with the offender’s release – it continues in the community. Similar to the dedicated team within the institution, offenders work with a Case Management Team that may include a Parole Officer, health care professionals, volunteers and an entire network of support.”

This confirms the rehabilitative penal objective. It implies that not only is rehabilitation a sentencing goal, but also a goal of incarceration. No doubt, this is a sensible vision that recognizes for the fact that 99% of the incarcerated offenders will be released.

Indeed, the idea of rehabilitation itself is futile without the possibility of release. This is what rehabilitation means: preparing inmates for a productive community life.

This study has connected programming with mental health, and mental health with the overall quality of life. Programming is also the root of the rehabilitative approach, acknowledged two decades ago when the correctional plans were introduced by the CSC. However, it appears as a useless waste of resources to force old people to take programs tailored for younger offenders. What good will a grade 12 class do to a retired 70 year old? How will he become a functional member of the society as long as his main problems, reflecting the realities he is facing, are not addressed? People that have been incarcerated for 30 years need intensive programming to teach them what is going on in the world when they will be released – from how the banking system functions, to how to create their social identities, and how to use a computer and a modern phone. The problems that await for them outside of prison are likely different than those of younger offenders. While family violence programs are crucial, they are not sufficient. These inmates are less likely to have a family upon release. They are, however, very likely to have chronic conditions, and to find themselves aging in a society they left as young adults. They need programs to teach them about the transformation their bodies are going through, to teach them to care for themselves, and to help them manage the frustrations of aging. Many senior inmates will have lost family and friends by the time they are released. They need grieving groups in prison, as well as organized and monitored peer support systems.

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By the time they are released, a good proportion of the older inmates will either be disabled, able to do only menial jobs, or too old to look for work. They will need something to fill their time and keep them away from old habits such as criminal activity or substance abuse. Cutting off the craft and hobbies programs in federal institutions deprived prisoners of the opportunity of developing their skills and passions, and it deprived them of a pastime which they could have continued on the outside. This may be a small issue but it is part of the landscape that distinguished older prisoners from their counterparts in the community.

In addition, reintegration chances are hindered if individuals are released in a degraded physical and mental condition. They will be less likely to obtain a job, to have normal relationships, or to be self-sufficient. This study shows that the response does not meet the demand when it comes to prison health care for older inmates, especially in the areas of pain management, mental health, emergencies, and diets. While there were examples of inmates whose life was saved by CSC intervention (generally because they were homeless on the outside or because they were heavy drinkers), there is a majority of people whose health seems to be going down due to prison practices such as improper feeding, unavailability of medical tools, use of segregation, and unavailability of medical services, as well as exposure to risk factors such as younger offenders.

One of the participants, a first time offender in his 50s, recently incarcerated, told me: “How can I focus on rehabilitation if worrying about my safety is a full-time job?” As presented above, safety is a main issue with older offenders. Numerous inmates complained about the abuse suffered at the hands of their younger peers, the noise that keeps them awake at night, and the stealing of food and medication. If punishment would
be the only correctional goal, such practice would be acceptable. But if rehabilitation has a role to play, than a different strategy needs to be adopted.

Undermining family relations is also detrimental to any rehabilitation attempts. As mentioned, some inmates have complained about the way their families are being treated by staff. This pushes visitors away and increases the burden on already strained relationships. This study shows that the more family connection a prisoner has, the more likely he is to behave appropriately in jail. It is likely that this pattern would continue upon release as well. In addition, staff should encourage family relations and act as a liaison where they are fading. While this is not the job of correctional officers, it should be of case managers.577

It is doubtful that there is a need for any individual deterrence in the case of some seriously ill individuals, like people reaching different stages of dementia or severe mental loss. Their condition is both incapacitating and deterring them from committing any more crimes. Some might argue that retribution or denunciation are important purposes of imprisonment and they are offence-related as opposed to offender-related. Thus, society has an interest in punishing individuals regardless of their capacity to perceive the incarceration treatment as a direct effect of their actions or the individual need to be deterred or rehabilitated in the future. However, maintaining a cognitively incapacitated individual in prison solely out of a retributive desire is in conflict with the other purposes of imprisonment discussed and with societal values.

The same line of thinking applies to terminally ill or very seriously ill individuals (with conditions such as MS, advanced cancer, Lou Gehrig’s etc). Indeed they are mentally

577 See above the American studies that have reached similar conclusions, Chapter 5, Literature Review.
intact, albeit frail. They know why they are incarcerated, but aside from vindictiveness no other goal is achieved by continued confinement. Again, they are physically incapacitated and deterred from reoffending. However, it appears that these cases take us back to the *lex talionis* and to medieval practices that our current legal framework abandoned. Surely, proportionality in the modern sense means more than this.

In regard to incapacitation, this principle is arguably frustrated by the inverse relation between age and crime. This study confirms that older people tend to create very little disciplinary problems. However, it does not address the issue of reoffending in old age. Nonetheless, in the literature, it was confirmed that even in this area an inverse relationship exists. It was argued:

>“The aging of the prison population also serves to undermine the goals of sentencing and correctional policy, which has been dominated in recent years by public safety and the idea of selective incapacitation. One of the most well-documented empirical regularities in the study of crime and criminal behavior is the inverse relationship between age and criminal activity, a phenomenon referred to as ‘aging out’ of criminal behavior: rates of individual offending peak in the teenage years, and decline sharply thereafter, approaching zero by the fourth decade of life. The phenomenon of ‘aging out’ is also demonstrated by the substantially low recidivism rates recorded for older releases. [...] In this sense, from the standpoint of incapacitation, additional prison time is wasted. Devoting an increasing proportion of scarce correctional resources to the housing of this population also limit our ability to more effectively use these resources to contain those offenders who actually do pose a greater threat to the community.”

Penal philosophy has struggled to offer a justification for punishment. Especially in an era where individual rights are at the heart of our criminal justice system, an intrusion into someone’s life and freedom needs a legitimate justification. Rehabilitation may be undermined by the way senior prisoners’ needs are being responded to. Other accepted

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purposes of incarceration are not being achieved either when people incapacitated by mental or physical conditions are being kept behind bars, or when their punishment becomes harsher than for younger offenders of comparable blameworthiness. Under these circumstances, the legitimacy of the punishment is questionable.
Chapter 9

Recommendations and Conclusion

9.1 Good Practices from Other Jurisdictions

As presented in the literature review, Canada is not the only country to face the challenges of an aging prison population. However, Canada has been particularly slow in acknowledging the problem and dealing with it. Other jurisdictions began taking measures and adapting to the changing realities of prison demographics two decades ago. Other nations’ experiences do not fully overlap with the Canadian one, as this study shows, nor can they be perfectly implemented here because of the different societal frame. It is however useful to review other systems’ handling of older prisoners, especially in regards to the specialized treatment that they have implemented. In this respect, the US is probably the best prepared to deal with older offenders.

a. Assessment

At the moment, the Level of Service Inventory – Revised is commonly used in Canada and the US for the assessment of offenders. Ten of the questions that assess criminogenic factors are irrelevant for older offenders, while others are suspect, considering the young-old differences (for example employment status which disregards the possibility of the individual being on disability or retired). In reforming the system for older offenders, the first step would be to revisit the assessment mechanism in a manner that would not be unfavorable to seniors because of their particular life circumstances.579

579 Kerbs, supra note 221 at 227.
It was recommended in the literature that prisons utilize the certified assessment measures used by gerontologists in their assessments. Thus, the Activities of Daily Living would assess seniors’ functionality in bathing, dressing, eating, toileting, transferring, and continence, while the Instrumental Activities of Daily Living measure the ability to use the phone, prepare food, take responsibility for their medication, etc.\(^{580}\) While not all are applicable in a prison setting, such instruments would generally allow for a fair assessment and re-assessment of older inmates, and a humane response to their needs.

b. Medical Services

The US delivers an apparently cost-efficient example of health services for any type of prisoner: telemedicine. In 2001, 27 states had telemedicine, or the delivering of medical consultation through technological consultations in their systems. This allows for a decrease of costs (in the US it was estimated that $102 were saved per prisoner) and for a more readily available specialized consultation even in remote penitentiary locations. This proved particularly useful in dealing with older offenders, who not only have increased health issues but may find it difficult to be escorted to community hospitals.\(^{581}\) It was reported that all studies done on telemedicine in prison had favorable conclusions about its use.\(^{582}\) This service exists in Canada, and some of the prisoners in this study have mentioned being seen by psychiatrists via telemedicine. However, I do not have knowledge of it being used for any other medical problems. While not a perfect replacement for in person consultations, it would still be better than waiting for months to be seen by someone.

\(^{580}\) Rikard, supra note 204 at 158.
\(^{581}\) Delgado & Delgado, supra note 1 at 143.
It could be particularly useful at least for initial consults and for some types of health problems, like the dermatological ones.

In his book on aging prisoners, Aday provides examples of very successful state facilities that focus on older prisoners.583 State Park in South Carolina houses 100 elderly handicapped inmates. There are 13 nurses/shift available 24/7 and one doctor. Inmates requiring chemotherapy or dialysis are bused on a daily basis to a hospital. The medical staff provide two daily sick calls, a pill line, emergency and routine treatment, as well as educational programs. The institution also offers inmates different crafts and horticultural activities, as well as work-release programs.

An even more impressive example is the McCain Correctional Hospital in North Carolina, which is licensed as a hospital. There is 24/7 nursing staff available, a medical laboratory, x-ray machine, pharmacy, urology services, and physical and respiratory therapy. The medical staff offers range-and-motion exercises for geriatric people as well geriatric walking programs three times a week. Seniors meet regularly with people in the community, especially seniors groups, and participate in off-site ballgames and movies. Rehabilitation therapy such as ceramics, artwork, collages, and bingo are available. Social workers are helping inmates to maintain contact with their families. They also provide care after release for these inmates. The institution also has a hospice program.

Laurel Highlands, a minimum security facility in Pennsylvania, offers a geriatric program for people over 55. There are different types of specialized units available such as a geriatric unit, one for terminally ill prisoners, and one for people in wheelchairs. The

583 Aday, *Aging Prisoners, supra* note 1 at 158 – 163.
institution offers substance abuse programs (Geriatric Substance Abuse Program) and specialized psychological services for geriatric people. Staff are being trained to identify signs of alcohol abuse and mental illnesses typical for old age, such as Alzheimer’s. Individual counseling is available for death and bereavement. “Spiritual relaxation” is available through the chaplaincy.

Ohio Department of Corrections supported a joint program between medical services and recreation. These programs are available in medium and minimum facilities. They are focused on health and wellness, providing age appropriate exercise groups, such as the Joggers/Walkers Program, as well as team sports for seniors. In order to encourage participation, participatory awards and achieved goals are displayed.584

In addition, the literature points out that US is strongly relying on partnerships to deliver medical services in prison. Correctional Departments generally partner with university hospitals and the private sector for health care delivery. While the success of these partnerships has not been widely researched, even 10 years ago they appeared to relieve corrections of some costs while offering a better quality of health care.585 One such example is offered by Montana, where a cooperative program exists between the Department of Corrections and Montana State University – Bozeman nursing program. Through this program nurses intern at Montana State Prison. It was said that this program helped reduce correctional costs, because inmates did not need to be transported outside for medical care.586

584 Ibid; for a review of medical services see also Lemieux, supra note 7 at 450.
585 Watson, supra note 582 at 125.
586 Rikard, supra note 204 at 156.
c. Hospice programs

Hospices are institutions that deliver palliative care for terminally ill people. In 2000, there were about 25 hospice programs in state prisons in the United States. The number increased to 35 by 2004. It was said that even if this type of program is perhaps not as widely used as it should be, it is emerging quickly in the US. Its benefits rest in the fact that they allow for a focus on the needs of the dying as opposed to safety and punishment.  

The principle components of a prison hospice have been identified as follows: multidisciplinary team (nurses, physicians, psychologists, psychiatrists, clergy, social workers, and security personnel), inmate volunteers, adjustment of prison environment, comfort care (contact with family, relaxed visits, special privileges, funeral or memorial services), and end-of-life care.  

At Angola, the State of Louisiana runs a hospice program. Inmate volunteers are used for support and in the infirmary, while outside volunteers run programs. The hospice requires no additional money from the correctional system. The Maryland Hospice Program, also heavily reliant on community volunteers, offers appropriate medical care, social work, pastoral care, mental health services and bereavement services for family and friends of inmates.  

Other prison hospice examples include: Broward Correctional Institution, Florida; Federal Medical Center at Carswell’ Ft. Worth, Texas; Dixon Correctional Center, Illinois; Dealgado & Delgado, supra note 1 at 147 – 149.
Ft. Lyon Correctional Facility, Colorado; Federal Medical Center, Ft. Worth, Texas; Michael Unit, Tennessee Colony, Texas; Oregon State Penitentiary, Oregon; US Medical Center for Federal Prisoners, Springfield, Missouri; and Vacaville State Prison, California.\textsuperscript{590}

d. Segregated living

In the 1980’s numerous US states began responding to the increasing number of people aging in prison. The US was the first country to introduce specialized units to cater to chronically ill prisoners. In North Carolina the McCain Correctional Hospital is a nursing home for frail elders and those with disabilities. It was followed by Kansas and South Carolina who developed special facilities for people with disabilities. In the 1990s Washington opened an assisted-living prison, an institution that cost 2 million dollars to operate while hosting 120 inmates. The inmates are not terminally ill, but all have serious chronic conditions. It was said that the institution is run more like a hospital than a correctional facility. Virginia and Ohio followed suit and each opened a similar facility.\textsuperscript{591} At present 90.7\% of Ohio’s senior inmate population is housed in one institution, Hocking Correctional Facility, which focuses on offering specialized support to older offenders in regard to physical and mental functioning, social connectedness, and personal growth through knowledge and skills acquisition in relationship to negotiating the process of aging.\textsuperscript{592}

\textsuperscript{590} Yampolskaya, \textit{supra} note 588 at 291.
\textsuperscript{591} Delgado & Delgado, \textit{supra} note 1 at 136.
\textsuperscript{592} Kerbs and Jolley 2014, \textit{supra} note 216 at 153-154.
Kentucky has the only licensed unit in a nursing care facility inside a medium security facility. New York opened a thirty bed unit specializing in treating dementia in incarcerated prisoners. Other examples of units specializing in chronically ill older prisoners are: Arkansas (Pine Bluff and Jefferson country correctional facility); Georgia (165 bed at Men’s Correctional Institution at Hartwick); Illinois (Dixon Correctional Center); Indiana, Louisiana, Maryland, Minnesota (The Minnesota Correctional Facility Stillwater Senior Dormitory; Mississippi (Mississippi State Penitentiary and Parchman); Missouri (Moberley Correctional Center); New Jersey, Nevada (Nevada Correctional Center); Nevada (Southern Nevada Correctional Center and North Las Vegas); Oklahoma (a 250 bed unit at Joseph Harp Correctional Center at Lexington); Pennsylvania (Laurel Highlands State Correctional Institute), Texas; West Virginia (Old Men’s Colony and a 450 bed unit conversion of a former mental retardation institution); Wyoming (Wyoming State Penitentiary).

All of these institutions provide more than just segregated accommodation, they also provide specialized medical care and programming. In addition, well over half of the country’s institutions have a bare minimum of age-segregated accommodation. In 2002, 50% of the state correctional systems had some form of age segregation.

e. Specialized programs

The need for age-sensitive specialized programs and support for offenders has been widely emphasized in the literature. Numerous US institutions that offer segregated accommodations or assisted living units, generally have some specialized programs as

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593 Delgado & Delgado, supra note 1 at 135 – 143.
594 Ibid at 140.
Some states have particularly ambitious programming for seniors (Florida, Ohio, Pennsylvania, Alabama, Georgia, Virginia, and Louisiana).\textsuperscript{595}

Reminiscence groups have been identified as being popular among seniors. Such groups offer opportunities for self-disclosure by revisiting childhood memories, school experiences, family rites, etc. \textsuperscript{596} Other focused groups include physical and mental impairment groups, ethnic pride, coping with loneliness and problems with institutionalization, and re-motivation groups (for people “burned-out” by long incarceration).\textsuperscript{597}

Angola Prison in Louisiana offers a program that allows for more elaborate funerals in the compounds of the prison. An older inmate is a carpenter and has been making coffins for the prison, to replace the cardboard boxes that were initially used for inmates. The inmates have also built a horse pulled hearse, and are allowed to sing songs and offer prayers at inmate funerals.\textsuperscript{598}

Ohio’s Hocking Correctional Facility offers a wide variety of programs targeting older prisoners, such as: prerelease programming in which individuals receive a card with information on how to access Social Security Services, human service providers, job seeking skills; vocational building and property maintenance training course; Maturing with Understanding while Behind Bars (physical, psychological and social impact of aging); and self-care in old age.\textsuperscript{599} Ohio also offers a program called Life Beyond Loss

\textsuperscript{595} Kerbs and Jolley 2014, \textit{supra} note 216 at 87.
\textsuperscript{596} \textit{Ibid} at 87.
\textsuperscript{597} Aday, \textit{Aging Prisoners, supra} note 1 at 154-158.
\textsuperscript{598} \textit{Ibid} at 210.
\textsuperscript{599} Rikard, \textit{supra} note 204 at 155.
which is essentially a grief group that helps inmates deal with the loss of loved ones, of their physical health, or own mortality. There are other death education programs that include sessions focused on topics such as fears of residing in an institution, previous death experiences, fantasies regarding one’s funeral, preparations for one’s death, reading and writing obituaries, education on euthanasia, living wills, and suicide, and fears about loved ones and closure. 600

The model program however is True Grit, run at the Nevada Correctional Centre. This program includes a special unit for some 160 individuals that commit themselves to completing daily tasks and attending up to ten programs weekly. The programs offers a case-management based approach that assigns task for individuals of different capabilities, including the terminally-ill. The senior living program is based on a combination of physical, mental, and emotional health programs that include recreational and physical therapy activities, group and individual, and chaplaincy. Prisoners are encouraged to attend as many activities as possibly, to the fullest extent of their abilities. The programs available vary from music, art, crafts, and sports (including softball or basketball in a wheelchair, and walking 10,000 steps daily) to making latch-hook rugs (for arthritis), doing puzzles, and attending education classes. The therapeutic activities listed in their program include life-skills training (such as meal planning, decision-making, time management, elderly victimization prevention such as identity theft and Internet scams, financial planning, and acquiring and requiring necessary identification documents), music appreciation, art

600 Aday, Aging Prisoners, supra note 1 at 85-86
appreciation, beading, puzzles and games, crafts, physical fitness, pet therapy, and writing groups. End-of-life realities are explored with people in terminal stages.  

In regards to work, some institutions offer employment opportunities targeting older offenders. Florida has a work camp at River Junction where inmates over 50 of different abilities are employed provided that do not have a history of escape or violence, and they are within 10 years of parole.

f. Staff training

Considering that officers are the main handlers of inmates, the relationship of staff members with prisoners is crucial to the well-being and rehabilitation of the individual. Officers, however, are not nurses and it can be very difficult for them to deal with the realities that aging prisoners are bringing to an institution. This is the reason why specialized training for staff, promoting age-sensitive treatment for seniors, is crucial.

The most impressive specialized training is offered by the Ohio Department of Rehabilitation and Correction in cooperation with the Ohio Department of Aging. The program called “Try Another Way” teaches prison officers how the functional limitations of seniors may diminish their capacity to adapt to prison requirements. Hocking Correctional Facility in Ohio also offers staff training on age sensitivity, legal issues, grieving, death and dying, prerelease and aftercare, supervision of older prisoners, programming, and medical and nutritional issues.

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601 Kerbs and Jolley 2014, supra note 216 at 87 – 90.
602 Hurley, supra note 587 at 164.
603 Kerbs and Jolley 2014, supra note 216 at 153.
604 Rikard, supra note 204 at 155.
River Junction Correctional Institution in Florida requires that staff take a mandatory course called Aging Inmate Supervision, as well as an Elder Abuse, Neglect and Exploitation program.605

Another issue is that medical staff working in prisons are used to treating a younger population. They have limited experience with geriatric conditions and chronic conditions associated with aging, as well as pain management. It was suggested that this lack of experience can be overcome by training sessions for the prison medical staff. In the US, such training is provided. For example, the Texas Department of Criminal Justice sponsors educational sessions on dealing with HIV patients. It was recommended that such educational sessions be introduce on pain evaluation and treatment, as well as for dealing with cancer.606

g. Compassionate release and medical parole

Compassionate release would be the cheapest solution to deal with older offenders. It has been implemented in the US, though critics have pointed out the fact that it is still controversial. It was said that:

“The mechanisms for compassionate release of terminally ill prisoners now operating in the United States are many and varied. These mechanisms share some common features, and they certainly exist with a common purpose. It is unfortunate, therefore, that much of the compassionate release programs are inefficient in accomplishing these laudable humanitarian goals. It is of even greater concern that some jurisdictions and the federal system are essentially devoid of compassionate mechanisms. The creation of systems that operate expeditious and fairly is essential for success in the endeavor to extend humanitarian assistance even to those we have imprisoned."

605 Ibid at 156.
606 Lin, supra note 254 at 472.
Ultimately, society itself is served if our compassionate impulses can reach beyond the issue of crime and punishment to serve all people as human beings.  

At the present, 80% of all states have some early-release options via parole and via post release supervisions which can be accessed by older offenders. Some states offer geriatric release programs either for terminally or chronically ill patients (Alabama, Colorado, Connecticut, District of Columbia, Louisiana, Maryland, Missouri, North Carolina, New Mexico, Oklahoma, Oregon, Texas, Virginia, Washington, Wisconsin, and Wyoming). Oftentimes, compassionate release is authorized by courts, as opposed to the Parole Boards responsible for other types of early release. The eligibility criteria differ from state to state. It has however been noted that few eligible inmates are being released through this avenue.

However, some scholars have gone beyond the idea of compassionate or medical parole. They recommended age-based paroles that would allow Parole Boards to review all prisoners that reach a certain age and evaluate the actual risk of recidivism. The same authors recommended compassionate release for all types of illnesses that remove the threat the offender poses to society. Finally they introduce the idea of family-based parole for seniors.

An extremely efficient US program that brings together correctional institutions and law schools is POPS (Project for Older People). POPS is created to help non-terminally ill aging prisoners obtain release. This is particularly innovative in the context in which few

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607 As cited in Delgado & Delgado, supra note 1 at 147
608 Kerbs and Jolley 2014, supra note 216 at 217.
609 Hurley, supra note 587 at 158-159.
610 Kerbs and Jolley 2014, supra note 216 at 217.
jurisdictions are willing to grant medical or compassionate release for non-terminally ill individuals.\textsuperscript{611} Run by a law professor at George Washington University, the program is focused on helping nonviolent older offenders who have served a substantial part of their sentence to obtain early release.\textsuperscript{612} By 2013, the program helped release over 500 prisoners with a very low rate of recidivism.\textsuperscript{613} The program is active in 5 states. The assessment to determine who is a good candidate is based on interviews with the offender, correctional staff, the victims, and a risk assessment. Once assessed as a good candidate, the law school students develop a release strategy for the offender (including residence, employment and finance plans) and present it to the parole board.\textsuperscript{614}

Though less focused, there are other programs that support seniors who obtained parole by offering post-release support. The geriatric and medical release programs are reasonably common, with the Seniors Ex-Offender Program (SEOP) in San Francisco being particularly successful.\textsuperscript{615}

A European example of dealing with severely ill prisoners comes from France. As a result of a number of successful cases at the European Court of Human Rights based on the fact that incarceration of very sick people amounts to a violation of article 3, the right to be free from torture and cruel and unusual treatment or punishment, France added some modifications to its Code of Criminal Procedure. According to this, the prison sentence may be suspended for prisoners whose life expectancy is threatened or whose health is

\textsuperscript{611}Rikard, supra note 204 at 153-154. 
\textsuperscript{612}William, supra note 216 at 66. 
\textsuperscript{613}Hurley, supra note 587 at 157. 
\textsuperscript{614}Kerbs and Jolley 2014, supra note 216 at 217- 218; Aday, Aging Prisoners, supra note 1 at 213-214. 
\textsuperscript{615}Kerbs and Jolley 2014, supra note 216 at 218.
incompatible with detention (with the exception of inmates held in special psychiatric units). The seriousness of the offence, length of sentence, or the threat to society are irrelevant for the sentence suspension. The terminal state of an individual or of health incompatible with detention are assessed by two independent physicians and the final decision rests with the judge. The release is subject to revocation if the individual’s health improves. While this law does not specifically address advanced age, the majority of people taking advantage of it are likely to be seniors.

9.2 Potential Solutions for Canada

9.2.1 Legal recommendations

1. Recognition of older offenders as a vulnerable prison group

Older Offenders need to be recognized as a vulnerable group of individuals within the correctional system. This needs to be done first and foremost through legislation – Correctional and Conditional Release Act and Regulations. This study shows that OPs are in need of special protection and different legal and institutional treatment within prison in order to preserve their quality of life and their rehabilitative opportunities. Until this is done, they will continue to be subjected to the same regime as their younger counterparts. Their needs will continue to be infrequently met, depending on the institution where they are serving their sentence. Moreover, correctional policies, such as pain medication dispensing, will disproportionately affect this group. The legal recognition of OPs as constituting a special needs group is the first step in setting up a framework that would account for the vulnerabilities brought about by aging.

2. Better application of international guidelines

The international framework provides a large number of documents that are geared towards an increased protection of prisoners’ rights. They constitute valuable guidelines on using resources to achieve rehabilitative results and provide humane treatment. These documents are based on research studies conducted by eminent scholars working for the UN or other international organizations.

While Canada has signed the majority of these documents, it has implemented few to none in its domestic framework. Standard Minimum Rules for the Protection of Prisoners should be implemented with priority, either through distinct legislation or the CCRA. The Code of Conduct for Law Enforcement Officers, The UN Principles for Older People, Declaration Regarding Terminal Illnesses, the Oath of Athens, the Declaration of Medical Prison Practitioners are just a few of the documents that should inform the daily work of prison staff. Their guidelines should find their place in Commissioner’s Directives and CSC Guidelines documents. This way, not only will the CSC show its commitment to the well-being of inmates, but will ensure an even application of its values and principles throughout all of its institutions, and would help create a coherent framework once OPs are recognized as a vulnerable group within the correctional system.

3. Enhanced application of section 12 of the Charter

Section 12 of the Charter, the right to be free from cruel and unusual treatment or punishment is a valuable source of legal protection that has successfully been applied to incarceration regimes in other jurisdictions, such as Europe. The application of this section
should be extended in Canada beyond sentencing matters, into prison practices, perhaps by lowering the threshold ("grossly disproportionate") applied to determine if an act is "cruel and unusual". Lower thresholds for "the cruel or unusual punishment" analysis are used extensively in other jurisdiction such as the US ("deliberate indifference") and Europe ("minimal level of impairment"). Canada should follow their model because a lower threshold for examining conditions of confinement would compensate for the little external oversight existent in a total institution. I have argued above that a fairly-rendered sentence could become cruel and unusual by the way it is carried out. The study provides examples of sick people waiting for an hour out in the cold to pick up medication every day, offenders struggling with unaddressed chronic or acute pain, terminally ill individuals dying in prison without any regard for their condition, diabetics whose conditions are worsening because of improper diet etc. When do these factors become cruel life conditions? Developing an appropriate juridical framework to evaluate these issues would give prisoners much needed ammunition to fight for their right to maintain dignity while incarcerated.

4. Compassionate release

Compassionate release in Canada is generally unavailable. The closest option to compassionate release is "parole by exception" regulated by s. 121 of the CCRA. This is, however, extremely restrictive because it only applies to prisoners not serving life or an indeterminate sentence:

617 CCRA, supra note 8, s. 121.
121. (1) Subject to section 102 — and despite sections 119 to 120.3 of this Act, sections 746.1 and 761 of the Criminal Code, subsection 226.1(2) of the National Defence Act and subsection 15(2) of the Crimes Against Humanity and War Crimes Act and any order made under section 743.6 of the Criminal Code or section 226.2 of the National Defence Act — parole may be granted at any time to an offender
(a) who is terminally ill;
(b) whose physical or mental health is likely to suffer serious damage if the offender continues to be held in confinement;
(c) for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the offender was sentenced; or
(d) who is the subject of an order of surrender under the Extradition Act and who is to be detained until surrendered.

(2) Paragraphs (1)(b) to (d) do not apply to an offender who is
(a) serving a life sentence imposed as a minimum punishment or commuted from a sentence of death; or
(b) serving, in a penitentiary, a sentence for an indeterminate period

The two categories of offenders excluded constitute over half of the older prisoners. No specific grounds on which an individual can request this parole are set up, and historically it has been very rarely used. None of the prisoners in this study knew that parole by exception was available in Canada, though many of them met the criteria set out in s. 121(a) and some of them, the criteria in s. 121 (b).

Compassionate release in any jurisdiction has its limitations. It raises issues regarding who will take care of the sick prisoner once released. Some offenders do not have families willing or able to take them and the waiting time for a place in a nursing home can be long. However, provided a proper review process is in place, reasonably available compassionate release can be an extremely useful tool for helping individuals return to their communities in their final years of life. The legislation may choose to restrict compassionate release to the terminally ill, or can provide criteria for assessing the objective risk the individuals pose. It is, for example, possible that a bedridden individual
is not terminally ill (i.e. has only 6 months left to live) but he is physically incapable of committing crimes. Other criteria could, and perhaps should, reflect the capacity of the institution to provide for the needs of an individual who is impaired by age or health, as well as the care options available to the inmate upon release. However, the type of sentence an individual is serving is not connected in anyway to the purpose and the situations under which compassionate release should be granted. Section 121(b) should be abolished.

In the circumstances of an aging prison population, where we will likely see an increase in chronic and terminal conditions, s.121 of the CCRA should be clearer and more inclusive. In addition, successful applications on this basis should increase in number, especially if the current CSC policies regarding older offenders do not significantly improve.618

5. The OCI is a governmental agency, independent from the CSC, which makes annual assessments of how prisoners’ rights are being upheld. Throughout the years, it has produced valuable reports regarding the main issues that have arisen in prison, and has provided guidelines that would bring the CSC in line with its legal obligations. The OCI’s mandate is entrenched in the CCRA,619 which provides that the CSC has an obligation to respond to all OCI reports. So far, the CSC has not been particularly responsive towards the OCI’s reports. The reply documents are often late,620 and the responses are short and

618 CCRA, supra note 8, ss 99 – 145.
619 CCRA, supra note 8, ss. 157 – 196.
620 For example, the CSC’s reply to the Office of the Correctional Investigator Report, “Inquiry into the Death of Ashley Smith” (2007), online: http://wwwOCI-bec.gc.ca/cnt/rpt/index-eng.aspx [“Ashley Smith”]) was issued in December 2014. Out of 104 recommendations about 10 led to some new developments. See the CSC reply on the Correctional Service Canada site, online: http://www.csc-scc.gc.ca/publications/rocidcs/grid3-eng.shtml.
dismissive (i.e. “there are no funds for that” or “we are already doing that”).

For example, responses to the issue of older offenders were of the following nature:

“Recommendation 6:

I recommend that the Service develop a more appropriate range of programming and activities tailored to the older offender, including physical fitness and exercise regimes, as well as other interventions that are responsive to the unique mobility, learning, assistive and independent living needs of the elderly inmate.

Upon admission, all older offenders and those with self-care needs undergo a functional assessment, which measures their ability to perform daily living activities. Results of this assessment influence further health related consultations as well as special needs for accommodation and services. Throughout the inmate's sentence he/she is assessed in terms of their ability to function in their environment.”

“Recommendation 9:

I recommend that the Service prepare a national older offender strategy for 2011-12 that includes a geriatric release component as well as enhanced post-release supports.

CSC recognizes that a comprehensive discharge plan that addresses the physical, mental, emotional, social and spiritual needs of individuals, best ensures post-release access to health care and other community services to facilitate continuity of care after a period of incarceration.

CSC will continue to implement the framework that is already in place to ensure appropriate release planning for offenders, including geriatric offenders. As part of the planning process, when indicated, a functional assessment is completed by health care services and identified areas of concern are taken into consideration in the development of an individualized release plan. For example, a functional assessment might suggest the need for a certain type of accommodation.” (emphasis added)


The report of the OCI made recommendations because they found the programs and the framework were, in fact, not appropriate for older offenders.\textsuperscript{623}

Under these circumstances, very important observations of the OCI remain not only unimplemented but barely considered. The CSC often does not appear to even offer an explanation as to why some recommendations are not feasible. In order to make the work of the OCI truly meaningful, an enforcement mechanism should exist in the legislation. While it is still of great value that the OCI is making serious prison issues public, it could achieve much more if the CSC were compelled to provide meaningful and timely answers for the problems identified by the OCI. A small but significant step in this direction would be giving the OCI direct access to the Parliament, by having the Correctional Investigator report to the Auditor-General instead of the Minister of Public Safety. The Ministry of Public Safety is also in charge of the CSC. Thus, the Minister is not a third party who can objectively assess the OCI’s reports and present them to the Parliament.

9.2.2 Policy recommendations

6. Commissioner’s Directive for older offenders

Commissioner’s Directives are administrative documents meant to set a framework for uniformly regulating issues among the CSC institutions. A CD regulating the treatment of older offenders behind bars would go a long way towards protecting this group’s needs. There are CDs recognizing the differences that women, native, and disabled prisoners have compared to the mainstream population. Hence, it is the duty of each correctional

institution to adapt to those needs in accordance with the guidelines provided in the directive. A similar directive is needed for older offenders. A correctional framework that accounts for the enhanced medical and programming needs, created in accordance with gerontology studies, would eliminate the differences in treatment existent at the moment among institutions and would ensure a minimum of protection in accordance with the national and international human rights.

7. Clearer directives regarding medical and disability issues

In addition to a CD addressing seniors’ needs, the already existent directives require improvement. The health care directives are extremely important. However at the moment they are vague and very difficult to apply. There are no guidelines in regards to what primary or essential health care is. It is not clear what “standards comparable to the community ones” are either. These concepts however, are key regarding what inmates are entitled to, and their definition is left to the whim of either the medical practitioners or, even worse, the warden of each institution. This is why, for example, it is possible that in some institutions chronic diseases are being managed by granting prisoners medical devices, while in others the doctor is completely forbidden to prescribe them. The directive and standing operating practices should not be a mere reiteration of the existing legislation. It should clarify it and provide a workable frame.
8. Enhanced supervision of the implementation of CDs and increased accountability of institutional senior officials

Based on the institutional differences that were encountered in this study, it is likely that the warden and assistant wardens have a high degree of discretion in making decisions that affect the inmates in their prisons. Considering that the prison population differs from one institution to another this could be a good thing. However, whenever such discretion is given, there needs to be some sort of supervision to ensure that the CDs are being implemented properly and that a minimum is insured for all inmates, regardless of where they serve their sentence. There should not be any differences between medical diets, capacity of the physician to prescribe medical props, programs available (at least those prescribed in correctional plans), dispensing of medication, availability of mental health professionals, etc. For example, CD 840 and 850 are clear about the mental health team that is supposed to be available to any individual in need. One psychologist is not a team, and one psychologist for 600 individuals is unlikely to deliver the services that CDs are presenting as available.

It is unclear what the supervision process is, if any, in regards to the implementation of such documents. There do not appear to be any regular audits on how officials are fulfilling their legal obligation. The grievance system is available to any individual that has a complaint, but it is slow and unlikely to solve systemic problems.
9. Rethinking the assessment and reassessment of older inmates

Despite the fact the CSC believes that the current assessment tools are working perfectly,\textsuperscript{626} much of it is irrelevant for OPs. Prisoners are being asked about previous medical conditions and disabilities, and they are being seen by a nurse. However, there is no review of their abilities using an Activities of Daily Living tool created for senior individuals in the community. Their actual functionality with bedding, walking, bathing etc., is ignored. These should be of primary importance in deciding the institution an individual will be sent to. However, at the moment, an individual convicted of murder, regardless of the circumstances, will inevitably score so high on the risk scale because of the nature of the crime that he will spend his first years at least in maximum security. This explains why the maximum security institution I visited housed individuals that were so physically and mentally disabled that it would be difficult to believe that they pose a physical risk in a lower security institution. Hence, it might be necessary that the assessment on in-take be different depending on the age of the individual. The current risk assessment tool should be coupled with appropriate community functionality assessment tools for seniors.

In addition, a psychiatrist specializing in geriatrics should make an assessment of each senior individual sentenced to prison. Oftentimes it is difficult to place a differentiated diagnosis when the physician is not familiar with the aging process.\textsuperscript{627}

\textsuperscript{627} The literature often mentions, for example, that the early signs of Alzheimer’s can often be mistaken for substance abuse withdrawal and vice-versa; Aday, Aging Prisoners, supra note 1.
The re-assessment of older individuals should take place early, based not only on the traditional tools but also on existing geriatric tools. Bedding, mobility, and dietary needs should be evaluated regularly and with priority. Currently there is a yearly psychiatric assessment in place for lifers. However, the participants in my study reported that this is a 5 minute consultation, in which they are basically asked if they are suicidal. This assessment should probably be done more seriously for all inmates. However, the psychiatrist should be familiar with geriatric psychiatry and be allowed to prescribe a variety of medications. Oftentimes the mental health medication given to elderly interacts with other pills they are taking, leading to polypharmacy. It is why options for treatment are essential. This psychiatric assessment should also be taken into account for potential transfers to better suited institutions in order to effectively respond to the needs of that particular individual.

10. Age segregation units

An overwhelming number of the participants in this study indicated that they believed their quality of life would increase if they were housed in seniors-only units.\textsuperscript{628} The American literature also shows that there are substantial benefits to such an approach, provided there is a thoughtful implementation. The cost of such facilities can be kept extremely low, as these examples illustrate.\textsuperscript{629} None of the institutions that I visited provided such units, or even a seniors’ lounge for daytime activities. Some institutions had a quieter unit where they generally housed the more vulnerable individuals. However, even in those institutions, the participants indicated that only so many seniors would fit in those

\textsuperscript{628} See above Chapter 6.
\textsuperscript{629} See above Chapter 5.
units and many were left on the outside. There was also a tendency to house younger, vulnerable inmates there, as a mild form of protective custody. In addition, in maximum security, a notoriously dangerous place, seniors tended to be placed in protective custody or on a mental health range. However, protective custody meant that the prisoner was locked up for 23 hours daily and stigma was associated with this type of accommodation. Once an individual was placed in protective custody, he could not be released into the general population without serious repercussions to his well-being.630

As argued in the previous chapter,631 a seniors’ unit in certain institutions would not be a very costly undertaking. It would allow for specialized medical care without the same concern about abuse or drug dealing. It would allow for targeted programs, and perhaps even a modified security system, since it appears that seniors across security levels have a low number of disciplinary incidents. Thus, the security cost would be lower, allowing for a higher investment in health and programming. Such accommodations would not have to be available in all institutions. However, prisons that cannot offer them should not house seniors.

As an interim measure, participants have indicated that even a seniors’ lounge where they can spend their daytime without fear of being bullied would be an improvement from the current state.

630 There appears to be a belief among prisoners that protective custody is for sex offenders, which is the most stigmatized and in-danger group of inmates. In that institution it was particularly so, as some high profile sex offender inmates were also housed on that unit.
631 See above Chapter 8.
11. Enhanced medical care and better programming

As mentioned, an age-segregated unit in itself would not meet the needs of older offenders. The purpose of this unit would be to enhance the provision of medical care and age-appropriate programming. The current state of affairs poses problems regarding indirect discrimination against seniors when the inefficient medical treatment disproportionately affects this age group. In addition to issues pertaining to breaches of rights, the failure to provide for the specific needs of older inmates brings into question the CSC’s potential of meeting rehabilitative goals.

The CSC should design a better medical and programming system by consulting with geriatric community specialists. In addition, as the number of senior inmates increases, the CSC should consider employing their own gerontologists. Some of the US models presented above could be used as examples for enhancing the correctional practices especially in the areas of pain management, mental health, and end-of-life care.

12. Systemic preparation for release for older offenders

Very few participants have been enrolled in any form of release programs. Many of them have indicated that the program they are looking for is one that prepares them for life outside. Numerous OPs have served long sentences in prison. They have been disconnected from the real world so they will likely have a hard time readjusting. Programs that help them create an identity on the outside should be high priority. There are programs that help inmates find a half-way house and sometimes a job but that is not enough. A large number of seniors will likely be unable to work when they come out. Finding a job is often understandably a priority for paroled prisoners. This might not be the case among seniors.
many of whom are at retirement age. They should be taught how to use banking systems, how to create an account, how to get a social insurance number, and how to use an ATM, a cell phone, a computer for basic tasks. They should be taught how to call and what to say when trying to access basic services over the phone. How to detect and avoid scams and identity theft should also be explained to them. Accessing the health care system, getting them an OHIP card, and helping them find a family doctor, should place high on the preparation for release list. Simple group sessions on what or how to ask for different services could go a long way in helping seniors succeed on the outside.

13. Enhanced communication between institutions and the community

Continuity in the treatment of older prisoners is essential. In general, the CSC is absolved of all responsibility once the individual is released. This leaves gaps in the medical care and other aspects of a prisoner’s life. OPs should be provided with family doctors if they do not already have one, and the prison medical files should be transferred to the community doctor. Often, the released prisoners will be left without medication or substance abuse treatment once in the community. It is up to them to ensure that there is continuity in the community, and this can be very challenging for them. Post-release communication should extend to helping the individual find seniors’ support groups and targeted programs that can help ex-prisoners to settle into their new lives outside as older individuals.
14. Mandatory staff training on geriatric matters

The US offers solid examples of staff training. In particular, front line staff members should undergo training about the transformations that occur because of aging, both mental and physical, as well as alternatives to managing older offenders. There should be at least one or two geriatric nurses available in each institution, and a gerontologist should be readily available for consultation, at least through the telemedicine system.

It is unacceptable to have correctional staff members making fun of incontinent individuals, no matter how difficult they are. It is equally unacceptable to steal prisoners’ walking aids in order to play tricks on them. Name calling has been reported by the participants as part of their daily living. While the younger prisoners cannot be stopped from verbally bullying seniors, the staff members should set a positive example. While calling prisoners “old fart” and “pops” may not be a big deal in the correctional setting, it hardly has a positive effect. While OPs learn to ignore the name calling, it does have an effect on them. They are reminded that they are more vulnerable, and so, somehow, less worthy of respect. Correctional officers are not just security guards, they should be role models. A prison environment is as good as their front line workers. It might be hard on the workers to understand that, with the aging of the population, care needs to be combined with security, more so than before – even though it is not a nursing home setting. This is why proper training is of primary importance.

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632 See above, Chapter 9, subchapter 1.
15. Creation of prison hospices/ palliative care units

Currently there are no hospice bed available in Canadian prisons. Coupled with the fact that compassionate release options are highly restrictive, the situation of terminally ill prisoners is not very good. Prison hospices and palliative care units have flourished throughout the US in response to the increased number of people who die in prison. While there are not as many terminally ill in Canadian prisons as in the US, there are enough to justify at least one such unit per region. This unit should have sufficient beds and the only criterion for admission should be related to health. Security should be relaxed, medical care enhanced, and family visits strongly encouraged and facilitated. These inmates should have access to legal advice for the writing of wills and advance directives. This would help put the minds of the dying prisoners at ease.

Even if compassionate release were to be introduced in legislation, hospices would still be needed. Releasing somebody without being able to ensure that he will be taken care of on the outside is not a better alternative. Nobody should die in prison; however when they have spent all their life behind bars and have nowhere to go, they should be allowed to die with dignity and free of pain, if not in liberty.

9.2.3 Institutional recommendations

16. Programs designed for older offenders

Many individuals sentenced to time in prison are assigned a correctional plan that they need to complete before applying for parole. High school courses are mandatory if the individual has not finished secondary school in Canada. This has led to situations where

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633 See above Chapter 9, subchapter 1.
inmates with Bachelor’s or Master’s Canadian degrees were forced to take high school courses in prison because they did not go to high school in Canada. One prisoner said “I reached 70 without a high school certificate. I don’t think I will need it from now on either.” Other common programs are violence prevention, anger management, substance abuse, and boosters for all of these. All of these programs are, without doubt, of value and correctional plans are crucial to achieving rehabilitation. Other programs are offered by volunteers – their numbers depend on institutions – and they were often praised by the participants in this study.

Nonetheless, the participants were not aware of any programs targeting older offenders. While they still participated in what was available, many of them had suggestions for activities that would address their specific needs. Physical activity programs were in high demand. Some institutions have attempted them but stopped. Others were offering yoga but only for a very small number of people (8, in a 600-bed institution). The crafts programs, very popular among seniors because they required no mobility skills, have been cut out because of budget constraints. Support groups, such as seniors’ groups and lifers’ groups were popular, but did not include any activities. Rather they were weekly meetings where people could order food. An assessment of the specific programming needs of older offenders should be carried out across CSC institutions and a better selection of programs – many run by volunteers - should be made available. Such programs might address the realities of aging, self-care in old age, grief and loss groups, preparing for death, craft and hobbies, gardening, managing finances, etc.
17. Physical activity

Like participation in programs, physical activities have been linked to mental well-being by this study. Asked where they exercise, many participants identified their cell or the range, when the yard is not available. In some institutions the yards are not properly cleaned or lit in winter, while the number of falls on the outside ice is worrisome and discourages seniors from keeping active. Few seniors appear to use the gym. The main reasons were the very few cardio machines or because it was not a safe place for them.634

In particular, in the institutions where there are numerous older offenders (i.e. over 20 or 30) there should be a small work-out gym dedicated to them or an indoor walking track. If that is not feasible, then the main gym should have a couple of hours in the evening or morning dedicated to seniors. That way they could use the cardio machines without embarrassment and fear of being bullied. In all cases, but especially where such a gym is not available, the yard should be cleaned and properly maintained throughout the winter.

18. Double-bunking

Seniors should never be on the top bunk. Because OPs should be paired with people of similar age, where double occupancy rooms cannot be avoided, the beds should be side by side. However, single cells should be made available to most seniors, and especially to those who are incontinent, or have certain diseases that might require an increased need for resting or privacy.

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634 See above Chapter 6.
19. Family connections

As noted in the literature, the correctional systems have a duty to encourage family support and contact. Family support is crucial for a successful parole application and likely for community re-integration.

The first step towards achieving better family connections is simple: treating visitors respectfully. Many offenders complained that their visitors are treated like inmates, harassed and disrespected. They had to travel long distances to visit and they were turned away for small issues. There were cases where either the family refused to visit, or the prisoner refused to see them in order to spare them the experience. The case manager should also take a more active role in promoting reconciliation between the family and the prisoner, especially where the inmate is very sick or soon to be released.

Because of the distances some families would have to travel, or because of their health conditions and age, visits might not be feasible. One inmate suggested supervised Skype access in visiting areas. This would be a simple and cheap alternative to visits, and it would avoid security hurdles altogether. It would allow older inmates to keep steady contact with their families and would give them something to look forward to. The same inmate also recommended that amplifiers be inserted in some phones, so that inmates with hearing problems could use them.

635 See above Chapter 5.
20. Physical health

Most of the medical concerns will need to be addressed at the CSC level, and they form policy matters rather than institutional matters. However, some issues arose in certain institutions more than others. Emergency care is a big problem. All front line workers should have CPR training, renewable at regular intervals. Panic buttons should be there for prisoners to use without fear of repercussions. While some way to dissuade inmates who abuse them should exist, this should not mean punishing people who believe they are in real need of help – be that a heart attack or a stomach pain. Especially in prisons where the number of old or disabled individuals is high, a nurse should be available around the clock.

Medical devices are important aids for increasing the quality of life of older offenders. For example, an extra blanket can go a long way towards regulating the body temperature or improving circulation in lower extremities. There should be a system for scanning requests. However, forbidding the physician to recommend devices altogether should not be an option. Basic devices should be readily available for people with certain diseases, even without prescription. Others could be prescription-based, or should be available for purchase.

Finally, physicals should be available on an annual basis to everyone over 50. The content of a physical should be similar to what it is provided in the community. This will initially increase the medical costs on the CSC but over the long term it would likely save money by prevention and early detection of diseases.
21. Mental health

Reiterating what the OCI has repeatedly requested,\textsuperscript{636} segregation should never be used for a person with mental health issues. It has no therapeutic value, and according to this study, its use makes prisoners determined not to seek help when they feel depressed or suicidal.

In addition, more medical staff is needed. Considering the percentages of people reporting mental illnesses, one psychiatrist and one psychologist are hardly sufficient in most institutions. The teams of specialists guaranteed in the CDs\textsuperscript{637} do not appear to be readily available. Once psychiatric staff is added – even through telemedicine – the issue of spending enough time with each patient and properly assessing them would be much easier to solve. Like most medical problems, the solution will take an initial toll on the budget. However, neglecting to address this issue and perpetuating the current situation leads to gross violations of human rights.

22. Caregivers

Caregivers are the number one solution for people with serious disabilities, most of whom are likely OPs. In addition, being a caregiver can also be a meaningful job for the person fulfilling it. However, only 3 institutions offered caregivers and none of them ensured adequate training for those filling these positions. This led to accidents and numerous complaints among the seniors. Just like staff members should receive training for dealing with older people, so should inmates before being given a caregiving job. This

\textsuperscript{636} OCI 2014, supra note 126; Sapers, Report 2012 – 2013, supra note 75; “Ashley Smith,” supra note 620.

\textsuperscript{637} CD 840, supra note 42; CD 850, supra note 43.
can be accomplished without any costs: caregivers that have been on the job for a while and have been successful, could, in turn train others.

23. Priority for seniors

Waiting in line for a prolonged period of time can be difficult for older people. Waiting in line in the cold, or heat, or rain or snow is even more difficult. Waiting in line under these circumstances while younger prisoners cut in line is often unbearable to the point that OPs quit taking their medication or skip meals or doctor appointments. Some institutions provide chairs for older offenders which is much better. No line should form outdoors because that defeats the purpose for which health care exists. In addition, seniors should have priority. It would not be too difficult to create a system in which seniors go in line first and thus they are protected from bullying and from standing too long. If a unit for older prisoners existed, that would be even easier to implement: the seniors’ unit would be the first in any line.

In addition, delivery of medication to the cell should be available to those who are very sick. In one of the medium security institutions, those housed in a certain unit were brought their food and some types of medication by their caregivers. This is a great example of the fact that food and medication delivery is, in fact, possible. It might be necessary to have a nurse deliver all medication to certain prisoners because of security concerns. Once again, if seniors could be housed together as opposed to being spread across the institution, this would be a very effective way of ensuring that both the medical and security needs are being met.
24. Diet

Food is one of the essentials of living that the CSC must ensure for its prisoners in accordance with the CCRA.\(^{638}\) The food needs to be adequate for the needs of the inmates that receive it. The CD and SOP\(^{639}\) regarding serving food guarantee the distribution of medical diets. However what these diets contain is not mentioned. These diets have been identified as one of the most serious problems OPs have.\(^{640}\) The diet must be medically sound while maintaining the required amounts of proteins and calories. As the CSC food system will be centralized, this problem will hopefully be solved. However, it might be necessary for more exact guidelines in relation to what a diet for certain common medical conditions entails.

25. Seniors’ Representative

One of the medium security institutions created the position of seniors’ representative. This person was in constant contact with the seniors and ensured their liaison with prison officials. Not surprisingly, this was one of the better prepared institutions to handle older offenders. This is an excellent model that should be followed in all prisons. Often the inmates’ representatives are younger people who represent the needs of their generation. Thus the needs of seniors, who are less vocal, tend to be pushed aside. Having a representative for an older age group only ensures that everyone is equally represented.

\(^{638}\) CCRA, supra note 8.

\(^{639}\) CD 880, supra note 45; SOP 880-1, supra note 46; SOP 880-2, supra note 47.

\(^{640}\) See above Chapter 6.
26. The Assessment Unit

Most of the participants I have talked with had been in prison for a while. Thus their worries concerned their day-to-day life more than the in-take process. However, from the discussion I had with participants from the assessment unit, this process is extremely harsh for older offenders. All but one of the AU participants were incarcerated in old age for the first time. They were confused and scared. Most of them had been in the unit for 2 weeks to 1.5 months and for most, I was the first person they spoke to. They had not seen a doctor, a parole officer, or an orientation staff member. All they had was word of mouth which increased their anxiety.

There should be an orientation session for older offenders immediately (no longer than a week) after incarceration. They should be introduced to the prison rules and to life in prison as an older person. The processing of inmates is slow and it may take a long time before their money is in their prison account, or before they get access to phone cards and visits. A proper orientation session that is age-sensitive is the least the system can do to help manage the anxiety brought about by incarceration. In addition, the access of these prisoners to health care upon admission should be a matter of hours or days, not weeks as it is now. Their outside medication and medical devices should be allowed until they are seen by a doctor and provided new ones.
9.3 Conclusion

In the last few years a large number of tough-on-crime laws have emerged in Canada. These will likely increase the percentage of people that will age and die behind bars. None of these pieces of legislation has been complemented by research studying the consequences of aging behind bars for individuals and for society.

Until recently, the tough-on-crime agenda included an increase in the number of mandatory minimum sentences, less opportunities for parole, restrictions in family visits, longer sentences etc.\textsuperscript{641} In an election year like 2015 the stakes are higher and the government has tabled a new Bill C-53 “Life Will Mean Life,” that would introduce life without parole for certain murders.\textsuperscript{642} Without possibility of being released, a substantially larger number of the people who receive a life sentence will add to the percentage of incarcerated older offenders and of those who die in prison. While tough-on-crime bills may be problematic in themselves, they are even more so when the correctional systems are not equipped to manage older prisoners. If at all, enacting such legislation should be postponed until all essential actors have a solid understanding of the demographic shift these laws will accelerate, and how to deal with it.

This study is a first attempt to assess the life of older incarcerated individuals, their needs, and what is currently missing in the federal correctional system to fill these needs. The data collected is often grim, but not surprising. Numerous agencies, national and foreign, have signaled the need for a seniors’ friendly prison environment that would allow

\textsuperscript{641} See Iftene & Manson, \textit{supra} note 576.
\textsuperscript{642} See the reports in the Globe and Mail, \textit{supra} note 455.
for adequate and humane treatment, with real, age sensitive rehabilitative potential. This study provides the numbers to allow the identification of problematic areas, and to support change.

More research in this area is needed. An in depth look at particular problems associated with aging and the effectiveness of standardize correctional interventions should be welcome. A similar study conducted with younger people would allow for a comparison between the two age groups, and would be extremely informative for future policies. A study conducted with older female offenders is also needed – the findings in this study are only male relevant and cannot be transposed to women. A confirmation of my self-reported data through a study based on data from older offenders’ medical files would also be useful.

For now, the data presented in this study are sufficient to encourage discussion about the changes we need, and the drafting of first steps towards achieving them. Absent such steps, lawyers and courts will need to be open to utilizing innovative legal actions that have the potential of pressuring the system into changing and of remediating some of the disproportionate suffering endured by senior offenders.
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Appendix A

Protocol for Quality of Life Assessment

General Questions

1. *How old are you?* (number)

2. *How long have you been incarcerated* (in this sentence)?

   *How long is your current sentence?* (number)

3. *When are you first eligible to apply for parole?*

4. *Did you apply?*

5. *Will you apply for parole again?* (please mention if you are waiting for your statutory release)

6. *If yes, do you think you will be successful? Why?*

7. *Have you been to prison before?*

Daily Living/ Adjustment to prison life

8. *Do you have any problems with some daily activities?* (such as walking, getting out and into bed, washing, using the toilet, stairs, eating etc) (yes/no + enumeration)

   Yes   No

   Walking

   Bed

   Washing

   Using the Toilet

   Stairs

   Eating
Other – mention which

9. Have you ever requested/ been offered assistance with any of those? Yes  No
   If yes, were you granted assistance? Yes  No
   Who helped you?
   Staff  Volunteers  Peer
   Other

10. Do you have any difficulties with some prison requirements such as work/ stand for
    headcount/ drop to the floor/ stand in line? (yes/no + description)
    Yes  No
    Work
    Headcount
    Dropping
    Standing in Line
    Other

11. In the last year, did you fall at all? YES NO
    If yes, how many times?
    If yes, did you hurt/break any bones?  YES NO
    Describe

12. Do you have any special diet requirement recommended to you by a doctor or
    nutritionist? Yes  No
    If yes, have they been followed in here from the beginning?  Yes  No

13. Do you have any hearing problems? Yes  No
    Sight problems?  Yes  No
14. Have you ever requested items to help you in here, for health reasons? (e.g. walking aids, extra blankets or pillows, special shampoo etc)  Yes No

If yes, what and was your request granted?  Yes No

Walking aids
Bedding
Toileting Items
Vitamins
Other

15. Have you ever find it difficult to do day to day activities in prison?  Yes No

If yes what:

16. Do you or did you drink alcohol daily?  YES NO

Take drugs?  Yes NO

Program and Exercise

17. Do you attend any programs/ activities and what? (enumeration).  Yes  No

Educational/vocational  Anger management
Therapy  Other – please mention which
AA/NA

If no, why not?

Not available  Not safe
Not interested  Other

18. Do you have access to support groups, such as group counseling, AA, grief group?

Yes No

Counseling  AA/NA  grief groups  don’t know
Other

19. Are there any programs you think should be available to someone like you? Yes NO

What:

20. Do you exercise every day? Yes NO

If yes, where? Gym cell yard other

For how long? A few minutes 30 min 1h over 1h

21. Have any special exercises been recommended to you by a doctor, nurse or therapist? Yes No

If yes, can you do them in prison? Yes NO

If no, why not?

Lack of tools lack of space lack of personnel other

22. Do you work? Yes No

23. Does your job or previous job in prison cause any physical problems? Yes No

24. If yes, have you asked for a change? Yes No

If yes, was it granted? Yes No

Health

25. If 1 is very bad and 5 is very good, what grade would you give to your health right now?

1 2 3 4 5

26. Do you think that, compared with when you entered prison, your health is the same, is better or is worse?
27. When did you last see a nurse?

When did you last see a doctor?

For what?

Nurse: Medication

Doctor: Illness

Physical/check up

Vaccination

Other

28. To your knowledge, is there a nurse available to you at all times? Yes No Don’t know

29. How often do you visit the infirmary? (weekly or often, a few times a month, once a month, a few times a year, seldom, never)

30. What are the health problems that you have right now?

Mental …. Oral problems

Asthma Foot issues

Rheumatologic Arthritis/osteoporosis cerebro-vascular

Digestive… infectious diseases

Skin…. 

Circulation Diabetes

Heart Hypertension

Disability

Wounds

Other – please mention which
31. Do you take any medication for them or other conditions? Yes No For some……

  Do you know for what? Yes No

  How many pills you take/day?

32. Do you suffer from serious pains on a regular basis? Yes No

  If yes, What Kind?

  Headaches

  Cancer associated

  Bones (back, arthritis)

  Feet

  oral

  If yes, do you take anything for them? Yes No Sometimes

  If yes, it is efficient? Yes No

  If no or sometimes: Don’t want to Not available

    Not strong enough Other

33. How often do you get the flu? NEVER RARELY EVERY YEAR

    VERY OFTEN

34. Do you ever get very cold or very hot? Yes No

    What do you do about it?

    Nothing

    Request extra items

    Other

35. In the last year, did it happen not to pee yourself? Yes No

    If yes, how often? Once Sometimes Often
36. Did you undergo any surgeries since you turned 50 (and since you are in prison)?

Yes   No

For what/what kind?

Where did they take place?

<table>
<thead>
<tr>
<th></th>
<th>Prison hospital</th>
<th>Community</th>
<th>Other</th>
</tr>
</thead>
</table>

Where did u recover?

<table>
<thead>
<tr>
<th></th>
<th>Same place</th>
<th>Other hospital</th>
<th>Infirmary</th>
</tr>
</thead>
</table>

|                   | Cell            | Other          |

37. Did you request to be medically tested for anything? Yes   No

If yes, for what?

If yes, what was the answer? Yes   No   Still waiting to be tested

Still waiting for an answer

38. Were you offered any testing/screening? Yes/ NO

For what?

Did you accept? Yes   No

If no, why not?

39. What vaccinations, if any, you received since in prison?

Don’t know   Influenza

Did not receive   Other

TB

Hepatitis

40. To your knowledge, do you receive an influenza vaccination every year?
Not sure  No

Yes

If no, why not?

Not available  Don’t want to

41. How often did you go through a routine physical check-up? (once, every few months, once a year, never).

42. Have you ever requested to see a specialist/a certain doctor? Yes  No

What was the answer?  Yes  No  Still waiting

What was the waiting time?

43. Do you have any sleep problems?  YES  NO  SOMETIMES

44. Do you ever feel very sad?  Yes  No

How often?

Daily  weekly  at least once a month  once  in  a while/rarely

Never  Other

45. What do you do when you have sad thoughts?

Pray  get angry/violent  ignore/nothing

Talk to someone  hurt myself  read  sleep  eat

other

46. Did you ever consider taking your own life? Yes  No

47. Did you talk to any medical staff about this? Yes  No

If yes, what did they do for you?
Ignore consult meds segregation negative
reaction
Other

If no why not:

Fear Useless didn’t think about it other

48. Do you ever get a sudden, overwhelming, inexplicable feeling of distress or unease?

Yes No Sometimes Not sure

49. Would you describe yourself as an alcoholic? Yes NO

If yes, did you get specialized treatment in prison? Yes NO

50. Overall, would you say that your health is generally: very good, good, ok, bad, very bad?

Safety

51. Are you separated from other prisoners based on age or health, here in prison?

Yes No

By age By health/ disability

52. If no, would you find that a good step? Yes No

If yes, do you like this arrangement? Yes No

53. Have you ever been physically or mentally abused by peers? Yes No

By staff? Yes No

If yes, can you give me examples?

Hitting pushing insults ridicule cut in line stigma
Isolate Sexual abuse other

54. Have you ever had your property stolen? Yes No
If yes: money clothes food electronics
other

55. Do you ever feel concerned for your safety? Yes No

If yes, why? (description)

Relations

56. Have you made any friends in prison? Yes No

57. Do you have much contact with younger inmates? Yes No

58. If yes, how do you get along with them, on a scale from 1 to 5? 1 2 3 4 5

59. How do you get along with people your age or older, on a scale from 1 to 5? 1 2 3 4 5

60. Do you have any family or friends on the outside? Yes No

61. Do they visit/call/write? Yes No

and which ones?

How often (weekly/monthly/a few times a year, once a year, never)

When did you have your last visit?

62. What are your feelings regarding the relations you have with your friends and family? (description)

Positive/love negative shame/embarrassment regret

Wish they were better gratitude other

63. How would you describe your relations with staff? (good, acceptable, bad)

Discipline

64. Have you ever been in segregation, since turning 50? Yes No

If yes, for what?
Violent disobedient self-harm requested

How long?

65. *Did you ever consider taking your life in segregation?* Yes No

66. *Have you been charged with any disciplinary offences since turning 50?* Yes No

*If yes, how many times?*

*If yes, for what?*

67. *Have you ever had troubles executing orders due to the fact that you could not physically perform them or did not understand them?* Yes No

Examples:

68. *If yes, were you punished?* Yes No

*If yes, how?*

Final Questions

69. *Describe your greatest fear regarding your life in prison.* (description)

Death Aging Family related Safety None

Other

70. *Have you ever felt in danger in prison?* Yes No Don’t remember

71. *Did you ever feel life is not worth living since you are in prison?* Yes No

72. *Finally, is there something that I did not ask and you would like to share with me about your health or life in prison?*
Appendix B
Ethics Certificate

February 05, 2013

GREB Ref #: GLAW-026-13; Romeo # 6007726

Title: "GLAW-026-13 Elderly Inmates in Canadian Prisons: Specific Needs and Institutional Responses"

Dear Ms. Iftene:

The General Research Ethics Board (GREB), by means of a delegated board review, has cleared your proposal entitled "GLAW-026-13 Elderly Inmates in Canadian Prisons: Specific Needs and Institutional Responses" for ethical compliance with the Tri-Council Guidelines (TCPS) and Queen's ethics policies. In accordance with the Tri-Council Guidelines (article D.1.6) and Senate Terms of Reference (article G), your project has been cleared for one year. At the end of each year, the GREB will ask if your project has been completed and if not, what changes have occurred or will occur in the next year.

You are reminded of your obligation to advise the GREB, with a copy to your unit REB, of any adverse event(s) that occur during this one year period (access this form at https://eservices.queensu.ca/romeo_researcher/ and click Events - GREB Adverse Event Report). An adverse event includes, but is not limited to, a complaint, a change or unexpected event that alters the level of risk for the researcher or participants or situation that requires a substantial change in approach to a participant(s). You are also advised that all adverse events must be reported to the GREB within 48 hours.

You are also reminded that all changes that might affect human participants must be cleared by the GREB. For example you must report changes to the level of risk, applicant characteristics, and implementation of new procedures. To make an amendment, access the application at https://eservices.queensu.ca/romeo_researcher/ and click Events - GREB Amendment to Approved Study Form. These changes will
automatically be sent to the Ethics Coordinator, Gail Irving, at the Office of Research Services or irvingg@queensu.ca for further review and clearance by the GREB or GREB Chair.

On behalf of the General Research Ethics Board, I wish you continued success in your research. Yours sincerely,

John Freeman,
Ph.D. Professor
and Acting
Chair
General Research Ethics Board

cc: Dr. Allan Manson, Faculty Supervisor
Dr. Felicia Iftene and Dr. Anthony Doob, Collaborators
January 10, 2014

GREB Romeo #: 6007726
Title: "GLAW-026-13 Elderly Inmates in Canadian Prisons: Specific Needs and Institutional Responses"

Dear Ms. Iftene:

The General Research Ethics Board (GREB) has reviewed and approved your request for renewal of ethics clearance for the above-named study. This renewal is valid for one year from February 5, 2014. Prior to the next renewal date you will be sent a reminder memo and the link to ROMEO to renew for another year.

You are reminded of your obligation to advise the GREB of any adverse event(s) that occur during this one year period. An adverse event includes, but is not limited to, a complaint, a change or unexpected event that alters the level of risk for the researcher or participants or situation that requires a substantial change in approach to a participant(s). You are also advised that all adverse events must be reported to the GREB within 48 hours. Report to GREB through either ROMEO Event Report or Adverse Event Report Form at http://www.queensu.ca/ors/researchethics/GeneralREB/forms.html.

You are also reminded that all changes that might affect human participants must be cleared by the GREB. For example you must report changes in study procedures or implementation of new aspects into the study procedures. Your request for protocol changes will be forwarded to the appropriate GREB reviewers and/or the GREB Chair. Please report changes to GREB through either ROMEO Event Reports or the Ethics Change Form at http://www.queensu.ca/ors/researchethics/GeneralREB/forms.html.

On behalf of the General Research Ethics Board, I wish you continued success in your research. Yours sincerely,

Joan Stevenso
n. Ph.D.