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The Pains of Incarceration: Aging, Rights, and Policy in Federal Penitentiaries

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Le nombre de détenus vieillissants a augmenté au cours des dernières décennies. Leurs besoins croissants sont un fardeau sur les établissements correctionnels, un fardeau sans précédent. Cet article présente les résultats d'une étude effectuée auprès de 197 détenus âgés. Ces résultats identifient les problématiques causées par les douleurs chroniques chez les détenus âgés et la gestion de cette douleur en prison. Le Service correctionnel du Canada (SCC) ne voit pas les détenus âgés comme un groupe vulnérable, et les politiques pénitentiaires n'ont pas tendance à inclure l'âge (et ses implications) comme variable digne de considération. Les données obtenues de cette étude soulèvent des problèmes peu explorés au sujet du vieillissement derrière les barreaux, problèmes qui doivent être étudiés plus profondément. Si les résultats sont confirmés dans le futur, le SCC pourrait voir ses politiques contestées devant les tribunaux. Pour prévenir ces contestations, une réforme systématique des politiques du SCC — notamment, les politiques médicales — devra être entreprise afin de les rendre appropriées à l'âge des détenus.

Mots clés : détenus âgés, gestion de la douleur, droits des détenus, politiques

The number of aging people in prison has been on the rise in the last few decades. Their heightened needs place burdens on correctional institutions that have not been encountered before. This article presents the results of a study conducted with 197 older prisoners. This study's findings identify issues raised by chronic pain in older prisoners and the management of this pain in a prison setting. Correctional Service Canada (CSC) does not acknowledge older prisoners as a vulnerable prison group, and correctional policies thus tend not to include age (and its implications) as a variable worthy of consideration. Data from this study raise some under-explored issues about the matter of aging behind bars that are in need of future research. If the findings are confirmed in the future, the CSC might find its policies challenged in court. To prevent that from happening, a systematic reform of the CSC's policies – in particular, the medical ones – will need to be undertaken, with the goal of making them age-sensitive.

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In the last few years, problems associated with aging have emerged in correctional environments. Extensive studies have been conducted in the U.S. since the 1990s (Colsher et al. 1992; Ornduff 1996; Arndt, Turvey, and Flaum 2002; Aday 2003; Delgado and Humm-Delgado 2009), but Canada has been slow in dealing with problems associated with the aging of the prison population. There has been only one independent study conducted in Canada with older male prisoners (Gallagher 2001).

A change of direction was evident four years ago, when the Office of the Correctional Investigator, the federal prison ombudsman, published in its annual report serious concerns regarding the needs and the treatment of older prisoners in Canadian federal institutions (Sapers 2011). The correctional investigator continued to highlight these concerns in the years that followed (Sapers 2012; 2015: 10–11), even though the response from Correctional Service Canada (CSC), the agency that administers the federal correctional system, has not been positive (Correctional Service Canada 2013b). Other authors, while not working with older prisoners, have recently highlighted health issues, which are common in old age, pertaining to the management of chronic diseases and dying in prison (Kouyoumdjian et al. 2016). Finally, the CSC itself has conducted a couple of studies with older male prisoners (Uzoaba 1998; Correctional Service Canada 2014) and three with older female prisoners (Greiner and Allenby 2010; Michel, Gobeil, and McConnell 2012; Gobeil 2014). However, they are brief, most pertain to criminogenic factors in an older age group, and all but one (Gobeil 2014) are based solely on data from the CSC's administrative databases.

Although federal imprisonment rates have been fairly stable for more than 50 years (Webster and Doob 2014: 328, fig. 1), the proportion of older people admitted to federal penitentiaries in Canada has increased dramatically in recent years. (Age-at-admission data are available; unfortunately, data on the average age of those in custody on an average or census day are not consistently available.) In 1993–94, 12.2% of those admitted to federal facilities were 45 years of age or older. Twenty years later, in 2013–14, 24.1% of those admitted to federal custody were 45 years of age or older. Indeed, in 1993–94, there were 96 people aged 60 or older admitted to federal penitentiaries (2.1% of those admitted). By 2013–14, this number had increased to 250 people aged 60 or older (4.9% of those admitted) (Public Safety Canada 1998,

2014). In 2014, the correctional investigator noted that one in five prisoners was over the age of 50 (Sapers 2014: 21), and in his latest report (Sapers 2015: 10–11), he stated that the older prison population has increased by 50% in the past 10 years, so that it now represents 25% of the incarcerated population. It has been predicted that the number of older incarcerated people will continue to grow, especially considering the number of people serving life sentences (Sapers 2011: 21).

The study had two main goals. First, it intended to describe the needs of older male penitentiary prisoners. Second, the data were interpreted in a legal rights context. The study was a broad, interview-based investigation into the quality of life of male prisoners over the age of 50. This age is generally accepted as an appropriate measure of seniority, as shown by both CSC documents and the American literature. According to these reports, most prisoners have the physical and psychiatric problems of people living in the community who are typically 10 to 15 years older because of the rigours of incarceration and the consequences of previous lifestyles (Aday 1994: 48; Uzoaba 1998; Lemieux, Dyeson, and Castiglione 2002; Canadian Public Health Association 2004; Sapers 2011: 20).

In this article, only two of the research questions that generated the study are addressed. The purpose of this article is to understand how physical pain is treated in prison from the perspective of prisoners over 50. In addition, quantitative and qualitative data are used to make a set of recommendations that could improve some of the CSC's policies and make them more age-friendly. The findings and discussion are also placed in the context of the Canadian statutory and constitutional framework, especially the *Corrections and Conditional Release Act* (CCRA) as well as the *Canadian Charter of Rights and Freedoms* (Charter).

1. Description of the study and methodology

The study was focused on determining the general quality of life of incarcerated older prisoners to be able to better understand the extent to which their rights were being upheld. For the purpose of this study, quality of life included the satisfaction of prisoners with their own health, the perceived quality of the treatment received in prison, the programming available, adjustment to the prison environment, the maintenance of family relations, and the presence or absence of abuse.

After receiving ethics approval from the General Research and Ethics Board of Queen's University, 197 interviews were carried out in seven federal correctional institutions in Ontario, at all levels of security. In 2012, when the study commenced, the population of male prisoners over 50 in federal institutions was roughly 2,000, according to data provided by the CSC (out of a total number of prisoners averaging 15,313 during the 2011–12 fiscal year) (Public Safety Canada 2014: 36).

Recruitment was carried out in each institution separately, either through posters and recruitment letters or group presentations. Participation was purely voluntary, and no one who asked to be interviewed was turned down. On average, one third to one half of the eligible prisoners (prisoners over 50) 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. Interviews took between 30 and 60 minutes, and they were based on a structured protocol of 71 questions.

The prisoners' answers were quantified by creating variable names and labels based on their similarities. The unusual answers were labelled "other." The codified answers were entered into an SPSS data table. The data were analysed in SPSS v. 12.0 by calculating frequency, distributions, and running cross-tabulations among answers in different sections of the protocol. Their statistical relevance was determined by using chi-square tests.

The study has several limitations. For administrative reasons, a comparison group was not available for this project (e.g., younger prisoners, people under supervision in the community, or another patient population in the community). The medical files of the prisoners were also not available for review; this means that the study is entirely self-reported, and it cannot objectively establish whether the general medical care practices of the CSC are below regular standards.

To minimize the limitations posed by the lack of a younger population control group, medical literature on older people in the community was reviewed to identify the problems recognized as associated with aging. The inability to corroborate the information received is obviously a limitation, so it needs to be kept in mind that the data come from the prisoners themselves. As a result, to attempt to compensate for this limitation, the number of questions in the protocol was increased to see whether there was internal consistency across responses within individuals'

answers. However, it is clear that this study cannot offer a comprehensive overview of the CSC's general medical practices.

This study is thus simply a first attempt to shed light on the challenges that aging presents in a system that has been used to dealing with a younger population. It is also an attempt to highlight the fact that if the policies do create the issues identified, they may give rise to serious legal issues in the future.

2. Pain management and health care in federal institutions

2.1 Overall health status

For this study, 197 male prisoners over the age of 50 from seven penitentiaries were interviewed (Tables 1 and 2). Slightly more than half of the participants (55.4%) had been to prison (either federal or provincial) before their current sentences. The rest were being incarcerated for the first time. As shown in Table 3, their sentences varied considerably.

Over 63% of the prisoners in the study stated that they believed their health had deteriorated since they entered prison on their current incarceration, because of both the natural aging process and the rigours

Table 1: Distribution of sample by age

Age	Number of Incarcerations (%)
50–59	109 (55.3)
60–69	65 (33.0)
70 and over	23 (11.7)

Table 2: Distribution of sample by security level

Level of Security	Number of Incarcerations (%)
Minimum	66 (33.5)
Medium	99 (50.3)
Maximum	18 (9.1)
Assessment unit	14 (7.1)

Table 3: Distribution of sample by sentence

Length of Sentence	Number of Incarcerations (%)
Short (2–5 years)	59 (29.9)
Medium (6–10 years)	27 (27.0)
Long determined (< 10 years)	10.7 (21.0)
Life	66 (33.5)
Indeterminate	24 (12.2)

Table 4: Overall perceived health by number of physical problems mentioned

Overall Perceived Health	Number of Physical Conditions Mentioned (%)			
	0–4	5–7	8–16	Total
Relatively poor	3 (5.7)	19 (35.8)	31 (58.5)	53 (100.0)
Average	21 (29.2)	32 (44.4)	19 (26.4)	72 (100.0)
Relatively good	45 (63.4)	20 (28.2)	6 (8.5)	71 (100.0)

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

of incarceration. Over 19% said their health had improved while incarcerated, with the main explanation being the lack of access to alcohol and illicit drugs. About 17% believed that their health had remained the same.

Regarding their perceived overall health, 27% graded it as relatively poor, 36.7% as average, and 36.2% reported being in relatively good shape (Table 4). Not surprisingly, there is a statistically relevant connection between perceived health and the reported number of physical conditions.

The most commonly mentioned diseases were arthritis, digestive problems, skin problems – especially psoriasis – severe heart problems, diabetes, hypertension, severe oral health problems, severe hearing problems, severe vision problems, back problems, and high cholesterol (Table 5).

Table 5: Distribution of physical illnesses

Illness/Problem	Number (%)
Asthma	24 (12.2)
Arthritis	100 (50.8)
Digestive problems	48 (24.4)
Skin problems	53 (26.9)
Severe heart problems	54 (27.4)
Cancer	14 (7.1)
Physical disability	37 (18.8)
Wounds	24 (12.2)
Diabetes	53 (26.9)
Hypertension	83 (42.1)
Severe oral health problems	48 (24.4)
Cerebral – vascular problems/epilepsy	19 (9.6)
Hepatitis	28 (14.2)
Circulation	39 (19.8)
Sleep apnea	16 (8.1)
Severe hearing problems	52 (26.4)
Severe vision problems	162 (82.2)
Pinched nerve	6 (3.0)
Back problems	63 (32.0)
Hernia	13 (6.6)
Thyroid	10 (5.1)
Sciatic nerve	11 (5.6)
High cholesterol	48 (24.4)
Foot problems	33 (16.8)
Bladder	11 (5.6)
Constipation	9 (4.6)
Severe prostate problems	15 (7.6)
Other	94 (47.7)

2.2 Chronic pain – Consequences and management: Qualitative and quantitative findings

Pain and effects

Pain was identified by numerous participants as the most debilitating aspect of their life in prison. Pain and the manner in which it was

Table 6: Distribution of pain by number of physical problems mentioned

Pain on Regular Basis	Number of Physical Problems Mentioned (%)			
	1–4	5–7	8–16	Total
No	48 (64.9)	19 (25.7)	7 (9.5)	74 (100.0)
Yes	21 (17.1)	53 (43.1)	49 (39.8)	123 (100.0)
Total	69 (35.0)	72 (36.5)	56 (28.4)	197 (100.0)

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

handled in prison was a recurring theme during the interviews, especially when participants were allowed to make unstructured comments about their experiences. Most of the participants – 62.4% – reported suffering from severe pain on a regular basis. When asked about the source of their pain, at the top of the list was arthritis or other joint pain (49.2% of the total sample) as well as headaches or migraines (8.6%). Other sources were cancer, foot pain, muscular pain, and nerve pain. The pain that individuals reported appeared to be directly proportional to the number of physical ailments they suffered (Table 6).

In addition, the physical conditions that appeared to have a statistically 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 health problems (32.5% versus 10.8%), hernia (9.8% versus 1.4%), sciatic nerve pain (8.9% versus 0%), high cholesterol (30.1% versus 14.9%), and foot problems (22.0% versus 8.1%). While not statistically relevant, there was 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%). Many of these health problems – most notably arthritis, severe back problems, physical disabilities, diabetes, severe oral health problems, hypertension, physical injuries, pulmonary diseases, and severe hearing and vision problems – are commonly associated with aging (Cassel, Cohen, and Larson 2003: 361–65, 509, 921; McKenna et al. 2005; Blackburn and Dulmus 2007; Jagger et al. 2007; Andrade 2010; Halter and Hazzard 2009).

It also appears that those who were in pain were more predisposed than the others to fall and injure themselves. Of those reporting pain,

Table 7: Distribution of drug abuse by effectiveness of pain treatment

Treatment of Pain Effective	Number of Drugs Consumed Daily (%)		
	No	Yes	Total
No	20 (46.5)	23 (53.5)	43 (100.0)
Yes	29 (58.0)	21 (42.0)	50 (100.0)
N/A (not in pain or not treated)	74 (71.2)	30 (28.8)	104 (100.0)
Total	123 (62.4)	74 (37.6)	197 (100.0)

Chi-square = 8.439, $df = 2$, $p = .015$

Table 8: Distribution of perceived health by reported pain, number (%)

Pain on Regular Basis	Overall Health			
	Relatively Poor	Average	Relatively Good	Total
No	9 (12.2)	23 (31.1)	42 (56.8)	74 (100.0)
Yes	44 (36.1)	49 (40.2)	29 (23.8)	122 (100.0)
Total	53 (27.0)	72 (36.7)	71 (36.2)	196 (100.0)

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

42.3% also reported falling at least once within the previous 12 months, as opposed to 23% of those who were pain-free. Sleep was also affected by pain. Of those reporting regular pain, 52.8% also reported serious sleep problems, as opposed to 36.5% of those not in pain. This was of particular concern, especially since a different set of the study's findings also identified sleep deprivation as having statistically relevant connections to other aspects of an inmate's well-being, especially mental health.

Perhaps not surprisingly, it appeared that those in pain were more likely to self-identify as drug abusers (46.3% as opposed to 23.0%). However, those who were treated effectively for pain were less likely to report drug abuse than the ones who received inefficient painkillers (Table 7). Finally, the pain that individuals were in was related to the way they perceived their overall health status (Table 8).

Pain management

Most people in pain reported receiving some treatment (Table 9). However, only a little over half of the people receiving regular treatment of

Table 9: Individuals in pain who received treatment

Pain Treated	Number (%)
No	31 (15.7)
Yes/sometimes	93 (47.2)

Table 10: Distribution of treatment reported to be effective

Treatment Effective	Number (%)
No	43 (21.8)
Yes	50 (25.4)
N/A (not in pain)	104 (52.8)

their pain reported getting relief from it. A little less than half identified the medication they received as not being strong enough for their type of pain (Table 10). The questions and answers regarding pain treatment referred to medication prescribed by the prison physician. The medication that generally seemed to be prescribed in cases of chronic or acute pain was Tylenol 3 (acetaminophen and codeine).

The majority of people not treated for pain identified as a reason for this that they were not prescribed any treatment by the prison doctor (7.1% 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. This activity placed added stress on their bodies and made the pain worse (6.6%). Several of the 47.2% who received pain treatment also reported the treatment as being ineffective in alleviating their suffering, and some of them mentioned having been on stronger medication in the community. From the 25.4% who were responsive to treatment, a small number were not on Tylenol 3. In particular, some reported receiving methadone for their drug addiction, which also functioned as a painkiller, and a few were receiving morphine. It did appear, however, that, aside from Tylenol 3 and morphine, nothing else was generally available.[1] The lack of pain medication options was best illustrated by two individuals in advanced stages of cancer, who complained that morphine was available only for those diagnosed with terminal cancer (i.e., who had only a maximum of six months to live). Nonetheless, they complained that their excruciating pain was too strong for Tylenol 3.

In addition to the lack of effective medication for their pain, prisoners complained about having to pick up painkillers every day from the

infirmary. Such requirements were governed by safety concerns as there have been instances in which people abused their medication, sold it, or were robbed by other inmates. However, asking a disabled person who is in pain to stand for an hour outside at −15 degrees Celsius (as is the case in some institutions in winter) to pick up their medication for that single day appears to defeat the purpose of medical care. As mentioned, this was one of the most important reasons that some individuals refused to take prescribed pain medication.

In addition, none of the institutions provided a palliative care unit. While there may have been attempts to provide palliative resources on an individual basis, this was seriously restricted because of the prisons' security policies. Without a palliative care unit, there were difficulties administering the strong medication available in the outside community to people in similar situations. The lack of a proper palliative care unit also meant that medical staff were not available at all times (only 19.8% believed that there was a nurse available around the clock), there was no special housing for people who were terminally ill or in severe pain, and there was no adjusted infrastructure. There is a CSC guideline called Hospice Palliative Care Guidelines for Correctional Service Canada (Correctional Service Canada 2009), which I have obtained through the *Access to Information Act*. This document offers instructions to different staff members regarding how to interact with dying prisoners and emphasizes the need for a team of individuals to help with end-of-life care. However, the material makes apparent that palliative care is not systematic, and dying prisoners are housed in the same facilities as everyone else and thus subjected to the same security rules and medical regulations.

People reporting pain also tended to report difficulty walking (53.7%, as opposed to 9.5% who were not in pain), getting into and out of bed (21.1% versus 9.5%), using the stairs (51.2% versus 13.5%), and standing for a prolonged time (37.4% versus 10.8%). The percentages take into account only the difficulties reported by people who were still required to perform these activities. Another 6.6% reported difficulties, but requirements had been modified to meet their needs; 6.1% had a peer caregiver to help them with different tasks, while 56.9% had requested items to help them with these activities. Only 21.3% of the total sample received what they had asked for, usually walking aids or medical devices. The CSC's National Essential Health Services Framework (Correctional Service Canada 2015), obtained through the *Access to Information Act,* contained the procedure to be followed for approval of the medical equipment and supplies that may be granted to

prisoners. However, regardless of the medical reasons for a request, supplies such as pillows, mattresses, orthopaedic shoes, heating pads, and hot water bottles are never available. Braces and walking aids are available, but the data suggest that they are actually quite difficult to obtain (ibid.: 10–11). There also appeared to be marked differences among institutions in how they dispensed medical supplies. For example, in one of the medium-security institutions, prisoners reported being quite satisfied with how their requests were fulfilled. However, at a different institution, the majority of the prisoners reported that they never even asked for medical supplies anymore because it was common knowledge that "the doctor is not allowed to prescribe any."

The high number of falls in the previous year is also a concern given the previously mentioned relationship between falls and pain. A full 35.0% of the participants had fallen at least once in the previous year, and 15.7% of the participants had fallen on ice. The fact that ice was not cleaned properly or salted in winter, as well as the lack of a safe recreation yard for prisoners during the winter months, is worrisome.

A final point worth noting relates to managerial responses to pain and illness. Pain has been statistically correlated with physical disability and physical conditions. In turn, people with physical illnesses and disabilities have reported significantly more time spent in segregation than those who did not report such conditions (Table 11). Only a small number reported spending time in segregation for their own protection (8%). It is not clear whether segregation and discipline are used to manage people's health or whether people become sicker in segregation. One could theorize that it may be both. However, knowing that segregation has no therapeutic benefits, policies should be rethought.

In addition, people suffering from physical illnesses and disabilities reported significantly more incidents of victimization from both staff and

Table 11: Time spent in segregation by number of physical conditions

Time Spent in Segregation	Number of Conditions (%)			
	1–4	5–7	8–16	Total
No	61 (38.1)	60 (37.5)	39 (24.4)	160 (100.0)
Yes	8 (21.6)	12 (32.4)	17 (45.9)	37 (100.0)

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

Table 12: Distribution of physical conditions by abuse by staff (No., %)

Number of Physical Conditions	Abuse by Staff		
	No	Yes	Total
1–4	44 (60.9)	29 (39.1)	69 (100.0)
5–7	37 (51.4)	35 (48.6)	72 (100.0)
8–16	20 (35.7)	36 (64.3)	56 (100.0)

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

Table 13: Distribution of physical conditions by abuse by peers (No., %)

Number of Physical Conditions	Abuse by Peers		
	No	Yes	Total
1–4	46 (66.7)	23 (33.3)	69 (100.0)
5–7	31 (43.1)	41 (56.9)	72 (100.0)
8–16	18 (32.1)	38 (67.9)	56 (100.0)

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

peers (Tables 12 and 13). Such abuse included name-calling, threats, physical violence, and sexual assaults. In about half of the institutions, prisoners reported that a few of the staff members were systematically harassing people with disabilities or who were unable to move because of pain. Most of them stated that they got used to the name-calling, but they had difficulties with the practical jokes. In a few cases, prisoners reported that some officers would steal, move, or tie their wheelchairs to a table as a "prank."

3. Pain management and health care in the legal context

The data presented above indicate several things. First, numerous older prisoners report chronic pain, which appears to be associated with age-related diseases. It is reasonable to infer that chronic pain is likely higher in this age group. Second, many people suffering from chronic pain do not appear to receive appropriate treatment, and the environmental conditions may increase their suffering. Third, when chronic pain is not fully treated, it appears to have direct and indirect repercussions on other aspects of life such as quality of sleep, drug abuse, discipline, and victimization. When interpreted in a legal context, the data suggest that there are potential issues with compliance with the law and that these issues will need to be addressed through CSC policy reform.

CSC activity is regulated by the CCRA. This is a broad framework that covers everything from intake and assessment in federal institutions to health care, discipline and solitary confinement, grievance procedure, and oversight by the Office of the Correctional Investigator. These provisions are mandatory for all CSC institutions, and they are implemented with the help of administrative directives (commissioner's directives, or CDs) and procedures that emanate from the CSC's National Headquarters. These documents do not have legal force, but they set out the CSC's policies and provide details on how the legal provisions ought to be implemented at the institutional level.

When prisoners have a complaint, they may file a grievance with the administration, and a judicial review request may be subsequently brought in the Federal Court upon an unfavourable response (CCRA, s. 90). Finally, CSC activity is bound by the Constitution and, in particular, by the Charter. Prisoners retain all rights that are compatible with incarceration, and correctional practices need to adhere to human rights norms (Arbour 1996: 181; Jackson 2002; Parkes and Pate 2006: 274–75; Parkes 2007; Kerr 2014; Arbel 2015: 134). When an individual believes her rights have been infringed, she may bring a Charter challenge directly to court without having to exhaust the grievance procedure first.

CSC practices in regard to pain management and health care for older prisoners need to be influenced by the legal and constitutional framework in which they exist. According to s. 86 of the CCRA, the CSC is under an obligation to provide every prisoner with essential health care as well as reasonable access to non-essential health care. In addition, the provision of health care should conform to professionally accepted standards. At the institutional level, the CCRA is implemented with the help of commissioner's directives (CDs) and related procedures, which need to be in accordance with the statute and the Charter. These CDs and procedures are thus meant to set a framework to uniformly regulate issues among CSC institutions. CD 800, Health Services (2011), is intended to bring clarity to the CCRA's health care provision and to detail the manner in which health care is administered within the CSC. However, it does neither of these things, and it is instead a two-page document filled with broad general statements.

The National Essential Health Services Framework (Correctional Service Canada 2015) brings more clarity. This document – in essence a guideline – explains what essential health care is: assessment and screening upon intake, intermediate mental health care, acute and

chronic health care, and planning for health care upon release (ibid.: 7). It also details the types of mental health and dental services available and the medical supplies that may be obtained by prisoners (Correctional Service Canada 2015: annexes A, B, D). However, it does not clarify the language used in the legislation and CDs – in particular, the references made to "acceptable standards of the profession" or "comparable standards of care." CD 805, Administration of Medication (2003), describes the process of medication distribution and sets out as a general rule that, aside from those in maximum security, prisoners are to pick up prescription medication, daily and in person. Age and pain are not factored into this rule. The list of medications available to prisoners, including pain medication, can be found in the CSC's National Drug Formulary (Correctional Service Canada 2013a). This document is the CSC's official list of drugs that prison physicians may prescribe. It confirms that, aside from Tylenol 3 and methadone, there is no pain medication available (Office of the Correctional Investigator 2015).

Without more detailed CDs, it is difficult to assess how the CCRA's medical provisions are being respected or implemented. Regardless of these gaps in the administrative framework, it would appear that chronic pain treatment and end-of-life care fall under essential health care (Correctional Service Canada 2015: 7), which is mandatory according to the statute (CCRA, s. 86). An in-depth study of the management of chronic pain would need to be undertaken to assess how pain management is treated in the community at "acceptable standards of the profession." However, it is reasonable to expect that there is more than Tylenol 3 available in the community and that people in pain are not being sent to segregation or expected to pick up medication daily by standing outside for hours. Thus, in the future, both the policy regarding the treatment of chronic pain and the CSC's practices in this regard may form the object of legal scrutiny under s. 86 of the CCRA.

S. 4(h) of the CCRA states that correctional policies, programs, and practices need to respect gender, ethnic, cultural, and linguistic differences and be responsive to the special needs of women and indigenous peoples as well as to the needs of *other groups of offenders with special requirements* (emphasis added). S. 70 of the act states that the CSC must take reasonable steps to ensure that the prison environment and its living and working conditions are safe, healthy, and free of practices that undermine a person's future reintegration into the community. The data collected point to the fact that CSC policies may not actually take into consideration some problems of older prisoners. The particular effects of age on health and the physical capacities of seniors do not

appear to factor into service performance and policy development. For instance, there is no mention of older prisoners in any medical or other type of CDs and regulations.

In contrast, there are CDs recognizing the differences that women, indigenous, and ethnocultural prisoners present compared to the mainstream population (Commissioner's Directive 577, 2013; 578, 2013; 702, 2013; 767, 2013; 800, 2011; 805, 2003; 821, 2009). A similar CD is needed for older prisoners since they appear to have special needs too. In addition, an administrative framework that accounts for their enhanced medical and programming needs, created in accordance with gerontology studies, would eliminate the differences in the treatment of older prisoners that currently exist among institutions. Such a framework would also raise awareness about the vulnerabilities of older people and might play a role in preventing the victimization of this group by staff as well as disciplinary responses to their illness-induced disruptive behaviour. Such practices may, in fact, be contrary to s. 70 of the CCRA, and efforts need to be made towards their systematic suppression.

As stated above, compliance with Charter rights is mandatory when devising any form of federal policy. However, the data collected for this study suggest that there may be some issues regarding the compliance of CSC policies, or their implementation, with the human rights framework. Three Charter sections come specifically to mind in the context of pain management. First, s. 12 guarantees everyone's right to be free from cruel and unusual treatment and punishment. This section has been interpreted to apply to conditions of confinement (*R v Smith* [1987]; *Trang v Alberta [Edmonton Remand Centre]* [2010]; *R v Munoz* [2006]). Thus, if certain conditions are so grossly disproportionate as to outrage the standard of decency, they may be found to be unconstitutional. Requesting someone in chronic pain to stand outdoors for an hour daily to pick up pain medication, which is often ineffective, might therefore constitute cruel and unusual treatment. Furthermore, if effective treatment or medical supplies that would ease the pain associated with the diseases of old age are indeed not generally available, and if the institutions' environment or infrastructure adds disproportionately to the challenges these prisoners face, such treatment may grossly exceed the punishment to which these people have been sentenced.

Second, s. 7 of the Charter states that "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." While this section has generally been applied to legislation, as opposed to

policy, there is no prohibition that would forbid courts from considering a challenge to prison policies under it. S. 7 has been interpreted as protecting physical liberty, the right not to be exposed to health risks, to have control over one's body, and to psychological integrity (Hogg 2013: 44–47, 47–48). In the past, it was found that legislation indirectly limiting access to medical care (*Chaoulli v Quebec [Attorney General]* [2005]), as well as ministerial decisions that restrict access to health care (*Canada [Attorney General] v PHS Community Services Society* [2011]), endanger life and security of the person in a manner incompatible with the principles of fundamental justice. For prisoners who essentially lack any control over their medical treatment, it is possible that some policies related to pain management (and, in particular, the prohibition of a wide variety of painkillers, assistive devices, and cell-to-cell distribution of medication) may, in certain circumstances, be found to endanger the life and security of the person.

Third, s. 15 of the Charter states that "every individual is equal before the law and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." S. 15 has been interpreted to apply to both direct and indirect discrimination (*Law v Canada [Minister of Employment and Immigration]* [1999]). As such, treating everyone the same does not ensure that s. 15 is respected. When the same treatment has disproportionate effects on a certain category of people based on their race, nationality, religion, sex, age, or mental or physical disability, the state may take affirmative action for the benefit of the disadvantaged group, especially since s. 15(2) insulates affirmative action programs from s. 15 challenges (*Eldridge v British Columbia [Attorney General]* [1997]; *R v Kapp* [2008]). Thus, when the same correctional policies and practices (such as distribution of medication, availability of supplies, types of discipline, etc.) are applied on a one-size-fits-all basis, without consideration of the fact that this may place considerable hardship on aging people, concerns regarding indirect age-based discrimination emerge.

Litigation, including Charter litigation, has been used before to force redress in correctional settings and compliance with human rights norms. At the moment, the use of solitary confinement for people with mental health issues is being litigated in both Ontario and British Columbia (CBC News Online 2015; Fine 2015; Metha 2015) following suicides in segregation, increased empirical research, and media outcry. However, as Michael Jackson remarked more than 15 years ago

when discussing the legality of solitary confinement and the administrative procedure that led to it, the strength of the Charter should not come from its litigation potential. Rather, its strength should come from the values with which it widely and systematically infuses governmental practices and policies and from "the climate and culture of respect it creates amongst both governments and citizens for fundamental human rights and freedoms" (Jackson 2002: 62). Litigation should instead occur in exceptional situations, while Charter values and rights should be found in all aspects of public life.

It is in this context that I suggest that some prison practices and policies need amending to ensure protection for older people. While my suggestion originates from my interviews with older prisoners, I am not the first to make it. The correctional investigator has also been reiterating the need for age-driven policies for the last five years (Sapers 2011: 20–25; 2012: 14; 2014: 15–18). Reform should be undertaken before litigation becomes the only feasible solution to enhancing older prisoners' rights.

4. Policy suggestions

The data derived from this study have their limitations, and they cannot be said to offer a comprehensive picture of the overall legality of the CSC's medical or other policies. However, they do offer a unique glimpse into the life of older prisoners living with chronic pain. Based on these accounts, the great medical needs of aging prisoners do not appear to be met with any regularity. Improving chronic pain management is more than providing access to better pain medication. While more diverse painkillers, a safer environment, better infrastructure, and a rethinking of medication distribution would go a long way, many policies will need to include consideration for the increasing number of aging bodies, their limitations, and the challenges they face. After all, the definition of essential health care and how it should be provided for a 20-year-old may be very different from what is appropriate for a 70-year-old. In the future, evaluating medical necessities by the same yardstick, without systematically considering age as a factor in correctional policies and practices, may lead to moral dilemmas and legal challenges analogous to those presented above. To prevent that from happening, some recommendations will be provided below that may help align correctional policies with the needs of older prisoners and their rights.

4.1 Improvement of commissioner's directives

Commissioner's directives (CDs) are administrative documents meant to set a framework for uniformly regulating issues among CSC institutions. A CD regulating the treatment of older prisoners behind bars would go a long way towards protecting this group's needs. There are CDs that recognize the differences of women, indigenous, and disabled prisoners compared to the mainstream population. Hence, it is the duty of each correctional institution to adapt to those needs in accordance with the CDs' guidelines. A similar CD is needed for older prisoners. The correctional investigator has already remarked that aging people, the mentally ill, and those in need of palliative care are some of the most vulnerable prison populations (Sapers 2014: 15). The indiscriminate application of the same medical practices across all age groups fails to account for seniors' particular problems and potentially enhanced medical needs.

It would not be surprising if future medical research proves that such a uniform application is medically inadequate and may not respond to the needs of older people. A correctional framework that accounts for enhanced medical and programming needs, created in accordance with gerontology studies, would eliminate treatment differences that currently exist among institutions, and it would ensure a minimum of protection in accordance with human rights. A CD on managing the problems of older prisoners would also reflect the CSC's understanding of such problems as well as its commitment to act in accordance with these people's needs, and it would serve as guidance for CSC staff members who deal with such people and their issues on a daily basis.

In addition to a CD addressing seniors' needs, the already existing directives require improvement. These health care CDs are extremely important, but at the moment, they are vague and very difficult to apply. There is little guidance regarding what primary or essential health care is. It is also not clear what "acceptable standards of the profession" are. However, these concepts are key to determining what prisoners are entitled to. This is why, for example, chronic diseases are being managed by granting prisoners medical equipment in some institutions, but the doctor is completely forbidden to prescribe them in other institutions. The CDs and standing operating practices should not be a mere reiteration of the existing legislation. They should instead clarify it and provide for a relevant framework.

4.2 Reconfiguration of the health care system

The Office of the Correctional Investigator noted in its last few reports that prison health care needs to be reformed with an aging population in mind (Sapers 2011: 25; 2014: 16; 2015: 11). The insufficient treatment options for chronic pain due to "ill-defined security, administrative, or institutional concerns" (Office of the Correctional Investigator 2015: n.p.) have been noted by the Office based on an extensive qualitative review of the CSC's National Drug Formulary. Based on this review, the Office recommended that the CSC amend its formulary in areas such as chronic pain management, where treatment options appear to be lacking (Office of the Correctional Investigator 2015; Sapers 2015: 10). Previously, the correctional investigator mentioned that neither pain management nor assistive medical devices for the aging exist in satisfactory quantities and quality (Sapers 2011: 22). He also noted that, in this environment, there is a need for staff members and specialists trained in gerontology and palliative care (Sapers 2011: 25).

The findings of this study confirm and add to these concerns raised by the correctional investigator. They reinforce the need for a restructuring of prison health care. Considering the growing number of older prisoners and the CSC's lack of experience with them, this restructuring should be done in consultation with gerontology specialists. However, a few things should be considered as starting points.

First, the medication available for pain management is insufficient and of limited diversity. The little medication available appears to lead to pain going untreated, which, in turn, appears to alter the quality of life of older prisoners, who cannot rest properly and are turning in higher numbers to drug and alcohol abuse.

Second, the consequences of ineffective treatment of pain and chronic diseases, as well as medication, may have unique impacts on the well-being of older people. Hence, the prison doctor should be able to consult with a gerontology specialist on a regular basis. The CSC should contract with gerontology specialists, who should regularly visit institutions with a higher number of older prisoners. This would be similar to CSC contracts with other specialists, such as dentists and psychiatrists. Where gerontologists cannot be brought on site, they should be available through tele-medicine. This is also not an unusual practice as the CSC already uses tele-psychiatry in some of its remote locations. In addition, in institutions with high numbers of seniors, a nurse trained in gerontology should be available at least during the day. Consulting with

gerontology specialists can prove crucial in determining which behaviour needs to be responded to with treatment or with discipline. For example, it appears common that disruptive behaviour in older prisoners is caused by mental or physical problems. Solitary confinement and other forms of punishment are not appropriate responses in such cases.

Third, in light of the increased number of chronic and acute diseases leading to the pain and other complications that seniors face, all prison facilities should have a nurse on site at all times. Under half of the prisons I visited had a nurse available 24/7, and some institutions are in remote locations, where even ambulances take longer to arrive.

Fourth, pain management means more than an adequate range of effective painkillers. The current list of assistive devices available is restrictive. Supplies such as extra pillows, medical mattresses, heating pads, and orthopaedic shoes are currently never prescribed. Others, such as braces, can be prescribed, but the interviews with older prisoners show that such prescriptions vary from institution to institution. Clearly, these rules have not been made with the problems of aging prisoners in mind. They need to be reconsidered, perhaps with the help of gerontology specialists.

Fifth, distribution of medication for the elderly needs to be redesigned. It is counter-intuitive to ask someone in pain to stand in line for an hour, outside, rain or shine, to pick up his pain medication. Of the seniors I interviewed, 90% reported taking prescription medication. Clearly, they are the most likely population to pick up medication daily when they are being afflicted by the pain associated with aging. If, for security reasons, they cannot be given a month's worth of medication at a time, then a nurse should bring their medication every day to their cells. This should be an integrated part of pain and disease management. While such reform is in progress, seniors should be given priority in picking up their medication, and pill distribution should begin for them half an hour or so earlier than for everyone else.

4.3 Creation of seniors-only units

A senior-centred health care system would be more achievable if at least some of the institutions offered seniors-only units. Such arrangements would also address other age-related concerns such as vulnerability, victimization, and appropriate infrastructure. An overwhelming number of the participants in this study (93%) indicated that they believed their quality of life would increase if they were housed in

seniors-only units. This may be explained by the high rates of victimization that some of the seniors encountered. However, 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 units and that many were left on the outside. There was also a tendency to house younger, vulnerable prisoners 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 a prisoner was locked up for 23 hours daily. Also, 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.

A seniors-only unit can be created in a manner that offers appropriate stimulation and socialization. It would also provide managerial benefits. Older prisoners reported relatively low disciplinary incidents (31%, with only 6.1% for violent behaviour) and relatively low rates of time spent in segregation (23.4%, with only 20% for violent behaviour). They also reported good relationships with staff (89.3%). For his part, the correctional investigator reported that older prisoners are, as a rule, a low-risk population (Sapers 2011: 23). Both my study and his report confirmed that disruptive behaviour in this population tends to be associated with illness (ibid.). Thus, the security cost in seniors-only units could be lower, in favour of higher investment in health and programming. It would allow for specialized medical care without the same concern about drug abuse or dealing. Medication could be distributed in a more age-sensitive manner, and the infrastructure could be adapted to be more disability-friendly. Such accommodations would not have to be available in all institutions, but prisons that cannot offer them should not house seniors. As an interim measure, participants indicated that even a seniors' lounge where they can spend their daytime without fear of being bullied would be an improvement over the current state of affairs.

Some U.S. models of older prisoner–care units (True Grit at the Nevada Correctional Centre; Ohio's Hocking Correctional Facility; Angola Prison, Louisiana; Pine Bluff, Arkansas; Whitworth Detention Center, Georgia; the Minnesota Correctional Facility's Stillwater seniors' dormitory; Mississippi State Penitentiary; and Old Men's Colony, West Virginia) could be used as examples for enhancing correctional

practices, especially in the areas of pain management, mental health, and end-of-life care (Aday 2003; Rikard and Rosenberg 2007).

4.4 Mandatory staff training on geriatric matters

Data suggest that some seniors are being stigmatized and that their vulnerability due to age and disability is exploited inside prisons. It is unacceptable to have correctional staff members making fun of incontinent individuals. It is equally unacceptable to steal prisoners' walking aids to play tricks on them. Name-calling by staff members was reported by the participants as part of their day-to-day living. While calling prisoners "Old fart" and "Pops" may not be regarded as a big deal in the correctional setting, and prisoners learn to ignore it, it still has negative psychological consequences. Name-calling reminds older people that they are more vulnerable and so, somehow, less worthy of respect.

In Ohio, geriatric correctional training called "Try Another Way" was introduced, and positive results were reported (Rikard and Rosenberg 2007; Kerbs and Jolley 2014). Correctional officers are not just security guards; they should also be role models, and a prison environment is only as good as its front-line workers. It might be hard for officers to understand that, with the aging of the population, care needs to be combined with security, more so than before. This is why proper training is of primary importance.

4.5 Creation of prison hospices/palliative care units

Currently, there are no hospice beds available in Canadian prisons, and palliative care is not systematic (Correctional Service Canada 2009; Sapers 2014). Palliative care is sometimes given to prisoners, but that happens because of the efforts of different agencies and volunteers, not because of the CSC (Sapers 2011: 24). Coupled with the fact that compassionate release options are highly restrictive (CCRA, s. 121), the situation of terminally ill prisoners is not very good. Compassionate release is not available to people serving life sentences, and it is rarely used even for other groups (Sapers 2013: 20).

In contrast, prison hospices and palliative care units have flourished throughout the U.S. (Angola Prison, Louisiana; Maryland Hospice Program; Federal Medical Center, Carswell Ft. Worth, Texas; Broward Correctional Institution, Florida; Oregon State Penitentiary; United States Medical Center for Federal Prisoners, Missouri; Vacaville State Prison, California; Michael Unit, Tennessee Colony, Texas; Dixon

Correctional Center, Illinois) in response to the increasing number of people who die in prison (Delgado and Humm-Delgado 2009).

While there are not as many terminally ill prisoners in Canadian prisons as in the U.S., there are enough to justify at least one such unit per region. All prisoners approaching death should be released or housed in a palliative care unit. Security should be relaxed, medical care enhanced, palliative care specialists available 24/7, and family visits strongly encouraged and facilitated. These prisoners should have access to legal advice for the writing of wills and advance directives. An alternative, or perhaps a better, solution would be to create palliative care units in correctional community centres. These centres are institutions where individuals are housed if they are on parole or under other types of releases. The community centres are still correctional institutions, but security is more flexible, and a significant number of older and sick prisoners are already housed there (Sapers 2014: 11–17). This would, however, mean a significant improvement in the compassionate release mechanism and a commitment to send most terminally ill prisoners to centres that include palliative care units.

5. Conclusion

The aging of the prison population is still an under-explored and emerging issue, and it will continue to present increasing burdens on correctional systems in the future. At present, this group of prisoners is the fastest growing, and their needs, based on the little information currently available, appear to be both great and different from those of the mainstream prison population. The study that I conducted, while far from sufficient for establishing with certainty the medical needs of, and the CSC's limitations in providing for, older prisoners, does illustrate how prisoners perceive aging, how they deal with chronic pain, and how chronic pain affects their life and adjustment to prison. These findings are aligned with some of the findings or suppositions of the Office of the Correctional Investigator, and it is likely that future research will also confirm them. Should this be the case, compliance of the correctional system with the legal framework in general, and the human rights one in particular, might be called into question. The current study points to problems pertaining to the enhanced hardship that older prisoners face in serving their sentences due to chronic pain, age-associated diseases, and lack of an age-sensitive environment. Arguments may be accordingly made that such issues are not part of the sentence rendered by the judge, that they make the experience of older

people harsher than that of their younger counterparts, and that the older prisoner's life and health is ultimately threatened by less than satisfactory and age-inappropriate "essential health care."

As mentioned, more research is needed. It is, however, likely that most studies would confirm that age-sensitive policies are required. Hence, it is advisable that the CSC use the information currently available and begin a systematic reform of its policies, especially its medical policies. Such reform would not only be humane, but would also prepare the CSC for an expected increase in the number of aging prisoners and minimize the likelihood of potential future litigation on such issues.

Note

1 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, http://www.medbroadcast.com/.

References

Aday, Ronald H.
1994 Golden years behind bars: Special programs and facilities for elderly inmates. Federal Probation 58 (2): 47–55.

Aday, Ronald H.
2003 Aging Prisoners. Westport, CT: Greenwood.

Andrade, Flavia C.
2010 Measuring the impact of diabetes on life expectancy and disability-free life expectancy among older adults in Mexico. Journals of Gerontology. Series B (Psychological Sciences and Social Sciences) 65 (3): 381–89. doi: 10.1093/geronb/gbp119.

Arbel, Efrat
2015 Contesting unmodulated deprivation: Sauvé v Canada and the normative limits of punishment. Canadian Journal of Human Rights 4 (1): 121–41.

Arbour, Louise
1996 Commission of Inquiry into Certain Events at the Prison for Women in Kingston. Ottawa: Public Works and Government Services.

Arndt, Stephan, Carolyn L. Turvey, and Michael Flaum
2002 Older offenders, substance abuse and treatment. American Journal of Geriatric Psychiatry 10 (6): 733–39. http://dx.doi.org/10.1097/00019442-200211000-00012.

Blackburn, James A. and Catherine N. Dulmus, eds.
2007 Handbook on Gerontology: Evidence-Based Approaches to Theory, Practice, and Policy. Hoboken, NJ: Wiley. http://dx.doi.org/10.1002/9781118269640.

Canadian Public Health Association
2004 A health care needs assessment of federal inmates in Canada. Canadian Journal of Public Health 95: 1–63.

Cassel, Christine K., Jarvey J. Cohen, and Eric B. Larson
2003 Geriatric Medicine: An Evidence-Based Approach. New York: Springer.

CBC News Online
2015 John Howard Society, BCCLA sue Ottawa over use of solitary confinement. 19 January. http://www.cbc.ca/news/canada/british-columbia/john-howard-society-bccla-sue-ottawa-over-solitary-confinement-1.2917930.

Colsher, Patricia L., Robert B. Wallace, Paul L. Loeffelholz, and Marilyn Sales
1992 Health status of older male prisoners: A comprehensive survey. American Journal of Public Health 82 (6): 881–84. http://dx.doi.org/10.2105/AJPH.82.6.881.

Correctional Service Canada
2009 Hospice Palliative Care Guidelines for Correctional Service Canada. Ottawa: Correctional Service Canada. Obtained through an *Access to Information Act* request.

Correctional Service Canada
2013a National Drug Formulary. Ottawa: Correctional Service Canada. Obtained through an *Access to Information Act* request.

Correctional Service Canada
2013b Response of the Correctional Service of Canada to the 38th Annual Report of the Correctional Investigator 2010–2011. Ottawa: Correctional Service Canada. http://www.csc-scc.gc.ca/publications/ci10-11/index-eng.shtml.

Correctional Service Canada
2014 Older Offenders in the Custody of the Correctional Service of Canada. Research in Brief No. 14-21. Ottawa: Correctional Service Canada. http://www.csc-scc.gc.ca/research/005008-rs14-21-eng.shtml.

Correctional Service Canada
2015 National Essential Health Services Framework. Ottawa: Correctional Service Canada. Obtained through an *Access to Information Act* request.

Delgado, Melvin and Denise Humm-Delgado
2009 Health and Health Care in the Nation's Prisons: Issues, Challenges, and Policies. Lanham, MD: Rowman & Littlefield.

Fine, Sean
2015 Ontario government sued for putting youth in solitary confinement. Globe and Mail, 4 November. http://www.theglobeandmail.com/news/national/ontario-faces-lawsuit-for-putting-young-offenders-in-solitary-confinement/article27107663/.

Gallagher, Elaine M.
2001 Elders in prison: Health and well-being of older inmates. International Journal of Law and Psychiatry 24 (2–3): 325–33. http://dx.doi.org/10.1016/S0160-2527(00)00080-7.

Gobeil, Renee
2014 Older women offenders. Research Snippet no. 14-3. Ottawa: Correctional Service Canada. http://www.csc-scc.gc.ca/research/005008-rs14-03-eng.shtml.

Greiner, Leigh and Kim Allenby
2010 A descriptive profile of older women offenders. Research Report no. R-229. Ottawa: Correctional Service Canada. http://www.csc-scc.gc.ca/research/005008-0229-eng.shtml.

Halter, Jaffrey B. and William R. Hazzard
2009 Hazzard's Geriatric Medicine and Gerontology. 6th ed. New York: McGraw-Hill Medical.

Hogg, Peter
2013 Constitutional Law of Canada. Toronto: Carswell.

Jackson, Michael
2002 Justice behind Walls. Toronto: Douglas & McIntyre.

Jagger, Carol, Ruth Matthews, Fiona Matthews, Thompson Robinson, Jean-Marie Robine, and Carol Brayne
2007 The burden of diseases on disability-free life expectancy in later life. Journals of Gerontology. Series A (Biological Sciences and Medical Sciences) 62 (4): 408–515. http://dx.doi.org/10.1093/gerona/62.4.408.

Kerbs, John J. and Jennifer M. Jolley
2014 Senior Citizens behind Bars: Challenges for the Criminal Justice System. London: Lynne Rienner.

Kerr, Lisa
2014 Contesting expertise in prison law. McGill Law Journal / Revue de droit de McGill 60 (1): 43–94. http://dx.doi.org/10.7202/1027719ar.

Kouyoumdjian, Fiona, Andrée Schuler, Flora I. Matheson, and Stephen W. Hwang
2016 Health status of prisoners in Canada: Narrative review. Canadian Family Physician 62 (3): 215–22.

Lemieux, Catherine M., Timothy B. Dyeson, and Brandi Castiglione
2002 Revisiting the literature on prisoners who are older: Are we wiser? Prison Journal 82 (4): 440–58. http://dx.doi.org/10.1177/0032885502238680.

McKenna, Matthew T., Catherine M. Michaud, Christopher J.L. Murray, and James S. Marks
2005 Assessing the burden of disease in the United States using disability-adjusted life years. American Journal of Preventive Medicine 28 (5): 415–23. http://dx.doi.org/10.1016/j.amepre.2005.02.009.

Metha, Diana
2015 Class-action suit launched over treatment of mentally ill inmates in federal prisons. thestar.com, 17 July. https://www.thestar.com/news/canada/2015/07/17/prisoners-class-action-lawsuit-federal-government-solitary-confinement-mental-illness-james-sayce-class-action-suit-launched-over-treatment-of-mentally-ill-inmates-in-federal-prisons.html.

Michel, S., R. Gobeil, and A. McConnell
2012 Older Incarcerated Women Offenders: Social Support and Health Needs. Research report no. R-275. Ottawa: Correctional Service Canada.

Office of the Correctional Investigator
2015 National Drug Formulary Investigation: Summary of Findings and Recommendations. http://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20150127-eng.aspx.

Ornduff, Jason S.
1996 Releasing the elderly inmate: A solution to prison overcrowding. Elder Law Journal 84: 173–82.

Parkes, Debra
2007 A prisoners' charter? Reflections on prisoner litigation under the *Canadian Charter of Rights and Freedoms*. University of British Columbia Law Review 40 (2): 662–705.

Parkes, Debra and Kim Pate
2006 Time for accountability: Effective oversight of women's prisons. Canadian Journal of Criminology and Criminal Justice (April): 251–85.

Public Safety Canada
1998 Corrections and Conditional Release Statistical Overview. Ottawa: Solicitor General Canada.

Public Safety Canada
2014 Corrections and Conditional Release: Statistical Overview. Ottawa: Public Safety Canada Portfolio Corrections Statistics Committee. https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ccrso-2014/index-en.aspx.

Rikard, R.V. and Ed Rosenberg
2007 Aging inmates: A convergence of trends in the American criminal justice system. Journal of Correctional Health Care 13 (3): 150–62. http://dx.doi.org/10.1177/1078345807303001.

Sapers, Howard
2011 Annual Report of the Office of the Correctional Investigator 2010–2011. Ottawa: Office of the Correctional Investigator. http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20102011-eng.aspx%23ss6.

Sapers, Howard
2012 Older federal prisoners in Canada: Summary of the issues and challenges. Paper presented at the annual meeting of the Academy of Criminal Justice Sciences, New York.

Sapers, Howard
2013 Annual Report of the Office of the Correctional Investigator 2012–2013. Ottawa: Office of the Correctional Investigator. http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20122013-eng.aspx.

Sapers, Howard
2014 Annual Report of the Office of the Correctional Investigator 2013–2014. Ottawa: Office of the Correctional Investigator. http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20132014-eng.aspx.

Sapers, Howard
2015 Annual Report of the Office of the Correctional Investigator 2014–2015. Ottawa: Office of the Correctional Investigator. http://www.oci-bec.gc.ca/cnt/rpt/annrpt/annrpt20142015-eng.aspx.

Uzoaba, Julius H.E.
1998 Managing Older Offenders: Where Do We Stand? Correctional Service Canada Research Report. http://www.csc-scc.gc.ca/research/r70-eng.shtml.

Webster, Cheryl Marie and Anthony N. Doob
2014 Penal reform "Canadian Style": Fiscal responsibility and decarceration in Alberta, Canada. Punishment & Society 16 (1): 3–31. http://dx.doi.org/10.1177/1462474513506272.

Legislation and policies cited

Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11.

Commissioner's Directive no. 081. Offender Complaints and Grievances. 2014, 13 January.

Commissioner's Directive no. 577. Staff Protocol in Women Offender Institutions. 2013, 22 July.

Commissioner's Directive no. 578. Intensive Intervention Strategy in Women's Institutions. 2013, 22 July.

Commissioner's Directive no. 702. Aboriginal Offenders. 2013, 12 November.

Commissioner's Directive no. 767. Ethnocultural Offender: Services and Interventions. 2013, 26 June.

Commissioner's Directive no. 800. Health Services. 2011.

Commissioner's Directive no. 805. Administration of Medication. 2003.

Commissioner's Directive no. 821. Management of Infectious Diseases. 2009.

Corrections and Conditional Release Act, SC 1990, c 20.

Cases cited

Canada (Attorney General) v. PHS Community Services Society, [2011] 3 SCR 134.

Chaoulli v. Quebec (Attorney General), [2005] 1 SCR 791.

Eldridge v. British Columbia (Attorney General), [1997] 3 SCR 624.

Law v. Canada (Minister of Employment and Immigration), [1999] 1 SCR 497.

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

R. v. Munoz, [2006] ABQB 901.

R v. Smith (Edward Dewey), [1987] 1 SCR 1045.

Trang v. Alberta (Edmonton Remand Centre), 2010 ABQB 6.