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A Framework for Legal Analysis:

The Aging & Elderly Prison Population

I. INTRODUCTION

The aging and elderly prison population in Canada faces challenges that require careful examination. When compared to the general public, older individuals in prisons have unique characteristics that cause them to experience greater incidents of chronic diseases, mobility impairments, and cognitive disorders.[1] The inaccessible and depreciating infrastructure, limited access to pain medication, and inadequate responses to peoples' health problems in penitentiaries worsen their physical and mental conditions and can cause premature death in some cases.[2] Older individuals require increased health and palliative care that prisons are not built to provide, which has led to complaints that involve healthcare and poor conditions of confinement.[3] Nevertheless, prisons have a duty to respond to their health concerns and provide the appropriate medical care.

A prison's duty of care to the individuals in its custody is established both in legislation and case law. **Correctional Service Canada (CSC) has a legal responsibility to provide health care services to those in its custody in the same capacity as they would receive health care outside of the prison.**[4] Unfortunately, this has not been the case. Incarceration disproportionately affects the elderly population in prisons, which has caused them greater health concerns from a lack of medical care and attention. Research on this subject also indicates that incarceration has had disproportionate psychological impact on elderly individuals from a fear of dying alone and not being able to be with their families at the end of their life. Gaps between CSC's policies and practices further heighten the risks this population experiences. Strategies to address these gaps would enhance CSC's ability to address those health care needs. By depriving this vulnerable population of their physical and mental health, CSC is at risk of legal battles for the breach of its duty of care to these individuals.

This framework looks at the legal context in which SLSC can advocate for elderly people in prison. It outlines the statutory duties and responsibilities of CSC within the legislation and shows how the experiences of the elderly population demonstrate how those duties are not being met. It also addresses gaps between CSC's policies and practices and recommends ways to improve the provision

[1] (Office of the Correctional Investigator, 2019).
[2] (Iftene, 2019a, August 15).
[3] (Public Safety Canada, 2019).
[4] (Correctional Service Canada, 2020).

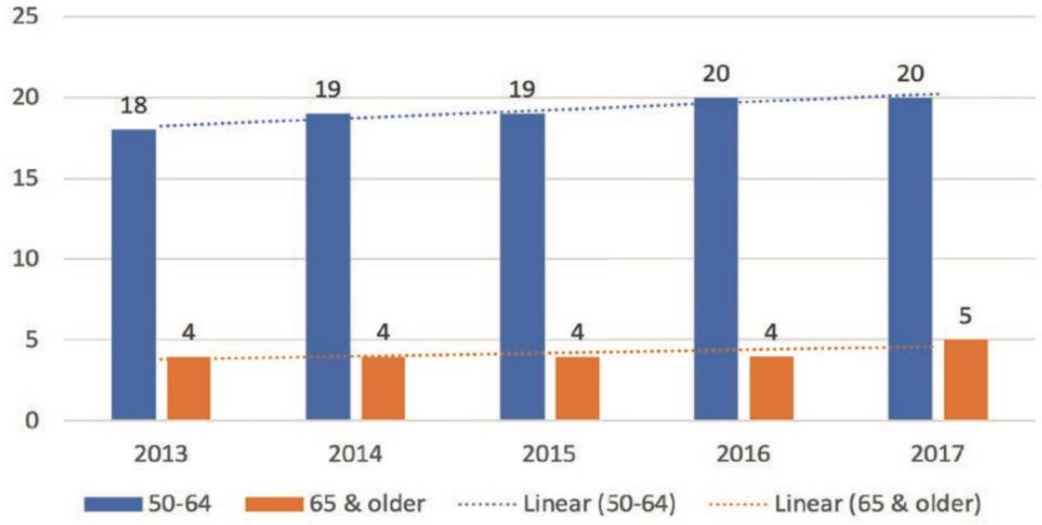
of services to the elderly population in prisons. The goal for this framework is to educate SLSC members and stakeholders on these legal responsibilities, the concerns being expressed within the community, and whether there are legal grounds for SLSC to advocate for change.

II. THE CURRENT STATE OF AFFAIRS

CSC's legal obligations become increasingly important as the older population in prisons continues to grow steadily. In the criminal justice context this has typically referred to people in conflict with the law age 50 and over, due to the accelerated aging effects of an institutionalized lifestyle. Age 50 is often demarcated by recognized authorities as the threshold for aging institutionalized individuals. In 2018, people aged 50 years and older in prison constituted 25.2% of the federally incarcerated population.[5] In 2017-18, there were 14,092 people in custody, with 2,833 individuals being 50 years of age or older.[6] Within this group, approximately 707 individuals were aged 65 and over.[7] Current trends have indicated a consistent increase in the elderly population under CSC custody, showing that people aged 50 (inclusive of people 65 and over) and people aged 65 and older in prisons have increased. **Figure 1** below shows this increase from 2013 to 2017.[8]

Figure 1

Growth Trends in Elderly Populations Under CSC Custody

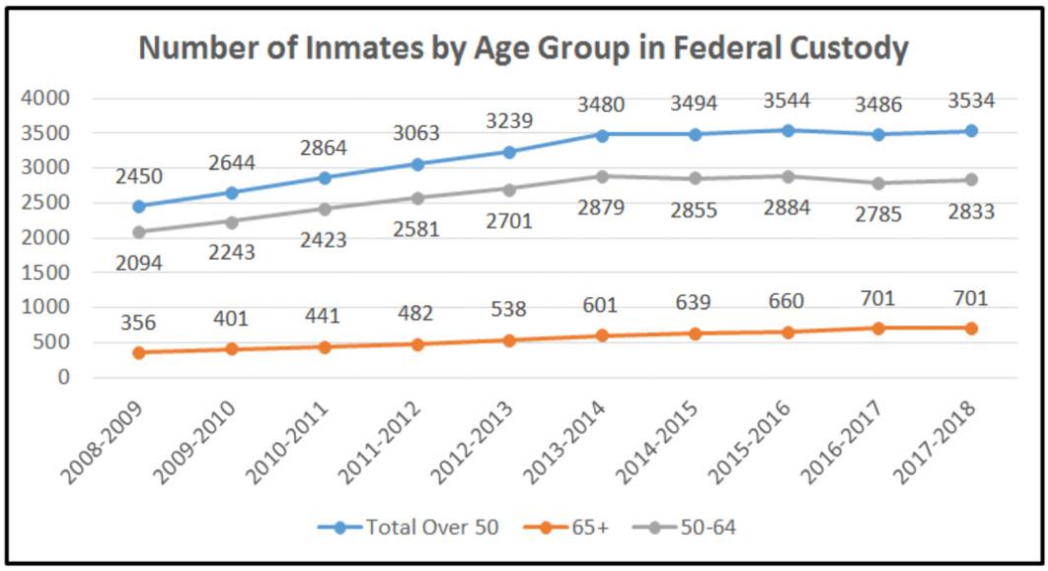


The Office of the Correctional Investigator (OCI) confirms these trends over the last 10 years. **Figure *2*** below shows the increase in the number of people in federal custody from 2008 to 2018 by age group.[9]

[5] (Iftene, 2019a, August 15).
[6] (Public Safety Canada, 2019)
[7] (Colibaba, 2019).
[8] (Colibaba, 2019).
[9] (Office of the Correctional Investigator, 2019).

Figure 2

Number of Inmates by Age Group in Federal Custody



- **For those 50 years of age and over:** in 2008-09 there were 2,450 individuals, while in 2017-18, there were 3,534, accounting for 25% of the federal prison population.
- **For those 50-64 years of age:** in 2008-09 there were 2,094 and 2,833 in 2017-18.
- For those 65 years of age and older: in 2008-09 there were 35 and 701 in 2017-18.

Based on sentence length and time served, there are many individuals aged 50 years and older who have aged behind bars. As of November 2018, the average age of those in federal prisons, including those previously incarcerated and released to the community, is now over 40 years of age and this is gradually increasing.[10] Specifically, there are:

- 316 individuals in federal penitentiaries aged 50 years and older who have served 20 years or more;
- 199 who have served 25 years or more;
- 125 who have served 30 years or more; and,
- 24 who have served 40 years or more.[11]

If we consider individuals aged 50 years and older serving their second or greater federal sentence:

- Approximately 600 individuals have spent 20 years (total, not consecutively) or more;
- Approximately 325 individuals spent 30 years or more; and
- Approximately 107 individuals spent 40 years or more.[12]

[10] (Office of the Correctional Investigator, 2019).
[11] (Office of the Correctional Investigator, 2019).
[12] (Office of the Correctional Investigator, 2019).

The rise in the aging population can be explained by the natural aging cohort in the community and effects of 'tough on crime' sentencing laws and policies that increased sentence lengths, increased periods of parole ineligibility, and reduced programming and staffing across prisons.[13] In many cases, long periods of incarceration no longer meet the original purpose of sentencing. The growing population of older individuals in federal custody being housed in facilities that were not designed to hold them in the first place, makes the issues of aging individuals in prison of increasing concern.

Deaths from Natural Causes

Between the 2009-10 and 2015-16 fiscal years, a total of 387 individuals died in federal custody.[14] Among those aged 55 or older who passed away, an overwhelming majority (88%) died of a natural cause compared to an unnatural cause (12%). Conversely, among those aged 18-54, a majority died of an unnatural cause (58%) compared to a natural cause (42%)[15]. This suggests that natural, health-related concerns were the leading cause of death for incarcerated individuals aged 55 and over.

Table 1

Deaths in Federal Custody, 2009/2010 to 2015/2016 by Cause of Death and Age[16]

Age	Natural	Unnatural	Total
18-54	78 (42%)	108 (58%)	186 (100%)
55+	176 (88%)	25 (12%)	201 (100%)
Total	254	133	387

Of the 254 people who died of a natural cause during this time period, 61% had four or more chronic health conditions.[17] The three most common chronic health conditions among those who passed away due to a natural cause were cardiovascular (71%), respiratory (46%), and gastrointestinal (39%).[18] Between the years 2009/2010 to 2014/2015, 212 incarcerated individuals passed away in custody due to a natural cause.[19] The three leading natural causes of death were cancer (35%), cardiovascular related (28%), and respiratory related (12%).[20] As such, these figures further reveal the current state of affairs and the increased need to provide adequate care to the older individuals.

[13] (Colibaba, 2019).
[14] (Correctional Service Canada, 2018a, January 12).
[15] (Office of the Correctional Investigator, 2019).
[16] (Correctional Service Canada, 2018a, January 12).
[17] (Colibaba, 2019); This data is not specific to those aged 55 and over because age-specific data was not available. Those aged 55 and over accounted for 69% of all-natural deaths during this period.
[18] (Colibaba, 2019).
[19] (Colibaba, 2019); Calculated from Table 5.
[20] (Colibaba, A. 2019); This data is not specific to those aged 55 and over because age-specific data was not available. Those aged 55 and over accounted for 69% of all-natural deaths during this period (see note 15).

III. WHAT ARE CSC'S LEGAL OBLIGATIONS?

Legislation imposes a duty of care on CSC that holds it liable for providing adequate services and a safe environment to the individuals in its custody. CSC's operation of its penitentiaries is regulated by *Corrections and Conditional Release Act* (CCRA), which imposes a number of standards onto CSC. In fact, the CCRA states that 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."[21] Consequently, CSC's mandate follows this provision of the CCRA. The CCRA regulates all aspects of life in prison to ensure individuals are in safe and humane custody and supervised for the purpose of habilitating and integrating them into the community. CSC's failure to meet its various obligations up to standard, particularly with regards to providing necessities of life and safe premises, can expose CSC to legal liability.

A Duty to Provide Medical Care

CSC has a duty to provide health care services to those in its custody. Under section 86(1) of the CCRA, **CSC is obligated to provide every incarcerated person essential health care and reasonable access to non-essential health care.**[22] The CCRA requires registered health care professionals to provide health care services to incarcerated individuals, which includes physical and mental health care, that conforms to professionally accepted standards.[23] CSC is also responsible for taking care of people in their custody according to the principles set out in the CCRA. In particular, the correctional policies, programs and practices **must be responsive to the needs of distinct groups, including those requiring mental health care and "other groups***"*.[24] These duties are also expected of prison staff and contracted health professionals who are not CSC employees.[25] Under Section 87 of the CCRA, CSC must take into consideration an individual's health status and health care needs for all decisions relating to placement, transfer, confinement in a Structured Intervention Unit (SIU; formerly administrative segregation, i.e. solitary confinement), disciplinary matters, release, and supervision.[26] Therefore, CSC must ultimately fulfil their obligations to assist individuals with their habilitation and community integration.

[21] (Corrections and Conditional Release Act, 1992).
[22] (Corrections and Conditional Release Act, 1992).
[23] (Corrections and Conditional Release Act, 1992).
[24] (Corrections and Conditional Release Act, 1992).
[25] Iftene et al., 2014).
[26] (Corrections and Conditional Release Act, 1992).

A Duty to Provide Access to Patient Advocacy Services

CSC has a duty to provide access to patient advocacy services to individuals in penitentiaries under section 89.1 of the CCRA.[27] Under this provision, the services are intended to (a) support incarcerated people in relation to their health care matters and (b) enable incarcerated people and their families/support person to understand the rights and responsibilities in relation to health care. CSC procedures are set out in Commissioner's Directives (CD), which are the internal governing policies that CSC's practices. Health Services Commissioner's Directive 800 indicates that the responsibility to provide patient advocacy services falls under the scope of health care professionals.[28]

A Duty to Provide a Safe and Healthful Environment

CSC has a duty to provide adequate accommodations to those serving a sentence in and out of prison walls. Under Section 70 of the CCRA, CSC has an obligation to ensure that the living conditions of individuals inside the prison are safe, healthful and free of practices that undermine a person's sense of dignity.[29] The purpose of the CCRA is for the corrections system to maintain a just, peaceful, and safe society by allowing individuals to carry out their sentences in safe and humane custody and assist with their habilitation and successful integration into the community.[30] As such, CSC is required to use the least restrictive measures and consider alternatives to prison custody while taking into account the safety of the individual, others in the penitentiary, and the public.[31]

A Duty Not to Discriminate Based on Age

Violations of human rights may face CSC if services and facilities provided are found to be inadequate to elderly individuals in prisons. Under the *Canadian Human Rights Act* (CHRA), every person has a right to equal treatment with respect to services, facilities, and accommodations without discrimination based on a number of prohibited grounds, including age and disability.[32] Many older individuals in prisons also have physical and mental disabilities, but have experienced significant barriers and delays to receiving the proper services.[33] There is also a lack of disability-friendly infrastructure, access to painkillers, and in certain institutions, an obligation to wait in line for their medication outdoors despite the weather conditions. Many older individuals also experience issues that are inherent in the lack of infrastructure, such as an overuse of top bunks, lack of accessibility ramps and working elevators, and slippery pathways. The failure to accommodate the older and disabled individuals can constitute discriminatory practices under human rights statutes.

[27] (Corrections and Conditional Release Act, 1992).
[28] (Correctional Service Canada, 2019a, June 10).
[29] (Corrections and Conditional Release Act, 1992).
[30] (Corrections and Conditional Release Act, 1992).
[31] (Iftene, 2019b, April 3).
[32] (Canadian Human Rights Act, 1985).
[33] (Office of the Correctional Investigator, 2019).

A Duty to Uphold Its Constitutional Obligations

The *Canadian Charter of Rights and Freedoms* (Charter) also imposes obligations on CSC as a government agency. Similar to the provisions under the CHRA, Section 15 of the Charter also prohibits discrimination based on grounds such as age or disability. Section 7 guarantees that everyone has a right to life, liberty, and security of the person in accordance with the principles of fundamental justice. Additionally, Section 12 provides that everyone has a right to be free from cruel and unusual punishment. The physical and psychological harm that has been experienced by many older individuals in prisons due to CSC's failure to meet their medical needs, as well as other limitations in CSC practices, could be the subject to future Charter challenges.

A Duty to Respect Its Obligations Under International Instruments

Canada has signed, ratified, or adhered to binding and non-binding international human rights obligations to incarcerated individuals.[34] In addition to supporting the principles under the Universal Declaration of Human Rights, Canada has also ratified several UN human rights treaties, conventions, and covenants including the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (ratified by Canada in 1987).[35] Binding international agreements, such as conventions and treaties, create obligations for dual states like Canada, to incorporate them in national law.[36] The non-binding documents, like principles, declarations, and codes, are standards states aim to achieve. For instance, the *United Nations Minimum Rules for the Protection of Prisoners* (the Nelson Mandela Rules) is a non-binding instrument that requires that all prisons provide adequate sanitary installations and showers, expeditious medical treatments, sufficient medical personnel, that everyone who complains of illness is immediately seen.[37] The *United Nations Principles for Older People* is another non-binding instrument that requires incarcerated individuals to receive an appropriate level of health care, habilitation opportunities, social and mental stimulation and a human and secure environment.[38] Therefore, the CSC must also abide by the international instruments that address the obligations of prisons to protect the life and health of those in its care.

IV. CSC'S LEGAL OBLIGATIONS HAVE NOT BEEN MET

There is concern within the prison community that the older population has not been adequately cared for in a manner consistent with CSC's legal obligations. There have been studies done by people who have either been able to go into the prisons themselves to hear the concerns and experiences from the older individuals or have been able to gather information from sources within the prison

[34] (Iftene, 2019b, April 3).
[35] (Government of Canada, 2019, January 25; United Nations Human Rights Office of the High Commissioner, 2021).
[36] (Government of Canada, 2019, January 25).
[37] (Iftene, 2019b, April 3).
[38] (Iftene, 2019b, April 3).

community. The first-hand information that has been gathered clearly shows that CSC has not been doing enough to provide the care it *should* and *must* be providing to every person under its custody.[39]

The Office of the Correctional Investigator and the Canadian Human Rights Commission Report (2019)

The Office of the Correctional Investigator (OCI) and the Canadian Human Rights Commission (CHRC) issued a report that examined the experiences, challenges, and vulnerabilities of older individuals in Canadian prisons. In their February 2019 report, *Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody*, it is evident that aging and elderly individuals are not receiving the proper care they need. As such, the report made a set of recommendations focused on the conditions of confinement and release options for the older individuals. In response, CSC stated it already created a new policy framework, "Promoting Wellness and Independence – Older Persons in Custody (2018)", stating CSC was committed to maintaining optimal wellness and quality of life for older persons in custody. However, these commitments have not yet been seen in practice.[40] In 2018, the Correctional Investigator, Ivan Zinger, stated in the OCI's Annual Report, "aging offenders use a disproportionate share of prison health care services, are vulnerable to victimization and often reside in prisons that are inaccessible and ill-equipped to manage their health care needs".[41] Despite the warnings from the OCI's report, there are more gaps CSC needs to fill in order to provide sufficient care to meet its duty under the CCRA.

Adelina Iftene's Study: *Punished for Aging* (2019)

Adelina Iftene has also done numerous studies on the experiences of older individuals in prison to address the failure of CSC in meeting its duties to this vulnerable population. Iftene is a law professor at Schulich School of Law at Dalhousie University, where she teaches criminal law and prison law. In her recent book, *Punished for Aging: Vulnerability, Rights, and Access to Justice in Canadian Penitentiaries (2019)*, she discusses her study, which commenced in 2012, of 197 older men living their "golden years" behind bars in institutions across Ontario. Ontario is the most populated region, with the most correctional institutions at all levels of security and incarcerates some of the most diverse people from across Canada. Iftene found there were a number of violations of CSC's duties with regards to providing access to health care and accommodations.

First, there was a lack of medical supplies and devices for older individuals. The study found that the overall trend was that individuals were more likely to be refused health items they requested than they were granted.[42] One participant stated medical devices and supplies were hard to come by, where some items such as an extra pillow to place under one's legs to improve circulation required a medical note that required further approval by the warden. Even if requests like this were

[39] (Apa, et al. 2012).
[40] (Iftene, 2019b, April 3).
[41] (Iftene, 2019b, April 3, p. 29).
[42] (Iftene, 2019b, April 3).

approved, individuals would often have to purchase the items.[43] In this participant's institution, most prisoners earned $4.00 a day of work and were only allowed to have and use $500 a year from their "currency account" for ongoing needs such as shampoo, vitamins, and cream. These individuals would have to save for over two months to purchase a $10 bottle of shampoo. Although these items are not considered "essential" under CSC policies, CSC is still obligated to provide "reasonable access to non-essential health care" needs under the CCRA. This participant also recounted that it took 3 years to have his hearing tested and get hearing aids after raising hearing problem concerns. What is most disconcerting is that the medical personnel were aware of his specialized needs.[44]

Second, prisons did not provide sufficient access to pain medication or other means to address poor health conditions. According to CSC's *National Drug Formulary*, Tylenol 3 is the only prescription pain medication available, but in special cases, methadone or morphine is available.[45] However, most individuals who have chronic pain and all individuals encountered in the study stated Tylenol 3 did not ease their severe pain. Additionally, older individuals were not able to physically access what little that *was* available because picking up the medication every day added stress to their bodies and worsened their pain. Further, a number of conditions reported by the participants, most notably diabetes, were prescribed a medical diet.[46] However, only 11% were able to follow the diet and those who did not stated they would starve to death if they did follow it. CSC's Commissioner's Directive 880, "Food Services", requires medical diets to be available, but its Standard Operating Practices (SOP) 800-01 states the general food served should be adapted to meet most therapeutic diets. This one-size-fits-all diet deprives these older individuals of nutrition they require at the highest level.

Lastly, the study found there was a lack of medical professionals available. For many, seeing a medical professional for the conditions they experienced was challenging. Iftene found that no Ontario institution had more than one physician. The CSC regional hospitals only had one physician, no psychologist, and no social workers or occupational therapists.[47] Overall, 54% of participants mentioned there was no nurse available 24/7 in their institution, and there were long wait times to see a professional regardless of the severity of the problem. The study also found that there was a lack of consistent access to mental health care professionals. Iftene obtained a list of medical hires for the Ontario region through an *Access to Information* request and found there was a shortage of psychiatrists.[48] For instance, she found that Warkworth Institution in Ontario fell particularly short of assisting those with mental illnesses. There was only one psychologist to 600 individuals, where each was entitled to three counselling sessions for the duration of their stay. All 36 participants in the study that were serving time at Warkworth Institution stated getting access to a psychiatrist was close to impossible. Again, this does not align with the health care older individuals would receive in the community, further contravening CSC's legal duty under the CCRA.

[43] (Iftene, 2019b, April 3).
[44] (Iftene, 2019b, April 3).
[45] (Iftene, 2019b, April 3).
[46] (Correctional Service Canada, 2019c, July 23).
[47] (Iftene, 2019b, April 3).
[48] (Iftene, 2019b, April 3).

The few examples presented from the studies represent only a small portion of the experiences of the older individuals in prisons and demonstrates that CSC struggled to meet their legal obligations.

V. GAPS BET WEEN POLICY AND PRACTICE

There are gaps between CSC's policies and practices that contribute to the quality of care available to the elderly prison population. CSC is guided by policies found in its Commissioner's Directives and Standard Operating Practices. However, the challenge lies in ensuring that policy reflects the legal standards in place that govern CSC. CSC is also guided by other documents, such as the *National Drug Formulary*, that sets guidelines for the availability of certain products and medication to those in prison.[49] Yet, a lack of clarity in CSC policies, especially with legal obligations adequately reflected, may prevent older individuals to receive proper care in prisons. A further gap arises from requiring staff to study and apply the Commissioner's Directives more so than they are expected to understand the law. This issue is further amplified when staff are obliged to place more emphasis on security concerns than the health needs of incarcerated individuals.

The Lack of Accessible and Available Health Care Services

Health Care Services

The Commissioner's Directives 800 (Health Services) and associated guidelines are the key references on essential health services. However, there are a number of ambiguities in the Directive, which if addressed, could create greater assistance for older individuals in prison.

Essential and Non-Essential Health Care

It is not completely clear on what is considered essential and non-essential health care as required by the CCRA. The Commissioner's Directive defines "health services" as physical and mental health services, which include health promotion, disease prevention, health maintenance, patient education, and diagnosis of treatment and illness, in accordance with the *National Essential Health Services Framework*.[50] This Framework defines and lists essential and non-essential health services as per the CCRA requirement to "provide every [incarcerated person] with essential health care and reasonable access to non-essential health care".[51]

However, the list of what constitutes as essential health care may not be inclusive of services that *would* be essential for the older prison population. Appendix A of the Framework lists the essential health services, medical equipment, and supplies. The following are examples of health services that are not considered essential, but may be essential for older individuals:

- Orthopaedic mattresses and pillows
- Orthotics (i.e. custom shoe inserts or over the counter orthotics)

[49] (Iftene, 2019b, April 3).
[50] (Correctional Service Canada, 2019a, June 10).
[51] (Correctional Service Canada, 2019b, November 30).

- Chiropractic services
- Electric wheelchairs (while manual wheelchairs are approved as essential, electric wheelchairs must be approved by special authorization)

Under Appendix D, essential mental health services include intervention, treatment and supports for individuals with mental health needs, mental health screening, and follow-up assessments (as required), but it does not list any services under non-essential mental health services, stating only that reasonable access must be provided to non-essential mental health services. It becomes even more difficult for an individual to gain reasonable access to non-essential health care when the non-essential health services are at the individual's complete expense.[52] Furthermore, without specifying what is considered reasonable, including whether it is based on the capacity of current staffing of the institution or what would be reasonable in the community, it is left open to interpretation. Putting a blanket prohibition on these items contravenes section 86 of the CCRA, which requires that CSC provides every incarcerated person with essential health care and reasonable access to non-essential health care. Yet, the costs associated with healthcare are prohibitive to reasonable access.

Responsibilities of CSC Health Care Professionals

Health care professionals, including those providing services under contract, have responsibilities that require further clarification. These health care professionals are required to ensure health services are sensitive to the needs of Indigenous people, and women specifically, and those with special needs.[53] However, there is no definition of what "special needs" entails. One reason the aging population does not receive adequate health care is because it is not treated as separate from the rest of the prison population. CSC previously maintained that its assessment measures were adequate in addressing the needs of all people.[54] Although CSC committed to implement an initiative to improve its assessment procedures by March 31, 2018, it is still in draft form and has not yet been released. Still, the initiatives will not address aging persons' issues because the proposed initiatives are focused on helping them "age in place" within existing prison infrastructures. If an individual's needs based on *age* can be included within the scope of "special needs", there may be a greater opportunity for older individuals to receive health care.

Furthermore, the CCRA provides that CSC must support health care professionals in their promotion of patient-centred care and patient advocacy.[55] However, "patient advocacy" has not been defined, nor *how* CSC must fulfil this obligation. CSC has only clarified in an Interim Policy Bulletin[56] that it is the responsibility of its health care professionals, including those providing services under contract, who are responsible for patient advocacy to advance the individuals' health and well-being.[57] Yet, it is still unclear as to what patient advocacy services include and how they are to be provided.

[52] (Correctional Service Canada, 2019c, July 23).
[53] (Correctional Service Canada, 2015, April 27).
[54] (Office of the Correctional Investigator, 2019).
[55] (Corrections and Conditional Release Act, 1992).
[56] (Correctional Service Canada, 2019a, June 10).
[57] (Correctional Service Canada, 2019b, November 30).

Health Care Units

The CCRA states that a penitentiary or any area in a penitentiary can be designated as a "health care unit",[58] however, criteria for what constitutes as a "health care unit" is unclear. Section 86.3 of the CCRA states that the purpose of a health care unit is to provide an appropriate living environment to facilitate an incarcerated person's access to health care. The CCRA provides no other description of a health care unit. In an Interim Policy Bulletin, however, CSC states that only if individuals meet the admission criteria will they be admitted and discharged to a "Health Care Unit (Regional Treatment Centre)".[59] Although the CCRA states the decision to admit an individual to a health care unit is designated by, and in accordance with, the Commissioner's Directives, this does not include designating *what* is a health care unit. The admission process to a health care unit also requires clarity and imposes further restrictions on an individual receiving medical assistance. The process starts with a clinical referral by the individual's "most responsible health care provider".[60] However, it is unclear *when* the clinical referral must be done, who constitutes as one's "most responsible" health care provider, and who can make this decision. Following the referral, one is clinically admitted by a designated health official if they meet the admission criteria: only those with a mental illness or cognitive impairment that impacts their ability to function in a mainstream institution, requires 24-hour clinical care, and requires access to clinical programming will be admitted. However, "clinical programming" is also not defined.

Health Care Assessments

It is not enough that CSC has health care services available, but it also has an obligation to assess individuals in its custody to properly distribute these services. However, according to the studies, many older individuals in prison have not been able to access health care services at all or in a timely manner. For instance, if the screening procedure does not screen for cognitive disorders like dementia, then CSC is less obligated to provide care to people with those needs. The Commissioner's Directive 705-3 (Immediate Needs Identification and Admission Interviews) and 705-5 (Supplementary Assessments) require CSC to identify an incarcerated person's needs upon admission and must follow standards for the admission review. There are a number of ambiguities with the assessment processes that may limit the ability of older individuals in prison to get reasonable access to health care services.

Immediate Needs Identification Interview

Within 24 hours of arrival at a new institution, CSC is required to review the immediate needs for security and critical concerns.[61] The Commissioner's Directives provide sample surveys (see Annex C and D) to assess the immediate needs. However, there is no evidence that CSC specifically assesses health care needs upon entry. The Commissioner's Directive explicitly looks for security and suicide risks, but health needs are not explicitly mentioned nor are they covered in the example surveys in

[58] (Corrections and Conditional Release Act, 1992).
[59] Correctional Service Canada. (2019b, November 30).
[60] Correctional Service Canada. (2019b, November 30).
[61] Correctional Service Canada. (2018b, January 18).

Annex C and D. It is unclear whether health needs are included in "all immediate needs" and other language in the Directive.

Admission Interview

CSC must conduct admission interviews within five working days of admission to identify areas of need requiring immediate attention and confirm referrals to the relevant services.[62] The admission interview also covers administrative matters, such as preferred language and information on visitations. Nevertheless, it is unclear what constitute as "immediate".

Supplementary Assessments

Supplementary assessments are designed to provide information about the nature and severity of the specific dynamic factor to assist in decision making and program referrals.[63] It is unclear whether assessments and screening for mental health is mandatory. The Commissioner's Directive states that mental health screening, mental health assessments, and psychological risk assessments are completed, "when required". It further states that supplementary assessments should be completed during the intake assessment process *if* CSC requires additional information or if there are reasons to believe that the assessment(s) may assist in clarifying the overall risk posed by the individual. However, even if supplementary assessments are conducted to assess mental health, the CSC staff are not fully trained to screen for particular mental illnesses. Specifically, the OCI reported that CSC staff received little to no training with respect to dementia or Alzheimer's disease which was also the case among staff in community-based residential facilities.[64] CSC staff also indicated there are few resources to complete assessments of possible dementia. If people's conditions are not screened or noted for, behaviours caused by mental illness or cognitive impairment can be misinterpreted as disobedience, which may result in punishment. Furthermore, inaccurate and incomplete assessments can cause uncertainty as to whether the older individuals will receive the proper care.

Ineffective and Underutilized Use of Parole by Exception

CSC has a legal duty to use the least restrictive measures and consider alternatives to prison custody while considering the safety of the incarcerated person, others in the penitentiary, and the public.[65] However, underutilization of alternatives may put CSC at risk of breaching its obligations. One such option is serving time in the community by being granted parole by exception. The CCRA provides that people who are terminally ill may be granted parole by exception.[66] However, this requires that a person's date of death is anticipated within 6 months, which does not account for those who are terminally ill but may not have an imminent date of death.[67] This is incredibly limiting for older individuals in prison who do not likely pose a realistic public safety concern due to their condition. From a moral perspective, someone who is terminally ill but is unable to pinpoint a date of death should still have reasonable access to compassionate release. This conditional release option would enable ill and elderly prisoners to serve their remaining time in the community and with dignity.

[62] (Correctional Service Canada, 2018b, January 18).
[63] (Correctional Service Canada, 2017).
[64] (Office of the Correctional Investigator, 2019)
[65] (Corrections and Conditional Release Act, 1992).
[66] (Corrections and Conditional Release Act, 1992).
[67] (Office of the Correctional Investigator, 2019; Iftene, 2017).

Despite this, the parole by exception system is not frequently utilized. Very few people are granted parole by exception, and no one has been granted royal prerogative of mercy.[68]

There are a number of barriers that prevent aging prisoners from exercising this option. First, the criteria that an aging individual is required meet to be granted parole by exception is extremely restrictive. The Parole Board of Canada (PBC) considers factors to determine if one is eligible for parole, but they do not include age and disability.[69] Second, there is a requirement to complete a correctional plan before being eligible to apply for parole by exception often cannot be met often due to circumstances outside of a person's control (e.g., waitlists for programs). **Aging prisoners have not been granted the opportunity to complete programming.** The eligibility criteria for parole are difficult to meet for aging prisoners, especially for those who are terminally ill and do not have such time to wait to be granted parole and meet all the requirements. Finally, and perhaps the most problematic, is that individuals in prison and CSC staff are often unaware of the conditional release options. With this option being underutilized, more elderly individuals are left behind in prisons despite CSC's duty to use the least restrictive measure to incarcerate an individual.

CSC's Internal Grievance Process

Individuals in prison have the right to access to CSC's internal grievance process to make a complaint when their needs are not being met. The CCRA states that the procedure must "fairly and expeditiously" resolve grievances on matters within the Commissioner's jurisdiction and that individuals have complete access to the procedure without negative consequences.[70] However, studies like those conducted by the OCI and Iftene, strongly suggest that CSC has not been meeting their obligations under the CCRA. Iftene found that of the 70 percent of the people she interviewed that were filing a grievance, less than 10 percent reported some positive outcome.[71] Iftene also found that the wait time for a response was between 6 months and 2 years. This becomes problematic for older individuals, especially as most interviewees stated their complaints were related to health care, including lack of medication and refusal to be scheduled for an appointment with a specialist. Similarly, the OCI noted in its annual report for 2014 – 2015 that the number of grievances was increasing, reaching 32,340 yearly.[72] In January 2015, CSC's compliance rate with the CCRA in terms of timelines was 30 percent overall and 13 percent for priority grievances. The wait time for a reply was often over a year. As such, there were significant backlogs and systemic delays.

Commissioner's Directive 081 (Offender Complaints and Grievances) provides timelines in which decision makers will render a decision regarding complaints and grievances. Decision makers will render a decision within 15 working days of receipt by the Grievance Coordinator for High Priority complaints and initial grievances, and 25 working days for those designated Routine Priorities.[73] For

[68] (Office of the Correctional Investigator, 2019; Iftene, 2017).
[69] (Iftene, 2017).
[70] (Corrections and Conditional Release Act, 1992).
[71] (Iftene, 2019b, April 3)
[72] (Office of the Correctional Investigator, 2015).
[73] (Correctional Service Canada, 2019d, June 28).

final grievances, the decision maker will render a decision within 60 working days of receipt by the National Grievance Coordinator and 80 working days for routine priority grievances. Individuals must exhaust this internal option before they can access the court system. Based on these timelines, CSC may be breaching their obligations to expeditiously resolve grievances if replies are provided over a year later.

Individuals in Canadian correctional institutions also have a legal right to a *fair* complaint and grievance process. CSC defines High Priority complaints and grievances as matters that "have a direct effect on life, liberty, or security of the person or that relate to a griever's access to the complaint and grievance process".[74] All other complaints and grievances are designated routine priority. This further emphasizes that CSC is bound by the *Charter* (CSC's policies use the same language found in section 7 of the *Charter*, which states that everyone has the right to "life, liberty and security of the person"). Many individuals Iftene (2019) interviewed had serious and urgent concerns that threatened their physical and mental health, but their complaints went unaddressed. Iftene's research demonstrated that the attitudes of some officers reflect the lack of efficiency, as individuals are perceived to be filing vexatious grievances. Although the remedies are not legally enforceable, CSC still has a duty to fulfil their legal obligations under the CCRA. It is important to have a functioning grievance system to maintain the right of individuals in prison, the rule of law, and the integrity of CSC.[75] Otherwise, this system will remain hampered by delays and lacking in accountability.

VI. RECOMMENDATIONS FOR SLSC

Based on the gaps discussed and knowledge of CSC's legal duties to those in prison, SLSC can address those issues to put additional pressure on CSC to comply with its legal obligations. In this section, there will be recommendations for SLSC under two parts:

1. How can SLSC work towards increasing compliance, practices, and tools *within existing* legislation to advance meaningful prison reform?

2. How can SLSC advocate for legislative *reform*?

Part 1: Increasing Compliance Within an Existing Legal Framework

SLSC can use the CCRA to advocate for elderly people in prisons to increase CSC's compliance with its policies. In particular, SLSC can aim to expand the scope of ambiguous terms within CSC policies, so the elderly population are adequately captured to receive proper care. Within the Commissioner's Directive regarding Health Services, there are a number of terms that lack clarity, making it difficult to hold CSC accountable because it is not clear on what its duties are, and who those duties are owed to. Equally, if the definition is too narrow, CSC will not be able to fulfil their duty to its growing

[74] (Correctional Service Canada, 2019d, June 28).
[75] (Iftene, 2019b, April 3).

population of elderly people in prisons. Clarifying the terms mentioned below can have the potential to address the needs of older individuals if CSC broadens the terms' scope.

It is the health care professionals in prisons that are able to assess the individuals in custody and make recommendations to CSC on their health care plan and treatment. CSC has clarified that these health care professionals are responsible for providing care to those with special needs and that it supports the promotion of patient advocacy. SLSC can push to have CSC update its Commissioner's Directives to clearly define what qualifies as "special needs" and who can qualify as a "patient advocate". SLSC can explore expanding the scope of who can be a patient advocate other than health professionals. For example, there are many stories about incarcerated people preferring to stay in their range rather than going to health services because the care they receive from other prisoners is better than what they receive from the security or health care professionals. SLSC can explore whether incarcerated people can be considered patient advocates and be able to alert health care professionals to another person's pressing health care needs. SLSC can also look into expanding the scope of "patient advocate" to those who understand the prison system since health care in prisons is not the same as health care in the community. SLSC can also work with organizations that already provide advocacy, such as National Associations Active in Criminal Justice (NAACJ), to widen their scope to provide broader advocacy to those who require medical attention in prisons.

Additionally, SLSC can request more clarity on "health care units". Health care units can provide the older individuals with the medical care they require, but only if they meet the requirements. However, if the requirements are not clear, it will be difficult for them to qualify. For instance, who qualifies as an individual's "most responsible" health care provider and who can make that decision? If one must require "clinical programming" to qualify, what does that include? The *Corrections and Conditional Release Regulations* (CCRR) states that admission to a health care unit is done in accordance with the criteria set out in the Commissioner's Directive.[76] Therefore, CSC is able to independently change and improve its policies within existing legislation in a way that can comply with the CCRA's purpose and principles. SLSC can collaborate with organizations that have health expertise beyond SLSC's knowledge to advocate for these improvements.

Further, SLSC can ask for greater clarity and enforceability on the timelines that complaints and grievances must be responded to. The timelines in Commissioner's Directive 081 (Offender Complaints and Grievances) still allows many complaints and grievances to be left unanswered or substantially delayed. For instance, CD 081 states decision makers "will" render a decision, rather than "must". Additionally, the CCRA states that the procedure must be fair and expeditious, but for high priority complaints and grievances, one may only receive a response in approximately 3 months *after* the decision maker receives the complaint from the Grievance Coordinator and National Grievance Coordinator. There are no timelines for either of these Coordinators. If a complaint is categorized as routine, then it will take even longer to receive a response. As it has been repeatedly observed, many complaints and grievances are responded to long after the timelines provided for in

[76] Corrections and Conditional Release Regulations (SOR 92/620).

the Directive. Under the CCRA, this may not be considered expeditious. As such, SLSC can inquire about the enforceability of the timelines in the Directive and explore whether requests made by the older individuals in prison can be designated as high priority or ensure quicker response times for routine grievances under CSC's timelines.

Part 2: Advocating for Legislative Reform

SLSC can advocate for shifting some non-essential health care services to essential for the aging and elderly prison population. For instance, SLSC can recommend reforming CSC's *National Essential Health Services Framework*[77], which designates items and services as essential and non-essential, so that services listed as non-essential are considered essential when an individual in prison turns age 50 or older. This may include an extra pillow to put under their back or legs, as this request has often failed to be responded to despite the chronic pain the older individuals experience. Further, many individuals aged 50 and over have been found to die of natural causes, more than the younger prison population. As such, the CSC should focus health care needs individually to the elderly population.

SLSC can also work to influence the improvement of CSC's Commissioner's Directives, particularly regarding health care assessments. Under section 15.1 of the CCRA, CSC must develop a Correctional Plan when an individual is admitted into a penitentiary.[78] This includes an obligation for CSC to conduct a mental health assessment to ensure the plan takes the mental health needs of the individual into consideration.[79] This assessment would at least assist an older individual the ability to participate in the prison programs, an objective of the Correctional Plan[80], as well as a requirement to qualify for parole. **Nevertheless, the application of the same assessments and practices across all age groups fails to account for the enhanced medical needs of older individuals.** Further, various policies from the Commissioner's Directive indicate that the initial assessments primarily look for mental health care needs that are "immediate" and would be a suicide concern, which does not necessarily allow for the accommodation of their real needs. SLSC can advocate for CSC to create a correctional framework that accounts for the age-specific needs of older individuals, in accordance with gerontology studies.[81] This would assist in eliminating treatment differences that would violate the Charter and other human rights legislation. An additional Directive on managing the problems of the aging individuals would also demonstrate CSC's understanding of the complex issues and the OCI report recommendations. A new Directive could also serve as a guidance to CSC staff who deal with the older individuals to better understand their issues. SLSC can also make recommendations regarding supplemental health assessments and recommend health assessments be conducted at various points in a sentence, in addition to assessing a person "when required". For instance, supplemental health assessments can occur annually once a person reaches the age of 50 years and

[77] (Correctional Service Canada, 2019c, July 23).
[78] (Corrections and Conditional Release Act, 1992).
[79] (Corrections and Conditional Release Act, 1992).
[80] (Corrections and Conditional Release Act, 1992).
[81] (Iftene, 2019b, April 3).

over. Increasing the frequency of health assessments for older individuals may result in greater likeliness of capturing potential or developing physical and mental health issues.

Moreover, SLSC can advocate for a comprehensive review of the process that grants parole by exception. Currently, the criteria one must meet to qualify for parole by exception is very stringent and often unable to be met. With an inconsistent and unregulated parole process, decisions can be unpredictable. This is partly due to the lack of other operational criteria in the CCRA and CCRR to guide the Parole Board of Canada (PBC) in its decision-making.[82] The PBC's *Decision-Making Policy Manual for Board Members* offers more criteria and elaborates on the main factors taken into consideration, with the objective of not creating undue risk to society.[83] However, factors like health status, disability, the physical capacity of committing further crime, and age, are not listed at all in this Manual or the Commissioner's Directives.[84] The factors and circumstances that make individuals low risk do not appear to be systematically considered, especially with regard to age. SLSC can work with their partners at the PBC to advocate to reform parole granting practices by looking at accessing parole based on age-related requirements. The criteria should ultimately meet the goal of helping individuals to be habilitated and integrated into the community as required by the law.

Pushing for a Paradigm Shift

SLSC members are actively pursuing a paradigm shift and adopting the principles of the Maison Cross Roads' *Aging Well* model. SLSC recognizes the need for a paradigm shift to change our thinking with respect to certain expectations (i.e., employment, relationships, independent living, and apprehension about responding to the needs of elderly individuals by strictly using a medical model). Initially, there was the belief that it was necessary to gather and share information on the experiences of elderly individuals and parolees for action to be taken. However, since little progress has been made, SLSC considers the hurdle and challenges to lie mostly on matters of ethical beliefs and choices we make as a response. SLSC can push for the adoption of a "Geronto-Criminology Intervention Model", or an "Aging Well Model", where principles from both gerontology and criminology are merged.

These principles and values inherent to moving forward include:

- **Autonomy**: allowing an individual to have control over and be free to make independent choices in their daily life within the constraints of the prison environment and with minimal help.
- **Fairness and Justice**: the assurance that one's needs (physical, mental, psychological, social, and spiritual) receive the same considerations as the needs of the rest of the population. In the context of aging individuals, this means having access to necessary resources and services without aged-based discrimination.
- **Dignity**: being treated with respect regardless of age or condition, enjoying a sense of self-worth, and being recognized and appreciated for contributing to the lives of family and friends, the prison community, and society as a whole. This can be shown by having programs and activities geared towards older individuals.

[82] (Iftene, 2019b, April 3).
[83] (Parole Board of Canada, 2021).
[84] (Iftene, 2019b, April 3).

- **Non-maleficence**: trusting that no harm will come to you, by commission or omission, and that you will not be put at risk of being harmed.
- **Beneficence**: failing to do what is beneficial for the elderly individuals when in a position to do. This is thought to violate CSC's mission statements.

Healthy aging inside a prison or in the community is not only a necessity and a just priority for the correctional network, but it is also a matter of basic human right.

VII. CONCLUSION

Based on various studies, it is clear that CSC has been failing to meet its legal obligations under the CCRA. CSC has statutory and constitutional obligations that make it bound to care for the individuals in its custody. With growing attention to the experiences of the older prison population, the pressure on CSC to comply with and reform its policies, in terms of health care, conditions of confinement, and release, is greater. Notwithstanding that CSC has a legal duty to treat people in prison with dignity under the CCRA, it is also a moral obligation. As seen with the issues surrounding administrative segregation and the massive class action that were brought against CSC for the breach of their legal duties, CSC's past, and current attitude towards providing an adequate level of care to the elderly can go down a similar path.

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