

HEALTH, ILLNESS, AND AGING IN CARCERAL SPACES

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ABSTRACT

In Canada, the number of adults over the age of 50 incarcerated in federal penitentiaries has doubled over the past ten years, now comprising nearly 25 percent of the federal prison population (Martin, 2017). As this population continues to grow, so too will the demands placed on prison health services. To address this issue, researchers, policymakers, and practitioners suggest creating more accessible bedspace within existing institutions, cordoning off age-segregated prison units, building specialized geriatric prisons, and/or increasing the use of compassionate release. These solutions implicate institutional and community-based corrections, which produce ‘carceral’ and ‘transcarceral’ spaces respectively. These spaces are characterized by the application of social control within, across, and outside of custodial settings, which can have enormous implications for accessing health and healthcare. This research project explores how the health of incarcerated and formerly incarcerated older adults unfolds in the spaces to which they are confined. Semi-structured interviews were conducted with staff (n=4) and older residents (n=5) at halfway houses in Ottawa, Ontario. Drawing upon French Marxist philosopher Henri Lefebvre’s theorization of space, including three ‘moments’ of spatial production, and complementary criminological literature on carceral space, a thematic analysis of interview data revealed several important findings. Ultimately, the present study highlights tensions with respect to how the aging body is negotiated in carceral space, how the everyday practices that shape the lives of incarcerated and formerly incarcerated older adults contribute to the production of space, and what this reveals about the nature of these spaces.

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LIST OF ACRONYMS

ADLs	Activities of Daily Living
AODA	Accessibility for Ontarians with Disability Act
CBRF	Community-Based Residential Facility
CCC	Community Correctional Centre
CCRA	Corrections and Conditional Release Act
CCRR	Corrections and Conditional Release Regulations
CDs	Commissioner's Directives
CRF	Community Residential Facility
CSC	Correctional Service Canada
GEM	Geriatric Emergency Response
IADLs	Instrumental Activities of Daily Living
LTSO	Long-Term Supervision Order
OCI	Office of the Correctional Investigator
OHIP	Ontario Health Insurance Plan
PADLs	Prison Activities of Daily Living
PBC	Parole Board of Canada
PO	Parole Officer
PSW	Personal Support Worker
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

I need a lifetime... I imagine within the next six months, I'll be the last one left of the crew. I didn't want that. When you find your humanity so late in life and after you've lived the life that you have, it's, uh... I have that empathy for people and that's all I can look for with what I give out today. Sympathy, I don't need that... The only thing I can do is if I'm out here in the world, the real world, then try to live the way I should, within the parameters sent down by God and the CSC... (resident-participant #1).

1.1 Locating the Study

In Canada, adults over the age of 50 have become the fastest growing population in federal penitentiaries (Correctional Service of Canada, 2013). Statistics provided by the Office of the Correctional Investigator (OCI) in 2011 report that this segment of the correctional population increased by 50 percent between 2000 and 2010. According to the 2016 *Corrections and Conditional Release Statistical Overview*, 24.1 percent of the Canadian federal prison population is now aged 50 and over. This figure varies regionally and by institution; for instance, 35 percent of the population at Bath Institution in Ontario is over the age of 50 (OCI, 2011). Importantly, the share of older adults under federal correctional supervision in the community (37.6%)¹ is even greater than the custodial population of men and women aged 50-plus.

Like in many other jurisdictions, the Correctional Service of Canada (CSC) uses a benchmark of 50 years of age to describe “older offenders” (Uzoaba, 1998). This reflects a body of literature that suggests that the natural processes associated with aging are accelerated by approximately 10 years in institutional settings (Aday, 2003; Blowers, 2015; Fazel et al., 2001b; Kerbs and Jolley, 2007; Linder, 2014; Loeb, Steffensmeier and Lawrence, 2008; Reimer, 2008; Stojkovic, 2007; Williams, Stern, et al., 2012). Despite the implications for the aging body while imprisoned, relatively few studies have examined the health status of incarcerated older adults and existing findings are largely inconclusive (Fazel et al., 2001b; Loeb and AbuDagga, 2006;

¹ This includes: day parole, full parole, statutory release, and long-term term supervision order (LTSO).

Mara, 2004; Marquart, Merianos and Doucet, 2000; Tarbuck, 2001). As such, little is known about older prisoners' health and functional status. Nevertheless, researchers agree that not only are incarcerated older adults less healthy than their age-matched peers in the free population, but they also have poorer health than younger prisoners (Aday, 1994; Aday, 2003; Gal, 2002; Loeb and Abudagga, 2006; Loeb et al., 2008; Potter, Cashin, Chenoweth and Jeon, 2007).

To date, much of the literature on aging in prison is U.S. or U.K. based. Furthermore, the vast majority is descriptive in nature and equally prescriptive in demanding a strategic resolution, whether this entails creating more accessible bedspace within existing institutions, cordoning off age-segregated prison units, constructing geriatric prisons, or increasing the use of compassionate release. Unfortunately, few confront the issue with more profundity. In part, these shortcomings provide the impetus for this project, which is further contextualized by few discernable and sustained attempts to address the needs of older adults in Canadian corrections.

In 2000, CSC established the Older Offender Division for the purpose of developing a federal correctional strategy to address the aging prison population (Crawford, 2012). The following year, the Division published a number of recommendations, calling for: accommodation planning in federal institutions; community supervision and programs on release; health and mental health care, including palliative care; hiring and training of staff to address the specific needs of older prisoners; as well as special assessment, management and release planning for this population (Crawford, 2012; Sapers, 2008). However, in his appearance before the *Special Senate Committee on Aging* in February 2008, the Correctional Investigator of Canada, Howard Sapers, claimed that the recommendations made in the 2001 report were never fully realized, superseded by new CSC provisions mandating healthcare and institutional programming matched to the needs of individual prisoners regardless of age. In 2012, Sapers

noted that the Older Offender Division had “long since been abandoned” (Crawford, 2012). Nevertheless, some noteworthy initiatives were introduced, including a palliative care program at the Pacific Institution (Sapers, 2008). Ultimately, efforts to address the needs of the aging correctional population have not been implemented uniformly, consisting primarily of initiatives undertaken by specific facilities.

This thesis aims to address the relative neglect of this segment of the correctional population in Canada, both academically and pragmatically, by providing a more nuanced understanding of their experiences and shedding light on potential implications associated with prescribed solutions, which are inherently spatial. It draws on participant narratives collected via semi-structured interviews with staff (4) and older residents (5) at community residential facilities (CRFs) in Ottawa, Ontario. The subsequent analysis of interview data is guided by significant developments following the spatial turn in the humanities, of which French Marxist philosopher Henri Lefebvre is widely considered to be the driving force. By focusing on the spatiality of these experiences, I endeavour to highlight tensions with respect to how the aged body is negotiated in carceral space, how the practices enacted by and for older people contribute to the production of space, and what this reveals about the nature of these spaces.

Once the domain of geography alone, concern for place and space has become increasingly prevalent across myriad disciplines. Today, “many humanities scholars...invoke such conceptions as a means to integrate how diverse social processes play out unevenly in different locations” (Arias, 2010, p. 30). Criminology is no exception. Over the last century, spatial theorizations and analyses have formed central lines of criminological inquiry, beginning with Robert Park and Ernest Burgess’ analysis of Chicago’s criminogenic spaces in the early 1920s (Hayward, 2012). Following these initial invocations of the spatial in criminological

scholarship, a number of others took shape (see Hayward, 2012). These contributions formalized the geography of crime. However, as Hayward (2012) notes:

Criminology has all too often taken space for granted, proceeding with an implicit notion of spatiality that approaches the environment simply as a geographic site and not as a product of power relations, cultural and social dynamics, or everyday values and meanings (p. 1).

Like Hayward, Arias (2010) denounces the uncritical application of key concepts from human geography across disciplines so often misconceived as the ‘spatial turn’. Instead, the spatial turn, as conceptualized by postmodern thinker Edward Soja, demands much more:

[It involves] a reworking of the very notion and significance of spatiality to offer a perspective in which space is every bit as important as time in the unfolding of human affairs, a view in which geography is not relegated to an afterthought of social relations, but is intimately involved in their construction (Warf and Arias, 2008, p. 1).

This is a call for greater consideration of the spatial in understanding social life. The spatial turn has led to the “recognition of space...as both the contingent condition and the outcome of human activity” (Arias, 2010, p. 39). In these terms, space is something that not only produces, but is also produced by social activity; it is both concrete and abstract, consisting not only of geographical landscapes, but also of allied discourses, social circumstances, and lived realities.

These emergent conceptions of space have been employed within critical prison scholarship, typically in empirical ways. I use these ideas to analyze experiences of aging in institutional and community-based correctional environments, which are conceptualized as ‘carceral’ and ‘transcarceral’ spaces.² These spaces are characterized by the application of social control within (carceral) and outside of or across (transcarceral) institutional settings (Lowman, Menzies and Palys, 1987). The practices that are inherent to these disciplinary spaces have devastating implications for accessing health and healthcare, contributing to the correctional population’s markedly poorer health when compared with the ‘free’ population (Christie, 2006;

² Unless otherwise discussed discretely, I use the term ‘carceral’ to refer to both carceral and transcarceral space.

Condon, Hek. Harris, Powell, Kemple and Price, 2007; Stojkovic, 2007; Stoller, 2013). For older adults who typically face more significant and/or numerous health challenges, these failings are even more pronounced (Kerbs, 2000a; Potter et al., 2007; Snyder, van Wormer, Chadha and Jagers, 2009), thereby necessitating the focussed study of these experiences in context.

1.2 Outline of Chapters

In the second chapter of this thesis, I provide a review of the literature on aging in prison. I begin by discussing how old age is defined in correctional contexts. Following this, I describe essential characteristics of this segment of the prison population, with a particular emphasis on health status. I then examine prison health more broadly, discussing key determinants of health. Later, I explore these determinants in relation to the experiences of incarcerated older adults reported in the literature. I end this chapter by discussing release and reintegration, specifically how older adults facing age-related health challenges experience community re-entry.

In the third chapter, I outline my theoretical framework, which informs my methodological and analytic approach. Broadly, this research project uses spatial theory to develop a nuanced understanding of aging in institutional and community-based correctional environments. I discuss these particular kinds of space first. Next, I explore key ideas presented in Henri Lefebvre's *The Production of Space*. I employ Lefebvre's (1991) inklings on space and, in particular, his conceptual triad comprised of three types of space, as a point of entry in decoding participants' experiences in and of carceral space. I conclude this chapter by discussing empirical research from the sub-discipline of carceral geography in order to explicate some of the specific means by which carceral space is produced and reproduced, and according to which logic(s). I use these works to further analyze participants' situated experiences.

In the fourth chapter, I describe the methods used to conduct this study. I begin by detailing key epistemological considerations, as relevant to the qualitative research paradigm and the spatial analysis. I then outline the research questions, and define key terms and concepts. Next, I describe the research design, rationalizing my use of semi-structured interviews conducted with a sample of CRF staff and residents. I also discuss ethical safeguards, reflexive considerations, and the participant recruitment process. Following this, I explain my use of thematic analysis to examine interview data. I close the chapter by discussing epistemic validity.

In the fifth chapter, I provide an overview of research findings. This chapter is divided into two main sections: the first comprises a descriptive analysis capturing the health status of the sample of older adults whose experiences inform the ensuing thematic analysis, while the second provides a more nuanced discussion of older adults' health experiences in institutional and community-based correctional settings. The latter explores three central themes. First, I discuss bedspace and related practices. I then examine the accessibility of healthcare available to incarcerated and formerly incarcerated older adults. Lastly, I explore the standard of care in carceral spaces. Together, these themes represent structural barriers to health and healthcare, which are inherent to carceral spaces.

In the final chapter, I provide a more explicitly theoretical discussion of these themes, inferring about the spaces that produce and are produced by participant experiences to a greater degree. In Chapter Five, I, in large part, situate carceral space as an impediment to health and healthcare, implying the fallacy of carceral constraint in responding to health needs, while saying little about these spaces themselves. I provide greater abstraction here. Following this discussion, I summarize the key findings of the current study, discuss its limitations, and offer considerations for future research.

CHAPTER 2: LITERATURE REVIEW

Researchers are paying greater attention to the growing influx of older adults in correctional facilities and advocating for policies and programs to better meet the needs of this population. With this, the literature on older prisoners has become increasingly diverse, emerging from a variety of disciplines, such as criminology, sociology, psychology, gerontology, nursing, and the health sciences. However, much of this work remains primarily descriptive, with few studies having explored aging in correctional settings with any theoretical depth. Notwithstanding a few discerning attempts to develop a more comprehensive approach to aging in prison, the literature on older prisoners is a patchwork rife with inconsistent findings, perhaps reflecting the heterogeneity of this population. This chapter reviews these studies in order to situate the subsequent analysis of older prisoners' health in the extant literature.

2.1 Older Adults in the Criminal Justice System

Older adults have become the fastest growing population in Canadian federal prisons (CSC, 2013). This growth is a collateral consequence of harsher sentencing practices—including the growing use of imprisonment, the increasing length of prison sentences, a paradigm shift away from rehabilitation, and fewer opportunities for parole—combined with the “greying” of the general population (Delgado and Humm-Delgado, 2009; Gaydon and Miller, 2007; Loeb and Abudagga, 2006; Loeb and Steffensmeier, 2011; Saunders, 2013; Yorston and Taylor, 2006). Changes in the “policing, prosecution, sentencing and post-release supervision of sex offenders, including those who have committed ‘historical’ sex offences” have additionally contributed to the growth of this population (Saunders, 2013, p. 43). Together, these factors created a ‘stacking effect’ whereby the population of older prisoners has grown in both proportion *and* number (Snyder et al., 2009).

2.1.1 Defining the Older Prisoner

Researchers, policymakers, and criminal justice administrators have not yet reached consensus on what age a person becomes ‘older’ in criminal justice contexts (Loeb and AbuDagga, 2006; Trotter and Baidawi, 2015; Williams, Goodwin, et al., 2012; Williams, Stern, et al., 2012). Definitions vary considerably, with some scholars drawing the distinction between younger and older prisoners as early as 45 years of age and some as late as 65 years of age (Williams, Goodwin, et al., 2012; Williams, Stern, et al., 2012; Yorston and Taylor, 2006). Due to these inconsistencies, what is known about older prisoners is noticeably fragmented, which impedes the development of appropriate responses to the needs of this group (Baidawi et al., 2011; Loeb and AbuDagga, 2006; Williams, Stern, et al., 2012).

The Correctional Service of Canada refers to older prisoners as those aged 50 and over (Uzoaba, 1998). In fact, for many correctional administrators across the globe, the cut-off between younger and older prisoners is set at age 50 (Aday, 2003; Stojkovic, 2007) and many scholars have also adopted this definition (Kerbs and Jolley, 2007, 2009).³ This definition is used in light of factors believed to cause the bodies of older prisoners to age approximately ten to fifteen years faster than those of their community counterparts (Aday, 2003; Blowers, 2015; Fazel et al., 2001b; Linder, 2014; Loeb et al., 2008; Reimer, 2008; Williams, Goodwin, et al., 2012). In the free population, the demarcation between middle and old age is typically 60 or 65 years. This is an arbitrary cut-off that reflects social legislation introduced in the nineteenth and twentieth centuries, as well as contemporary social purposes, including the age of retirement (Aday, 2003). Research has indicated that the health status of free, community-dwelling adults aged 60 to 65 is comparable to the health status of 50-year old prisoners (Loeb et al., 2008). This

³ In light of this, the term ‘older’, when used in reference to incarcerated and formerly incarcerated adults will henceforth denote those aged 50-plus unless otherwise specified.

suggests that prisoners' biological or physiological age, which is a reflection of a person's overall physical and mental health and accompanying level of function (Flynn, 1992), is significantly "older" than their community-dwelling counterparts of the same chronological age. This observation is attributed to 'accelerated aging', which involves a series of physical and mental changes occurring at different times for different people over a lifetime, as opposed to a single substantive transformation that happens when an individual reaches a fixed chronological age (Aday, 2003; Loeb and Abudagga, 2006; Williams, Stern, et al., 2012).

Accelerated aging can be attributed to factors emerging prior to and during incarceration (Loeb et al., 2008; Williams, Goodwin, et al., 2012). Quite consistently, rates of physical and mental illness amongst criminalized populations have exceeded the prevalence of ill health amongst those who have not come into conflict with the law (Rutherford and Duggan, 2009; Senior and Shaw, 2007). The rates of illness observed among correctional populations arise from pervasive social inequities that result in high rates of unemployment, poverty, homelessness, greater behavioural health risk factors, and limited access to quality care in the community among certain groups (de Viggiani, 2006; Goetting, 1984; Linder, 2014; Morton, 1992; Potter et al., 2007; Williams, Goodwin, et al., 2012; Woodall, Dixey and South, 2013). By virtue of their age, older prisoners experience these challenges over a long period of time, constituting "lifetime histories of cumulative disadvantage" that lead to poor health outcomes and functional decline (Maschi, Viola, Morgen and Koskinen, 2015, p. 113).⁴ Once incarcerated, the conditions of confinement, including overcrowding, isolation, victimization, and inadequate health and dental care, compound the effects of these structural disadvantages, further accelerating the aging process (Human Rights Watch, 2012; Loeb et al., 2008).

⁴ It is important to recognize that the population of older prisoners is not homogeneous and, as a result, their life experiences may vary considerably, their health suffering more or less accordingly.

Because justice-involved individuals tend to experience accelerated biological aging, researchers call for a measure of age-related vulnerability that does not focus solely on chronological age, but also a person's functional and cognitive capacities (Stojkovic, 2007; Williams, Goodwin, et al., 2012; Williams, Stern, et al., 2012). To this end, some researchers suggest the need for a distinction to be made between 'geriatric' and 'non-geriatric' older prisoners (Snyder et al., 2009). The former would include those who are unable to perform routine activities of daily living (ADLs), such as bathing and toileting, on an independent basis. As such, they require regular assistance to complete these basic tasks. The latter group would include older prisoners who are still able to function independently, but may need environmental supports, such as ramps and elevators, so that they may continue to care for themselves.

2.1.2 Describing the Older Prisoner

Incarcerated older adults differ from their younger counterparts not only in terms of their health, but also in terms of their personal characteristics, incarceration history, conformity to institutional rules, and participation in recreation and work programs. I address these differences briefly to situate concerns specific to the health of older prisoners.

Personal Characteristics. Marked differences have been observed between older and younger prisoners with respect to marital status, number of children, educational attainment, and literacy (Goetting 1984). Younger prisoners are more likely to have never been married—and are thus less likely to be separated, divorced, and/or widowed—than their older counterparts and also tend to have fewer children. These differences are largely a function of time (Goetting, 1984). Consistent with a trend towards increased educational attainment, younger prisoners attended higher grade levels and had higher literacy rates than older prisoners (Goetting, 1984).

Incarceration History. Early studies of older adults in the criminal justice system focused on classifying older prisoners according to their criminal history. For instance, Teller and Howell (1981) distinguished between two types of older prisoners: those incarcerated for the first time and those previously incarcerated on multiple occasions. Alternatively, Metzler (1981) trichotomized a sample of 26 older prisoners to represent those incarcerated for the first time at an older age (i.e. “older first offenders”), those incarcerated at a young age who have grown old in prison (i.e. “long-term first-time offenders”), and those who have served more than one term in prison (i.e. “chronic recidivists”) (as cited in Goetting, 1984). Goetting (1984) built on Metzler’s scheme, dividing the second group to distinguish between “oldtimers” incarcerated prior to age 55 and having served more than 20 continuous years in prison, and “young short-term first offenders” incarcerated prior to age 55 but having served less than 20 consecutive years in prison (pp. 18-19).⁵

Metzler’s three-pronged typology is used most widely (Aday, 1994; Aday, 2003). Currently in Canada, most older men in federal correctional facilities are considered ‘chronic recidivists’ (45%); a smaller proportion are incarcerated for the first time over the age of 50 (28%), or are ‘long-term first-time offenders’ serving sentences greater than 10 years (24%) (Gobeil, Allenby and Greiner, 2014). In all groups, older prisoners represent a special population with unique offending trajectories, health care needs, family relationships, and problems of institutional adjustment (Aday, 1994).

Generally, older prisoners are more likely to have been incarcerated for violent crimes against persons to whom which they are often well acquainted, including spouses, family members, friends, and neighbours (Aday, 2003; Krajick, 1979; Teller and Howell, 1981). In particular, older prisoners are more likely than their younger counterparts to have been convicted

⁵ It should be noted that Goetting’s typology uses 55 years of age years as the point of demarcation for old age.

of homicide or a sexual offence (Bouchard, 2004; Grant and Lefebvre, 1994). ‘Long-term first-time offenders’ are more likely to be imprisoned for these crimes; this is because growing old in prison is primarily a function of offence type (Goetting, 1984). ‘Older first-offenders’ are also more likely to be serving time for violent crimes. Aday (1994) explains that, as we age, our range of social interaction grows smaller and smaller, resulting in more intense interpersonal relationships that yield increased opportunities for violence. Furthermore, biological changes due to aging, such as those occurring in the brain, can lead to aggressiveness, lowered inhibitions, and volatility (Aday, 1994).

Conformity to Prison Rules. The literature suggests that older prisoners are less likely to be observed violating institutional rules than their younger counterparts (Blowers and Blevins, 2015; Goetting, 1984; McShane and Williams, 1990). These two groups also differ in the nature of their rule-breaking behaviours: while younger prisoners are more likely to have major violations including assault, older prisoners are more likely to have minor violations such as disobeying orders, being out of place, or drug and alcohol-related infractions (Blowers and Blevins, 2015). The nature of the disciplinary action taken against older prisoners was no more or less lenient than that which was taken against younger prisoners (Goetting, 1984).

Program Participation. In one study, older prisoners were more inclined to watch television and less likely to attend movie events; play sports, cards, and games; and read (Goetting, 1984). These findings suggest that older prisoners are less inclined to participate in social activities and reflect lower literacy rates among this group. Fewer older prisoners reported having work assignments than younger prisoners, many of them attributing this to a lack of appropriate work (Goetting, 1984). The literature also cites a lack of appropriate ‘rehabilitative’ programming for older prisoners (Blowers, 2015; Ginn, 2012; Goetting, 1983; Kerbs, 2000a,

2000b; Snyder et al., 2009; Trotter and Baidawi, 2015). These studies indicate that despite their interest, older prisoners' access to programming was often thwarted by correctional administrators (Kerbs, 2000a, 2000b; Snyder et al., 2009). Older prisoners who were able to participate in institutional programming reported that it helped to keep them occupied (Loeb and Steffensmeier, 2011).

2.2 The Health Status of Older Prisoners

To date, few studies have explored older prisoners' health status and researchers indicate that findings are largely inconclusive (Fazel et al., 2001b; Loeb and AbuDagga, 2006; Marquart et al., 2000; Tarbuck, 2001). This is partly due to the fact that data on prisoner health is lacking and there are many constraints associated with accessing this sensitive information (Bouchard, 2004). Research about the health of older prisoners is further impeded by the heterogeneity of this population and consequent inconsistencies in defining the older prisoner (Blowers, 2015). As such, relatively little is known about the health and functional status of older prisoners (Mara, 2004). In spite of this, there is considerable agreement that, in addition to being less healthy than their age-matched peers in the free population, older prisoners are, on average, in poorer health than younger prisoners (Aday, 1994; Aday, 2003; Gal, 2002; Loeb and Abudagga, 2006; Loeb et al., 2008; Potter et al., 2007) the extent to which is explored in the next section.

2.2.1 Physical Health

Physical health refers to the performance of biological functions for physiological development and ultimately, the preservation of life (Aday, 2003). A person's physical health can be compromised by chronic ailments, infectious disease, acute incidents and injuries, and terminal illness. By virtue of their designation as "older," which considers processes associated with accelerated biological aging, older prisoners are expected to experience deteriorating

physical health, at least to some degree.⁶ Indeed, older prisoners have previously rated their physical health as fair to bad, or very bad (Aday, 1994; Fazel et al., 2001b). However, some studies have found that older prisoners describe their health more positively (see Colsher, 1992).

Chronic Conditions. The literature suggests that the incidence and prevalence of chronic disease among prisoners becomes problematic after the age of 50 (Loeb and Steffensmeier, 2011; Stojkovic, 2007). On average, older prisoners have two to three chronic health conditions (Aday, 1994; Loeb and Steffensmeier, 2006; McCarthy, 1983). As such, older prisoners have more chronic diseases than older free adults (Colsher et al., 1992; Fazel et al., 2001b; Williams, Stern, et al., 2012). The most commonly reported chronic health conditions among older prisoners include: arthritis (Aday, 2003; Colsher et al., 1992; Fazel et al., 2001b; Loeb et al., 2008; Marquart et al., 2000); cardiovascular disease (Aday, 2003; Colsher et al., 1992; Fazel et al., 2001b; Fazel et al., 2004; Loeb and AbuDagga, 2006; Marquart et al., 2000); and pulmonary disease, including chronic obstructive pulmonary disease (COPD) and emphysema (Aday 2003; Fazel et al., 2001b; Fazel et al., 2004). Other common chronic illnesses, listed in no particular order, include hypertension (Loeb and AbuDagga, 2006; Loeb et al., 2008); endocrine disease (Aday, 1994; Fazel et al. 2004; Loeb and AbuDagga, 2006); and Parkinson's disease (Aday, 1994). Further to this, Aday (2003) reports that asthma, cancer, diabetes, prostate and urinary problems, stomach ulcers, and liver disease are also common among older prisoners.

Infectious Disease. Infectious diseases are illnesses caused by pathogens that can be transmitted from one person to another (Aday, 2003). Examples include but are not limited to: influenza, pneumonia, tuberculosis, hepatitis, sexually transmitted infections (STIs), and HIV/AIDS. Although the prevalence of infectious disease among older prisoners is unknown, researchers anticipate that such conditions are common among this population for a number of

⁶ Of course, this is not to say that old age and physical health problems are synonymous.

reasons. First, chronic illnesses can result in infection complications, making older prisoners who are more likely to have multiple chronic conditions highly susceptible to infection (Glaser, Warchol, D'Angelo and Guterman, 1990). For instance, older prisoners with cardiac disease are more likely to develop pneumonia and to die as a result (Glaser et al., 1990). Histories of alcohol and/or drug abuse also increase the likelihood of transmitting infectious disease (Glaser et al., 1990). Indeed, older prisoners are more likely than their younger counterparts to have abused alcohol and/or illicit substances (Uzoaba, 1998), thus increasing their susceptibility to infection. In particular, alcohol abuse has been associated with higher rates of pneumonia, tuberculosis, listeria meningitis, hepatitis B, and HIV/AIDS (Glaser et al., 1990). The conditions of confinement also increase the likelihood of transmitting infectious disease (Glaser et al., 1990). Since their inception, prisons have been criticized for their insalubriousness (see Evans, 1982) and despite numerous attempts to improve the conditions of confinement, pathogens easily spread within institutions and pose a threat to older prisoners (Glaser et al., 1990). Poor living conditions are associated with higher rates of tuberculosis, influenza, gastroenteritis, and resistant bacteria such as *Clostridium difficile* (*C. difficile*) and *methicillin-resistant Staphylococcus aureus* (MRSA) (Glaser et al., 1990).

Acute Incidents. Acute conditions are severe, sudden in onset, and run a relatively short course; they can result from any number of circumstances, but, in many cases, arise from chronic illness (Aday, 2003). For instance, osteoporosis, which is characterized by weakening of the bones, may result in a bone fracture. In this way, chronic conditions can predispose an individual to acute illness. Because there are disproportionately high rates of chronic disease among older prisoners, this group is especially vulnerable to acute illness (Aday, 1994). With the exception of younger prisoners with HIV/AIDS-related symptoms, older prisoners are admitted to the hospital

for acute treatment more often than their younger counterparts (Glaser et al., 1990). Poor health care in prisons increases the likelihood of acute emergencies, especially for those with chronic medical conditions that need to be properly monitored and managed (Aday, 2003). Further to this, the often violent nature of prison life can increase the likelihood of traumatic injuries that require acute medical care; the literature demonstrates older prisoners are more vulnerable to this kind of victimization (Aday, 2003; Tarbuck, 2001; Snyder et al., 2009). Finally, older prisoners with mobility issues may find it particularly difficult to navigate the institution without mechanical devices, such as canes, walkers, and grab bars in showers. Where these supports are absent, older prisoners are at risk of falling and becoming injured.

2.2.2 Mental Health

Concern for the mental health of older prisoners is frequently cited in the literature. This is unsurprising given that physical and mental health share a many of the same determinants (de Viggiani, 2006). Furthermore, physical illness can be a significant source of stress; to the extent that physical ailments are highly prevalent among older prisoners, this group is likely to experience considerable stress in their attempt to treat and/or manage these conditions (Aday, 2003). For these reasons, co-morbid physical and mental health challenges are common among older prisoners (Fazel et al., 2002; Maschi et al., 2012).

Early research suggests that the prevalence of mental health problems among older prisoners is five times greater than that of a comparable sample of older adults in the free community (Fazel et al., 2001a). More recent research has indicated that between 16 and 36 percent of older adults incarcerated in American correctional facilities have diagnosed mental health problems, a figure that grossly underestimates prevalence rates provided by Fazel and colleagues (2001a). Maschi et al. (2015) suspect that the prevalence of mental illness among

older prisoners is much greater than their research suggests, pointing to a lack of resources to provide ongoing mental health assessments that would otherwise help diagnose and treat.

The high prevalence of mental illness among older prisoners at intake can be attributed to multiple experiences of trauma, stress, grief, separation, and loss. Maschi et al. (2015) studied the life experiences of older prisoners in the U.S. and found that nearly 70 percent of respondents reported direct experience with at least one traumatic or stressful life experience, including having been in combat or a serious accident, having been emotionally abused, or having been physically or sexually assaulted. These experiences can have enormous psychological implications, which are often undetected, untreated and cumulative, predisposing the individual to mental decline in later life. Early life trauma in particular can have devastating effects. Often, trauma in early life stems from witnessing violence, namely familial violence, and/or suffering physical or sexual assault before age of 16 (Maschi et al., 2015). These traumatic experiences are associated with risky health behaviours such as substance abuse (Stessman et al., 2008).

Internal coping resources can have a significant positive influence on mental well-being, even when an individual is exposed to cumulative traumatic and stressful life experiences (Maschi et al., 2015). However, Aday (2003) describes older prisoners as less able to cope with stressors due to limited formal education, poor overall health, and fewer social connections on the outside. As such, older prisoners are generally not well equipped to deal with stressful events, including incarceration, and therefore may be more prone to mental illness.

For the reasons stated above, older prisoners are more likely than their younger counterparts to experience mental health problems such as anxiety, depression,⁷ and substance

⁷ Research on the incidence of depression among older prisoners is inconclusive. Some authors suggest that older adults are more likely to experience depressive symptoms, but that the detection of depression in elderly persons tends to be much more difficult due to differential ideas of what constitutes normal and abnormal affect for the aging whose lives are often characterized by loss and isolation (see Bouchard, 2004).

abuse (Aday, 2003; Fazel et al., 2001a; Maschi et al., 2012; Tarbuck, 2001; Uzoaba, 1998). One study found that the prevalence of depression in particular is five times greater among older prisoners than younger prisoners and age-matched community counterparts (Fazel et al., 2001a). Schizophrenia is also common among older prisoners (Maschi et al., 2012).⁸ Moreover, older prisoners may be more likely to exhibit suicidal tendencies (Aday, 2003; Dooley, 1990; Gal, 2002), although some studies suggest otherwise (see Laishes, 1994). Other studies found that older prisoners are more neurotic and hypochondriacal, but less psychotic and anti-social than younger prisoners (Gal, 2002).

Concern for older prisoners with dementia is heavily cited in the literature on aging in prison. Unsurprisingly, older prisoners are more likely to develop dementia than younger prisoners (Gal, 2002). Nevertheless, there is very little data on the incidence and prevalence of dementia in correctional facilities (Stojkovic, 2007; Williams, Goodwin, et al., 2012; Williams, Stern, et al., 2012). Some preliminary studies have indicated that the prevalence of cognitive impairment among older prisoners is high, with estimated prevalence rates of approximately 40 percent (Williams et al., 2009). Studies suggest that incarcerated individuals may be more likely to develop dementia than their community counterparts because many prisoners have experienced traumatic brain injuries, low educational attainment, and substance abuse issues, all of which increase a person's likelihood of developing dementia (Loeb and AbuDagga, 2006; Williams, Goodwin, et al., 2012).

2.2.3 Functional Ability

As demonstrated, older prisoners can experience significant physical and mental health challenges. Both physical and mental health can predict an individual's ability to successfully

⁸ This study was based on older adults in prisons and forensic institutions and, as such, it is unclear what the prevalence of schizophrenia is among older adults in prisons specifically.

navigate their environment when it is designed for people who do not face similar challenges. Indeed, the literature suggests that prisoners report greater levels of disability than the general population (Condon et al., 2007; Mara, 2004) and that older prisoners have higher rates of disability than younger prisoners, predicting significant differences in functional ability (Aday, 2003; Mara, 2002; Williams, Goodwin, et al., 2012).⁹ This is mainly attributed to the high incidence and prevalence of chronic illness among older prisoners (Colsher et al., 1992; Mara, 2004). As a result, older adults are more likely to need personal care during (and after) their incarceration (Mara, 2002; Mara, 2004; Potter et al., 2007).

Functional status is a measure of a person's ability to perform routine activities of daily living (ADLs). ADLs include bathing, toileting, feeding, grooming, clothing, walking, transferring, and maintaining continence; the ability to perform each of these tasks independently indicates a basic level of functioning that is necessary for survival (Massie, 1997). Instrumental activities of daily living (IADLs) on the other hand, are not imperative for daily functioning, but are still necessary to live independently (Massie, 1997). These are more complex activities that require higher order functioning and include cooking meals, performing housekeeping duties, and managing medications (Massie, 1997).

Using performance of ADLs and IADLs as a measure of functional ability, approximately 9 to 16 percent of older prisoners have been found to have functional impairments (Fazel et al., 2001b; Williams et al., 2006). One study, which used a proxy prison group of older community-dwelling adults matched on aggregate characteristics such as low educational

⁹ Traditionally, disability has been defined as a restricted ability, whether physical, intellectual, psychiatric, or sensory, to perform certain functions (Altman, 2001; Devlin and Pothier, 2005). Devlin and Pothier (2005) explain that disability may result from 'functional impairment', which is described as the loss or abnormality of physiological or psychological function. Functional impairments can arise from a number of conditions, including acute illnesses and injuries that may have lasting effects. This conceptualization is problematic for a number of reasons, which are discussed in the next chapter.

attainment and socioeconomic status, found that 46 percent of prison group participants had difficulty performing ADLs, while only 24 percent of the non-prison group reported problems (Merianos et al., 1997). Other studies suggest that rates of functional impairment among older prisoners are actually much greater than what these studies reveal; this is because prisoners, by virtue of their incarceration, are seldom required to engage in conventional IADLs (Williams et al., 2006). Alternatively, Williams et al. (2006) considers prison activities for daily living (PADLs), such as climbing onto and off of top bunks, standing for headcounts, and getting down on the floor during alarms. When PADLs are taken into account, the proportion of older prisoners with functional impairments rises to approximately two thirds (Williams et al., 2006).

It is worth noting that functional impairments can also develop in the absence of illness. Age-related functional and sensory decline can be understood as an individual's loss of or acquired limitation in their ability to perform daily tasks independently due to aging or age-related problems and not illness (Martin and Grotewiel, 2006). This presupposes a definition of aging as the "progressive deterioration of physiological function that impairs the ability of an organism to maintain homeostasis and consequently increases the organism's susceptibility to disease and death" (Martin and Grotewiel, 2006, p. 411). This deterioration results from the accumulation of oxidative damage to cells, tissues, organs, and whole body systems and is manifested as functional and sensory senescence (Martin and Grotewiel, 2006).

2.3 Constituting Prison Health

Regardless of age, a person's health typically deteriorates during incarceration due to the inherently unhealthy nature of these institutions (Christie, 2006). Fattah and Sacco (1989) suggest that the reasons for this are threefold: poor health prior to incarceration, unhealthy lifestyles fostered in prison, and the harshness of prison life itself. In what follows, I address

Fattah and Sacco's latter two concerns by examining how the social and physical structure of prison shape older prisoners' health.¹⁰ This will be followed by a review of relevant literature that examines how healthcare is affected by the prison milieu and how older prisoners' health is in turn affected by their healthcare experiences while inside.

2.3.1 Environmental and Socio-Structural Determinants

The literature suggests that the greatest obstacle to service provision for older prisoners is the presence of ageism in correctional systems (Kerbs, 2000b; Saunders, 2013; Wahidin, 2004). Pervasive ageism is rooted in a number of key assumptions about the age, ability, and mobility of prisoners that are intrinsic to the architecture, operation, and ethos of prisons, which are not compatible with the particular needs of older prisoners. Because of this, older prisoners often blame the prison for their physical and mental deterioration (Goetting, 1983; Loeb and Steffensmeier, 2011; Wahidin, 2004).

Prisons are “overwhelmingly ‘ableist’ spaces” designed for the young, able-bodied man (Moran, 2015, p. 76). In Canada, the physical infrastructure of its federal penitentiaries does not take into account the needs of older prisoners (OCI, 2011). On average, these facilities were constructed 47 years prior and were designed for younger men. As such, they tend to be physically inaccessible and create obstacles for those with limited mobility, vision problems, and other health-related concerns (Moran, 2015; Potter et al., 2007; Trotter and Baidawi, 2015). For instance, many prisons feature narrow corridors and cells that cannot accommodate a wheelchair, or in some cases even a walker; long distances between various units and/or buildings that

¹⁰ An earlier discussion of accelerated biological aging addresses Fattah and Sacco's concern for older prisoners' health prior to incarceration. I noted that the poor health of criminalized populations often reflects broader socioeconomic disparities that contribute to poor living conditions, risky health behaviours, and limited access to health care services. I also noted that these disparities disproportionately affect older prisoners, contributing to their markedly poorer health (Crawley, 2005; Loeb and Steffensmeier, 2011). As such, older prisoners are more likely to have entered the prison system with pre-existing symptomologies (Davis and Pacchiana, 2004; de Viggiani, 2006; Fattah and Sacco, 1989). In this sense, ill health has been ‘imported’ into the prison (de Viggiani, 2006).

prisoners access on a daily basis; and a complete lack of supportive equipment such as grab rails, shower benches, and commodes (Potter et al., 2007; Trotter and Baidawi, 2015).

The implications of inaccessible prisons are many and varied. For some older adults, an unsupportive prison environment constitutes a significant psychological stressor (Potter et al., 2007; Williams et al., 2006). It can also severely limit their movement. For instance, older adults who experience difficulty ambulating may be less likely to attend meal times, participate in activities and programs, and retrieve medications; instead, they are more likely to remain isolated in their cells (Trotter and Baidawi, 2015). Consequently, their nutrition, physical fitness, psychosocial well-being, and overall health may decline. For those who are not able to use bathroom facilities safely, their hygiene may also suffer, putting them at risk of developing dermatological conditions and infections.

Assumptions about the age, ability, and mobility of prisoners are also entrenched in prison regime. The regimented pattern of life administered in prison is designed for young, able-bodied men able who are expected to fully participate in hyper-managed daily routines. Indeed, the literature suggests that older prisoners often report having more difficulty adjusting to prison life than do younger prisoners (Aday, 2003; Blowers and Blevins, 2015; Vito and Wilson, 1985)¹¹. At the same time, older prisoners, who have been described as ‘doubly disadvantaged’ and multiply marginalized’ (McShane and Williams, 1990), are at an elevated risk of becoming physically, psychologically, and socially dependent on the prison as compared to their younger counterparts (Aday, 1994; Kerbs, 2000a; Potter et al., 2007).

To study this trend, Aday and Webster (1979) tested a model of aging in prison that could demonstrate whether the totalizing effects of the prison regime were intensified among older prisoners, resulting in increased dependency. They found that the prison, conceptualized in terms

¹¹ This is most common among those incarcerated for the first time over the age of 50 (Aday, 2003).

of its totalizing effects¹², did not support the proposed model of institutional dependency. This means that the impact of the social structure of the prison, when conceived as totalizing, had little effect on the institutional adjustment of older prisoners.¹³ However, they did find that individual characteristics such as length of prison sentence, age at first imprisonment, marital status, and whether the inmate was a ‘chronic’ or ‘first-time offender’ had bearing on levels of institutional adjustment (Aday and Webster, 1979). Generally, those who are unmarried and have either grown old in prison or been imprisoned on multiple occasions are most likely to be dependent on the protective environment of the prison (Aday and Webster 1979; Fattah and Sacco, 1989; Kerbs, 2000a). This suggests that institutional dependency is a function of the length of time spent in prison and limited social connections outside the institution.

Indeed, many older prisoners report losing their sense of control due to the highly routinized and oppressive nature of prison life (Woodall, Dixie and South, 2013). Older prisoners also exhibit significantly less participation in health-promoting behaviours, encounter more barriers to engaging in health behaviours, and have lower program attendance when compared with their community-dwelling counterparts (Loeb and Steffensmeier, 2011).¹⁴ However, some studies have revealed that older prisoners may find the structure of prison life helpful, enabling them to reclaim their health (Loeb and Steffensmeier, 2011; Woodall et al., 2013).

Older prisoners have employed a number of strategies in their attempts to gain control over their well-being. One study revealed that older prisoners engage in self-care practices such

¹² Characteristic of Erving Goffman’s ‘total institution’ comprising an “enclosed formally administered round of life” thought to represent a total attack on the self through the regulation of one’s sense of autonomy in accordance with the values of the institution (Goffman, 1961, p. 11).

¹³ This is consistent with Farrington’s (1992) alternative conceptualization, the ‘not-so-total’ institution, which accounts for the importation of values and norms into the prison, as well as various forms of prisoner agency.

¹⁴ This particular study targeted prisoners in minimum-security institutions. In these facilities, prisoners are afforded more autonomy to engage in health-promoting behaviours than would be granted in medium- or maximum-security prisons. It is possible that these findings would be more pronounced in prisoners housed in medium- or maximum-security institutions.

as physical exercise, so that others perceive them as strong and healthy (Loeb and Steffensmeier, 2011). Older prisoners also reported seeking out support from family and friends on the outside, as well as health service providers in the prison (Loeb and Steffensmeier, 2011). Ultimately, many believed that they received better treatment when they were educated about their conditions (Loeb and Steffensmeier, 2011). Older prisoners also underscored the importance of staying positive and keeping themselves busy with meaningful activities that help to preserve their emotional health (Loeb and Steffensmeier, 2011; Woodall et al., 2013). Incarcerated older adults, particularly chronic recidivists, also engage in risky health behaviours (e.g. illicit substance use) during their incarceration (Fattah and Sacco, 1989). While these practices are, on one hand, health averse, some researchers assert that engaging in these behaviours reflect agentic practice and as such, provide release; that is, a way of coping with incarceration and a way to hold on to one's sense of self (Moran, 2015). These strategies can thus be understood as health *enhancing* to the extent that they provide for 'psychic survival' (Graham, 1984 as cited in Moran, 2015).

A number of scholars have identified aspects of contemporary regimes that are imperceptive to challenges faced by older prisoners. In an attempt to regulate life inside, the prison has become synonymous with deprivation (de Viggiani, 2006). Primarily based on the work of Clemmer (1958) and Sykes (1958), the deprivation perspective posits that the prison deprives individuals of certain rights and freedoms and as a result causes physical, psychological, and social pain. Crawley (2005) argues that the pains of imprisonment "are intensified among the old and complicated by experiences of physical debility and emotional isolation" (p. 359). Ultimately, the prison produces more harm in its failure to recognize the distinct physical, psychological, and social needs of older prisoners. The literature considers the

harms inflicted by certain custodial practices that present challenges for older prisoners due to high rates of disability among this group. In particular, researchers problematize older prisoners' having to: occupy top bunks due to mass incarceration and resultant double-bunking; get down on the floor when the security alarm sounds; and perform ADLs under time limits (Moran, 2015; Trotter and Baidawi, 2015).

The literature also considers the suitability of prison programming for older prisoners. Consistent with Feeley and Simon's (1992) 'new penology' thesis, the administration of criminal justice has become preoccupied with risk. As such, correctional programming is designed to address risk factors associated with (re)offending. Furthermore, the new penology reflects a shift in perspective away from "the traditional concerns of criminal law and criminology, which have focused on the individual, and redirects it to actuarial consideration of aggregates" (Feeley and Simon, 1992, p. 449). Comparison of the individual to norms observed in the aggregate group is problematic for older cohorts. Because older prisoners are low risk to reoffend and comprise a relatively small proportion of the general prison population, aggregate data is not specific to this population and instead reflects the risks and needs of younger adults (Helmus, Thornton, Hanson and Babchishin, 2012). Researchers have indicated that the educational and vocational needs of older prisoners are much different from younger prisoners and as such, few existing programs provide meaningful occupation (Blowers, 2015; Ginn, 2012; Goetting, 1983; Kerbs, 2000a, 2000b; Snyder et al., 2009). Moreover, available recreational activities can be too high in intensity for older prisoners (Trotter and Baidawi, 2015). Some older prisoners have also noted that the type of work offered in prison is too physically demanding (Snyder et al., 2009). Older prisoners' exclusion from or inability to fully participate in programs can be isolating and instill a sense of meaninglessness and helplessness that can be damaging to their emotional health

(Snyder et al., 2009). In spite of these inadequacies, many older prisoners enjoy participating in programs and work opportunities as a means to help them cope, to help occupy their time, and to fulfil socio-emotional needs (Trotter and Baidawi, 2015; Loeb and Steffensmeier, 2011).

Ultimately, the prison is intensively controlled by policies and practices reflective of broader custodial and disciplinary priorities that restrict movement. These policies and practices “can create significant delays, roadblocks, and detours on the routes to care” (Stoller, 2003, p. 2263) where concern for order and security takes priority over other concerns such as the provision of care (Stoller, 2003; Wright, Jordan and Kane, 2014). The detection and diagnosis of dementia among older prisoners provides an example. According to researchers, diagnosing dementia among prisoners is expressly difficult, which may account for the lack of information on the prevalence of dementia in correctional institutions (Moll, 2013; Williams, Goodwin, et al., 2012; Williams, Stern, et al., 2012). In addition to memory loss, other symptoms of dementia may include changes in personality, attention deficits, hallucinations, delusions, hypersexual behaviours, agitation, and aggression (Williams, Stern, et al., 2012). Some of these symptoms may be misinterpreted and met with unwarranted disciplinary action or altogether overlooked in the prison context (Williams, Stern, et al., 2012). For instance, personality changes, irritability, and aggression can be misattributed to an individual’s struggle to adjust to institutional life. Williams, Stern, et al. (2012) add that it may be more difficult to detect cognitive impairments in prisoners because they are not often responsible for the independent completion of routine tasks, including cooking and laundry, and they are not required to complete more complicated tasks such as managing finances. Difficulty completing such tasks might otherwise indicate some sort of cognitive decline. The challenge of detecting dementia among older prisoners is made worse by the lack of cognitive screening tools appropriate for use in prisons. Tools that are used in the

community may not accurately detect cognitive deficits in prisons setting because of lower educational attainment and literacy among prisoners (Williams, Stern, et al., 2012).

As aforementioned, the “ethos” or “culture” of prisons is also constructed “around an implied figure of a young, able-bodied...prisoner” (Crawley, 2005, pp. 351-2). The organizational culture among correctional staff contributes to the harm experienced by older prisoners. Potter et al. (2007) suggest the correctional staff resist awareness of the needs of older prisoners not directly related to management priorities. In this regard, older prisoners, who typically pose little threat to the established order, are neglected by correctional staff who are preoccupied with disruptive prisoners (Potter et al., 2001; Williams, Goodwin, et al., 2012). Additionally, some correctional staff perceive working with high needs, low risk older prisoners to be a form of domestic work that falls far outside their job description (Crawley, 2005).

Of course, this is not to suggest that incarcerated older adults are muted and acquiescent; alternatively, some researchers have reported some older prisoners are quite ornery (Teller and Howell, 1981). However, in cases where older prisoners demonstrate inadvertence or indifference, it is more often perceived as resistance to the regime and is met with disciplinary action; there is little consideration for the possibility that a pre-existing condition or disability precludes their full and timely compliance with these activities. To this end, older prisoners’ non-compliance, would, in many cases, be better interpreted as an “[indicator] of need or difficulty” (Crawley, 2005, p. 358). Crawley (2005) uses the term ‘institutional thoughtlessness’ to describe the prison’s failure to recognize interruptions to or delays in care as little else than deliberate noncompliance. Institutional thoughtlessness arises out of the need to treat all prisoners equally. Responding to younger and older prisoners according to the principle of sameness constitutes “equality as unfairness” as the particular needs of older prisoners demand a different response in

order to be satisfactorily addressed (Crawley, 2005, p. 355). Instead, “the more needy, more dependent, and more compliant the prisoner group in question, the easier it becomes for prison staff to find recourse within the sameness principle for conferring or denying benefits and burdens arbitrarily” (Crawley, 2005, p. 356).

The literature also suggests that some correctional officers treat prisoners differently according to the nature of the offence for which they were imprisoned. In this regard, relationships between staff and older prisoners are also affected by the disproportionate representation of those convicted of sexual offences against children among the older prisoner population. Mann (2012) found that “despite a number of narratives praising the prison officers... these were unfortunately outnumbered by less positive accounts of disrespectful behaviour and general insolence towards the sex offender” (p. 352). These kinds of relationships are entirely problematic as correctional officers serve as gatekeepers to many programs and services, including healthcare services (Bretschneider and Elder, 2014; Stoller, 2003). According to Stoller (2003), “prisoners always need explicit approval from both correctional and medical staff to cross the doorsill into a clinic or emergency room” (p. 2265). Poor relationships with staff can lead to delays in or prohibited access to treatment (Stoller, 2003).

In addition to tensions observed between older prisoners and correctional staff, friction also exists between older prisoners and their younger counterparts. These relations are often characterized by the perceived threat of violent victimization by younger prisoners (Tarbuck, 2001). Indeed, older prisoners are more prone to victimization than their younger counterparts (Cohen and Taylor, 1981; Mann, 2012; Snyder et al., 2009; Tarbuck, 2001). Due to the nature of their crimes, which are more likely to include sexual offences against children, some older prisoners find themselves at the bottom of the prison hierarchy (Cohen and Taylor, 1981). Due to

their poor health, older prisoners are also more likely to be perceived by other prisoners as frail and as such may be exploited by younger people who are much stronger (Fattah and Sacco, 1989). Kerbs and Jolley (2007) indicate that most victimization experienced by older prisoners is in the form of psychological victimization (i.e. threats) and property victimization. Snyder et al. (2009) claim that the threat of victimization by stronger, younger prisoners elicits such fear that it “often reduces the older adult’s physical movement” (p. 119) and has been cited as the “strongest predictor” of mental health (Kerbs, 2000a). Many older prisoners have indicated that they are afraid to get caught up in a fight or incident with a younger prisoner and avoid areas where they would be in close proximity to them; some even reported that they avoid seeking health services that would require them to transfer to a higher security unit and/or facility (Trotter and Baidawi, 2015). Others have “attempt[ed] to create safe physical and psychological havens by becoming as inconspicuous as possible... [disconnecting] from the people and events around them—withdrawing deeply into themselves” (Snyder et al., 2009, p. 122).

2.3.2 (Mis)Managing Older Prisoners’ Health Challenges

Legally, correctional institutions are required to provide a standard of healthcare that is commensurate with that which is available in the community. Specific to Canada, Section 86 of the *Corrections and Conditional Release Act* (1992) states:

1. The [Correctional Service] shall provide every inmate with:
 - a. Essential health care;
 - b. Reasonable access to non-essential mental health care that will contribute to the inmate’s rehabilitation and successful reintegration into the community.
2. The provision of health care under Subsection 1 shall conform to professionally accepted standards.

In Section 151, the CCRA (1992) further states that: “Correctional policies, programs and practices... be responsive to the needs of women and Aboriginal peoples as well as to the needs of *other groups of offenders with special requirements*” (emphasis added). In earlier sections of

this chapter, I demonstrated that older prisoners have unique health needs, while acknowledging that this population is not homogeneous and that there are significant challenges associated with defining older prisoners. By and large, older prisoners have significant health needs and are expected to place considerable demands on prison health services as they age (Snyder et al., 2009; Stojkovic, 2007; Tarbuck, 2001; Williams, Goodwin, et al., 2012; Williams, Stern, et al., 2012). Under the *CCRA*, it can be argued that CSC is therefore obligated to be receptive to the needs of this special population. Further to this, Section 69 of the *CCRA* (1992) specifies that no person be subjected to “any cruel, inhumane or degrading treatment.” Some scholars have argued that indifference to medical needs constitutes an unnecessarily cruel infliction of pain (Stojkovic, 2007). In this way, ageism inherent to the prison system could constitute cruel and unusual punishment in cases where it leads to medical neglect.

In spite of legislative measures designed to protect prisoners, many questions have been raised with regard to whether older prisoners receive equivalent care. The principle of equivalency “aims to ensure both ethically and legally acceptable standards of health care for detainees and the protection of their health and their human dignity despite their imprisonment” (Bretschneider and Elger, 2014, p. 320). As stated, custodial populations have the right to a standard of health care equivalent to care available on the outside. For many prisoners, however:

The dearth of options in managing the most problematical prisoners has fostered an environment of serious neglect. Included among this group is the elderly prisoner. In fact, the elderly prisoner suffers more due to a dearth of correctional options. Given the complexity of his needs, the elderly prisoner’s plight is compounded when his need cannot be reasonably met, thereby experiencing “extra” abuse and neglect at the hands of correctional administrators (Stojkovic, 2007, p. 105).

These failures disproportionately affect older prisoners. Due to their greater health needs, older prisoners actually require *more* care than many younger prisoners to reach a predetermined minimum standard of care that serves their health and dignity to the same measure. In this sense,

not only are older prisoners unlikely to be receiving equivalent care to their community counterparts, but they are also unlikely to receive equivalent care to their younger correctional counterparts due to differential need (Bretschneider and Elger, 2014). Lines (2006) has called for superior health care standards in prisons than those that exist in the community, advocating not for an improved standard of equivalency, but rather standards that would achieve outcome-based equivalency objectives.

The literature identifies a number of problems related to the delivery of health services in correctional institutions. It is suggested that healthcare services are deeply affected by the prison milieu via the imposition of limitations on medical caring in accordance with custodial priorities:

The spatial organization and structure of the prison reflect management goals in opposition to the putative goals of a committed health care provider. Where humanistic health practice requires an acknowledgement of interconnectedness, prisons are based on principles of exclusion, separation, and confinement. Where physicians and nurses provide care and comfort to those in pain and those who are disabled, a prison system demands discipline and the stripping of identity, possessions, affection, and touch. And where medicine attempts to provide cure and management of disease, the primary goal of [twenty-first] century corrections... is typically detention and punishment (Stoller, 2003, p. 2265).

Stoller's (2003) assertion constructs the prison as a place where the provision of care is fundamentally at odds with the punitive ideology underpinning correctional services. For this reason, a patient will often remain a prisoner first in carceral settings (Mellor, 2003). This implies a dichotomous identity, specifically that of the prisoner-patient, who is frequently denied the fundamental rights conventionally afforded to patients (e.g. privacy) because these rights are incompatible with the custodial culture (Crampton and Turner, 2014). Furthermore, Christie (2006) contends that prisons are dominated by "economic thinking with the priority given to economic goals over all other possible goals and concerns" (p. 64). As such, budgetary restrictions lead to the cancellation of 'non-essential' services, including specialized healthcare

services that may provide a standard of care beyond a bare minimum. For these reasons, healthcare in prisons is often described as inadequate.

Nevertheless, “the quality of healthcare delivery is suspect” for prisoners of all ages (Stojkovic, 2007, p. 102). Condon et al. (2007) found that participants reported long wait times, as well as inefficiency and poor communication among medical staff, resulting in further delays and increased suffering. They also cited a lack of privacy when accessing healthcare services, making it difficult to deal with more sensitive issues and potentially deterring some prisoners from bringing certain issues to the attention of staff. Those suffering from chronic conditions like diabetes also expressed concern that their dietary needs were not being met despite the involvement of medical staff (Condon et al., 2007). This reveals a lack of coordinated and integrated efforts to improve the health outcomes of incarcerated men and women, but due to their greater need, older prisoners are likely to experience even larger gaps in service delivery (Kerbs, 2000a; Potter et al., 2007; Snyder et al., 2009). To examine the extent of this concern, I proceed with a brief review of literature specific to different forms of care in prison.

Medical and Psychiatric Care. De Viggiani (2006) contends that emphasis on disease, illness, and disability “has led to heavy preoccupation...with acute secondary health care and treatment and, to a lesser extent, primary care provision. Prison health services are thus principally orientated towards short-term problem solution rather than...public health goals” (p. 72). Responding to health concerns in a primarily reactive manner is consistent with the biomedical or techno-medical paradigm (de Viggiani, 2006; Stoller, 2003), which has been heavily criticized for its failure to promote holistic health and well-being insofar as it fails to treat the root causes of poor health, which are not strictly biological in nature (Christie, 2006). Stoller (2003) explains that “there is a difference between the work of ‘caring’ which arises from

a responsibility to the other and the work of diagnosing and curing the physical body” (p. 2274), which raises concern for the ethics of medical care in prison given its diagnostic and curative preoccupation. For example, Stojkovic (2007) notes that many chronic conditions can be better managed through healthy eating habits, proper exercise, and improved health literacy. In the non-incarcerated population, there have been “targeted efforts to address early signs of [chronic] illnesses and to develop appropriate treatment protocols. In...prison, more often than not, this is not the case” (Stojkovic, 2007, p. 102).

Personal and Long-Term Care. Personal care (or social care) involves providing support and assistance through ADLs (O’Hara et al., 2015). While old age and long-term care are not synonymous, age-related illness and functional decline often lead to long-term care. In the community, this kind of care is often provided by social workers, personal support workers, and in some cases, trained medical professionals like registered nurses. Instead, other prisoners often provide this form of care, sometimes as part of a formal program (see, for instance, Stewart, 2000) and other times on an informal basis (O’Hara et al., 2015).¹⁵ The latter can lead to health complications such as infection where proper training is not available (O’Hara et al., 2015).

End-of-Life Care. End-of-life or hospice care is intended for those who have been given a prognosis of six or fewer months to live (Linder, 2014). In the community, the goal of hospice care is a “patient-defined dying experience that neither hastens nor impedes the dying process” (Linder, 2014, p. 185). As such, patient comfort takes priority. Hospice care is interdisciplinary and attends to medical, psychosocial, relational, spiritual, and/or existential patient needs (Linder, 2014). It is important to note that hospice care does not exclude diagnostic and

¹⁵ Formal responsibility for the provision of personal or social care is unclear: “while prisons have a broad duty of care to provide adequate provision for daily living they do not have specific responsibility to provide or commission social care” (Justice Committee, 2013, p. 30). The result is that prisoners often help provide aspects of both formal and informal social care.

“curative” medical interventions. Rather, these courses of action may be administered to hospice patients with the aim of increasing patient comfort and not their traditional disease containing or eliminating purposes (i.e. disease-directed therapy).¹⁶

It is estimated that approximately one-third of older prisoners will die while incarcerated (Stojkovic, 2007). However, it is unlikely that they will receive the level of care described above (Linder, 2014). Given this reality, older prisoners’ fears of dying alone while incarcerated are not unwarranted (Aday, 1994; Saunders, 2013; Wahidin, 2004). Linder (2014) explains that in prison, there are often fewer options for managing pain and other acute symptoms, fewer specialized health professionals who have received adequate training in palliative or end-of-life care, rotating medical and correctional staff that can lead to discontinuity of treatment, and other difficulties that stem from the physical environment and create impediments to care. The hospice experience in prison is also characterized by significant patient-provider mistrust (Williams, Stern, et al., 2012). Yates and Gillespie (2000) add that terminally ill prisoners typically lack access to visitors as well as to estate planning, advance directives, and do-not-resuscitate orders. They are also unlikely to receive any mental and/or spiritual preparation (Aday, 1994). Often, the only amenities provided to prisoners receiving hospice services are basic nursing and medical care (Snyder et al., 2009). Moreover, prisoner volunteers are often responsible for providing hospice care in correctional facilities (Linder, 2014).

Despite the many shortcomings of correctional healthcare described above, the literature suggests that access to healthcare while incarcerated can actually have a stabilizing effect on prisoner health that should not go unnoticed (Woodall et al., 2013; Loeb and Steffensmeier,

¹⁶ This is to be differentiated from palliative care, which combines elements of disease-directed care and hospice care to treat the seriously ill (Linder, 2014). Ultimately, the aim is to ameliorate suffering whether the treatment is hospice or disease-directed.

2011).¹⁷ Loeb and Steffensmeier (2011) found that among a sample of older adults incarcerated in a U.S. prison, some participants reported health improvements during their imprisonment, such as lower blood pressure, being more physically active, and abstinence from alcohol and/or drugs. Others, though their health may not have improved, reported that it had not deteriorated, but rather remained the same (Loeb and Steffensmeier, 2011). In these cases, the level of care provided in prison was greater than that which prisoners had access to in the community; this is especially true where universal healthcare is not available, but is also common in Canada among prisoners who are street-involved or homeless and who do not access healthcare unless they are facing an emergency.

2.4 Release and Re-entry

The extant literature suggests that the transition from custody to community can be exceptionally challenging for older adults who may experience the “pains of reintegration” (Shantz and Frigon, 2009, p. 13) more profoundly. Researchers have found that individuals often receive limited direction from correctional staff regarding their release, including few details about where they would be living and what would happen to them once there (Crawley and Sparks, 2006). Older prisoners facing release have also expressed anxiety over “hostel living” (i.e. halfway houses), which they expected to be disorderly and dangerous (Crawley, 2004). These perceptions demonstrate a “need for privacy, calm, safety and structure in their environment” (Stewart, 2002, p. 1) and are more pronounced among older adults who have endured long-term incarceration, becoming highly habituated to the prison regime (Crawley and Sparks, 2006). The psychosocial adjustments made in order to “survive” prison life impede community reintegration (Crawley and Sparks, 2006).

¹⁷ It is important to note that these gains are often undone in the community when prisoners return to the same places that perpetuated their health issues in the first place (Woodall et al., 2013).

Older prisoners often have limited social networks in the community, which affects their resettlement. As mentioned, older prisoners are more likely than their younger counterparts to be charged with sexual or violent offences and as such, they are more likely to be serving a long-term sentence (Rikard and Rosenberg, 2007; Uzoaba, 1998). In order to cope with long-term incarceration, many prisoners distance themselves from family and friends in the community (Crawley and Sparks, 2006). One study found that most older prisoners “had no contact with family or community members” which suggests they have few “supports to assist them through the challenges of every day prison experiences, let alone provide for any re-integration” (Maschi et al., 2014, p. 64). Having “nothing and no one to go out to” and too little time left to ‘start over’, older prisoners tend to experience heightened anxiety over their impending release (Jamieson, Crawley, Noble, and Grounds, 2002, p. 4). Even for those with supportive networks in the community, older ex-prisoners with significant health needs may impose an enormous burden on loved ones who may not be willing or able to care for them (Stojkovic, 2007).

Meaningful occupation is also important to community reintegration, but often eludes older ex-prisoners. Crawley (2004) explains that much like their younger counterparts, “older people also need to feel that they are a ‘part of something’; this entails engaging in meaningful activities with others” (p. 32). Regrettably, community correctional programming typically addresses vocational needs; older adults who are of retirement age or are unable to work due to physical health, mobility issues, or cognitive impairments are less likely to glean anything from these programs and may fail to achieve a sense of purpose, causing them to withdraw into isolation (Stewart, 2000).

Finally, older adults may struggle with re-entry because of ill health. As discussed, high rates of illness have been observed among correctional populations, in part due to limited access

to quality care in the community prior to incarceration (de Viggiani, 2006; Goetting, 1984; Linder, 2014; Potter et al., 2007; Williams, Stern, et al., 2012; Woodall et al., 2013). Moreover, penal institutions are known to exacerbate illness (Christie, 2006; Condon et al., 2007; Stoller, 2003). Upon release then, many prisoners return to the community in a state of disrepair (Davies, 2011). For others, prison has a stabilizing effect on health because the care they receive inside is better than that which they have access to in the community, which is notably marred by impoverished socio-environmental conditions that many return to upon release (Woodall et al., 2013). Crawley and Sparks (2006) indicated that elderly prisoners had significant concerns with regard to whether they would be able to access the healthcare they need in the community. Expectedly, those with severe health problems are most likely to experience the anxieties due to their dependence upon the formal and informal provision of health care in prison (Davies, 2011). Given these circumstances, Maschi et al. (2014) call for institutional disease prevention programs, improved medical care for the incarcerated, and for healthcare providers to ‘anticipate’ transitions to community-based care through enhanced release planning.

2.5 Concluding Comments

To summarize, the extant literature on aging in prison illustrates the disproportionately poorer health of older adults involved in the criminal justice system and begins to explore possible explanations for these observations, implicating the correctional system in its failure to recognize and respond to the unique needs of this population. To better understand this relationship, I endeavour to highlight spatiality and how it affects incarcerated and formerly incarcerated older adults’ access to health and healthcare by focusing on characteristic features of penal institutions and community-based correctional settings. By examining the spaces in which criminalized populations grow old, we may improve our capacity to address the health

challenges that incarcerated and formerly incarcerated older adults face. In the next chapter, I outline key literature that theorizes space and spatiality as relevant to institutional and community-based correctional settings in order to construct the framework through which I analyze older adults' health experiences.

CHAPTER 3: THEORETICAL FRAMEWORK

As briefly introduced at the outset of this thesis, there is enormous diversity in how scholars think about space and spatiality, giving rise to “multiple, sometimes contradictory, layers of meaning” (Arias, 2010, p. 31). In what follows, I consider several ways to approach the spatial, in its various material and discursive forms, for the purpose of locating a point of entry for the subsequent analysis of formerly incarcerated older adults’ health experiences in institutional and community-based correctional settings. First, I provide a brief overview of early developments in spatial thinking. I then proceed by explicating the (re)spatialization of social theory, to which French Marxist philosopher Henri Lefebvre is increasingly recognized as having been one of the most important contributors. I conclude this chapter by situating this literature within relevant theorizations of carceral space that are central to carceral geography, an emergent sub-discipline within human geography.

3.1 Theorizing Space and Spatiality

In this section, I explore mid- to late-twentieth century works that drove the contemporary reassertion of space and spatiality in critical social theory, focusing primarily on the work of Henri Lefebvre whose persistent “spatializing voice” is credited for sparking the reworking of space and spatial theory (Soja, 1989, p. 16). As mentioned, space was once conceptualized as an inert container as per Newtonian and Cartesian ontologies emerging in the late seventeenth century (Janzen, 2002). Soja (1989) explains that space and spatiality were primarily understood in these terms until the 1960s. Until this time, social theory was dominated by historicism, which emphasized the temporal contextualization of social life (Soja, 1989). Accordingly, social meaning and action were primarily understood according to the logic of

time. This hegemonic historicism was largely inattentive to the “formative spatiality” of social being, resulting in the “theoretical peripheralization of space” (Soja, 1989, p. 31, 15).

By the early twentieth century, in the wake of proliferating modernization and the rise of the imperialist state, several prominent Marxists, including Vladimir Lenin, became attuned to geographical issues arising from capitalist systems. Around the same time, social science started to grow critical of this persistent historicism and with this, writers like Max Weber and Emile Durkheim began considering human geography. However, Soja (1989) asserts that in both cases, this emerging “geography of modernity remained essentially an adjunct” (p. 33). The subordination of spatiality would persist for another 50 years with the “involution of Modern geography” (Soja, 1989, p. 35). During this time, disconnect grew between geographical analysis and social theorization and the latter became almost entirely de-spatialized. Human geographies were limited to studying the ways in which the environment could influence human behaviour and, alternatively, the role that social life plays in changing the physical geographical landscape (Soja, 1989). Only a few traces of “provocative geographical analysis and theorization” remained intact through this “spatial acquiescence,” including the Chicago School’s urban sociology emerging in the 1920s and 1930s (Soja, 1989, p. 39).

Beginning in the 1960s, a restructuring of western Marxist tradition and the historical materialist understanding of modernity led to the rediscovery of the spatiality of social life. In this, Soja (1989) sees the emergence of a postmodern discourse that would open Marxism up to a materialist understanding of space and spatiality. Indeed, a post-historicist, postmodern critical geography soon emerged out of French Marxist tradition. With this, “Lefebvre is discovered seemingly out of nowhere... his constancy [leading] the way for a host of other attempted spatializations” (Soja, 1989, p. 41).

3.1.1 The Production of (Social) Space

Lefebvre's most explicit theorization of space is found in *The Production of Space*. In this text, Lefebvre (1991) articulates the need for a "unitary theory" of space that addresses "the *physical*—nature, the Cosmos; secondly, the *mental*, including logical and formal abstractions; and, thirdly, the *social*" (p. 11, emphasis in original). He is primarily concerned with explicating the latter, social space, which he describes as a kind of reconciliatory space that encompasses both physical and mental space, "[subsuming] things produced, and [encompassing] their interrelationships in their coexistence and simultaneity—their (relative) order and/or (relative) disorder" (Lefebvre, 1991, p. 73). In short, it is the space of all social life; "a general means, medium, and milieu of all social practices" (Stanek, 2011, p. 134).

Grounded in Marxist tradition, *The Production of Space* offers a critical spatialization of social life in which Lefebvre contends that political-economic relations are inscribed into the spatiality of social being (Janzen, 2002). Specifically, Lefebvre theorized that space is produced (and produces) according to the logic of capitalism and as such, is contingent upon the mode of production. In these terms, space is not merely a "passive surface...that enables things to take place" (Merrifield, 2006, p. 107). Instead, Lefebvre asserts space as the "form of a relation between things" which is both "organic and alive. It has a pulse. It palpitates, flows, and collides... with other spaces" (Merrifield, 2006, p. 107). Therefore, space must be known as a *production*, an "active moment in social reality" (Merrifield, 2006, p. 106). But it is also *producing* insofar as it shapes and orders social life—again, according to the dictates of capitalism. In this regard, space constitutes a means of control, having derived from ideological, political, and economic forces "that seek to delimit, regulate and control the activities that occur within and through it" (Zieleniec, 2007, p. 61). Ultimately, space is something that is politically,

economically, socially, and culturally constituted and constituting, both a product and determinant of social relations.

Thinking about space in this way, Lefebvre introduced a conceptual triad that demonstrates the simultaneity of both material and representational practices and their role in co-constitution of space (Janzen, 2002). Lefebvre's framework consists of three different kinds of space, which I detail below: representations of space, spatial practice, and spaces of representation. This three-part dialectic depicts social space, encompassing the various spatial forms of all social relations. Importantly, these "fields" of space cannot be apprehended separately, for "fragmentation and conceptual dislocation...[serve] distinctly ideological ends... [propping] up the status quo" (Merrifield, 2006, p. 104). Instead, they are best understood as "specific moments that blur into each other" (Merrifield, 2006, p. 132), inseparable from one another insofar as "each involves, underpins and presupposes the other" (van Ingen, 2003, p. 202). Importantly, the relationships that exist between each field of space are not linear, nor are they stable; in fact, these 'moments' may reinforce or contradict one another with no part of the triad being "superior or determinative of the others" (Friedman and van Ingen, 2011, p. 96). Given this, examining the surrounding context (i.e. the conditions that may have an impact on the production and reproduction of a particular space) is gravely important (Merrifield, 2006).

Representations of Space. Representations of space refer to conceived space (Lefebvre, 1991). For Lefebvre (1991), this is the most prominent kind of space. It is "the space of scientists, planners...and social engineers...whom identify what is lived and what is perceived with what is conceived" (p. 38). It is deliberately planned and has an intended function matched to its form, rendering these spaces coherent and systematic. Broadly, these spaces consist of "arcane signs and jargon, objectified plans and paradigms used by...institutions" (Merrifield,

2006, p. 109) and are very closely “tied to the relations of production and to the ‘order’ which those relations impose, and hence to knowledge” (Lefebvre, 1991, p. 33). In light of this, Zieleniec (2007) suggests that these forms of space can be thought of as spatialized discourses. These discourses “[overlay] physical space, making symbolic use of its objects, and non-verbal codes, signs, and the physical and visual environment guide how this space is experienced” (Lefebvre, 1991, p. 39). Representations of space are “imposed by business, the state and bureaucratic apparatuses” that subscribe to particular ideologies (Merrifield, 1995, p. 297). Because these entities control how a given space is represented, they control how it is organized and used. However, in order to exert total control and become fully determinative, these spaces would have to “crush lived sensual representational space” (Merrifield, 1995, p. 297). That is, these spaces would have to inhibit re-appropriation by the individuals and communities that make unique use of them.

Representations of space are identifiable by examining the processes through which institutional space is physically and aesthetically designed (or refashioned) by architects, engineers, and civic leaders (Lefebvre, 1991). These processes can be understood through an analysis of the discourses utilized by planners and overseeing officials, the logics through which architects designed the space, and the rules that administrators established to govern a particular space (Friedman and van Ingen, 2011).

Spatial Practice. Spatial practice refers to perceived space; it is “concrete, material, and physical” (Elden, 2004, p. 189). This kind of space comprises the empirically observable practices of everyday life (Peterson and Minnery, 2013; Stanek, 2011). Spatial practice “derives from the physical field of nature and materiality and intersects with material production to produce a space which can be perceived” (Stanek, 2011, p. 129). Specifically, it refers to the

ways in which social life is produced and reproduced through “physical and material flows (of individuals, groups or commodities), circulations, transfers and interactions that occur in and across space” (Zieleniec, 2007, pp. 72-73). Not only does it encompass physical objects and specific sites or locations (i.e. material places), it also comprises the everyday activities occurring within these places, many of which are embodied (van Ingen, 2003; Friedman and van Ingen, 2011). Navigating these routines entails the “use of an established spatial economy characteristic of each social formation (place)” ultimately “demonstrate[ing] the ways in which bodies interact with material space” (van Ingen, 2003, p. 201). These everyday activities “take place” in a fairly enduring and consistent manner and “secrete” their own social space in doing so (McMann, 1999, p. 172).

Spatial practice presupposes the use of the body, often in predictable, unthinking ways (Shields, 1999 as cited in van Ingen, 2003). As such, spatial practices embody representations of space (Janzen, 2002). To this end, spatial practice serves “to achieve, preserve, perpetuate and expand the distribution of social, political and economic power” by structuring the use of space in precise ways, as circumscribed by civic elites and designers (Zieleniec, 2007, p. 120). The material practices are inherent to the “economic process of production, consumption and distribution” and it is for this reason that Lefebvre conceptualizes spatial practice as fundamental to the “reproduction of capitalist social relationships” (Stanek, 2011, p. 130).

These practices “help to identify what places are accessible and forbidden, the boundaries that define and separate spaces from each other, and the types of interactions that occur within a space, as well as structuring the flows of people in and through space” (Friedman and van Ingen, 2011, p. 96). While these practices (including various routes, networks, patterns, and

interactions) help structure our lived reality (Merrifield, 2006), they also “provide for the possibility of representational spaces” (Janzen, 2002, p. 112).

Spaces of Representation. This kind of space, also referred to as representational space, is understood as “the space of ‘inhabitants’ and ‘users’”; it is “directly *lived* through its associated images and symbols” and modified through everyday life (Lefebvre, 1991, p. 39, emphasis in original). Importantly, inhabitants’ use of a particular space does not necessarily match its prescribed usage, as indicated by representations of that space. While representations of space comprise a coherent “system of interrelated signs,” spaces of representation comprise our response to ordered space; we appropriate space by “tracing out desires that are neither determined nor captured by the systems in which they develop” (Stanek, 2011, p. 131). Put differently, we use spaces in ways that are different from that which its designers intended, in turn transforming that space, its meaning, and its uses (Lefebvre, 1991). In this sense, representational space is the “space of the body, of everyday life, of desire, and of Anti-Logos... which opposes the rational, analytical and technocratic knowledge” of spaces of representation (Merrifield, 1995, p. 297). In consequence, representational space is conceptualized as fully lived space, reconciling conceived space and perceived space.

Importantly, spaces of representation are spaces of “pure subjectivity” that comprise the human experience in terms of “sense-making, imagination, and feeling,” encompassing a person’s “local knowledge of the space as they encounter it” (Zhang, 2006, p. 221). This kind of space largely consists of systems of non-verbal symbols and as such, spatial meaning often cannot be verbalized. Instead, meaning has an aesthetic dimension; that is, knowledge of space “is realized, in the first instance, not in words but in affectively charged bodily response[s]” (Wynn, 2009, p. 114). Representational space is felt more than thought. Given this, spaces of

representation are often marked by disruptive practices, whether this entails minor acts of nonconformity to the expectations of designers and/or administrators, or major disruptions that are explicitly prohibited through rules and laws (Friedman and van Ingen, 2011). As such, representational space can be understood as “both enabling and oppressive” (van Ingen, 2003, p. 204). It produces counterhegemonic social space via resistant and oppositional practices, but it also produces and enforces marginalization via discriminatory practices such as racism, sexism, and ageism (van Ingen, 2003).

Lefebvre and Other Prominent Spatial Thinkers. To further elaborate on the production of space, I draw on the work of French scholar Michel de Certeau. De Certeau (1984) describes space as something that is “actuated by the ensemble of movements deployed within it. [It] occurs as the effect produced by the operations that orient it, situate it, temporalize it, and make it function...” (p. 117). It is, most simply, a practiced place. As such, a “space” defined by planners, does not become so until it is lived: “the street geometrically defined by urban planning is *transformed into a space by walkers*” (de Certeau, 1984, p. 117). In asserting this, de Certeau distinguishes between ‘strategies’ and ‘tactics’. The term ‘strategies’ refers to the “purview of the powerful” to carry out their mandates in a predictable and consistent manner, thereby defining the space within which these campaigns are instituted (de Certeau, 1984, p. xix). However, de Certeau (1984) contends that space is largely inaccessible through the “usual political and economic determinations” (p. xxiii) thus implying the necessity of tactics in the production of space. Tactics refer to actions that are adapted to the environment by users. They are the ways of operating that “constitute the innumerable practices by means of which users appropriate the space organized by techniques of sociocultural production” and “trace out...other interests and desires” that coherent systems are oblivious to (de Certeau, 1984, p. xiv, xviii).

I also draw on the work of Michel Foucault. In spite of some fundamental differences between Lefebvre and Foucault in what Elden (2001) calls a “problematic relationship” (p. 81), their writing is in some ways complementary. Much to the same effect as Lefebvre, Foucault (1986) rejected the idea of space as an inert container and “focused our attention on another spatiality of social life, an ‘external space’, the actually lived (and socially produced) space of sites and the relations between them” (Soja, 1989, p. 17). However, unlike Lefebvre who was largely preoccupied with explicating the relations between space and society, Foucault was especially attentive to interrelations between spaces. In his musings, he describes the current era as the “epoch of space... one in which space takes for us the form of *relations among sites*” (Foucault, 1986, pp. 22-23, emphasis added).

In spite of these differences, we are able to draw connections between Lefebvre’s spaces of representation and Foucault’s heterotopias.¹⁸ Foucault (1986) uses the term ‘heterotopia’ to refer to “heterogeneous spaces of sites and relations” (Soja, 1989, p. 17). These places are *real*, unlike the perfect and meticulously arranged yet unreal and placeless sites known as utopias. These are counter-sites, but are not *dystopic*; rather, they are sites *of the other* to the extent that they are “messy, ill constructed and jumbled” (Foucault, 1986, p. 27). These spaces are predominately relational, not “substanceless [voids] to be filled by cognitive intuition not a repository of physical forms to be phenomenologically described in all its resplendent variability” (Soja, 1989, p. 187). They are simultaneously concrete and abstract, “[spaces] rarely seen for [they have] been obscured by a bifocal vision that views space as physical form *or* mental construct” (Soja, 1989, p. 18, emphasis added).

Foucault distinguishes between two kinds of heterotopias. The first is the ‘crisis heterotopia’. These spaces are privileged places where those in “crisis” live out of sight. Here,

¹⁸ Lefebvre also conceptualizes his own ‘heterotopias’, but his approach is vastly different from Foucault’s.

crises include various “rites of passage” ranging from menstruation to old age. There are also ‘heterotopias of deviance’—places to which we relegate those who behave outside of prescribed norms (e.g. prisons). Importantly, Foucault’s heterotopias can be thought of as “particular spaces of representation” linked to the more clandestine side of the social and are thus never completely knowable (Cenzatti, 2008, p. 82). In this way, they are not simply the counter-spaces Lefebvre calls representational space; rather, Foucault’s heterotopias are more othered, “stem[ing] from an endless series of difference *within* the space of representation” (Cenzatti, 2008, p. 82). Essentially, they are subverted representational spaces.

3.1.2 Embracing Spatial Inquiry

Ultimately, Lefebvre’s triad comprises an explicit framework through which we can examine spaces for the types of social relations that are implicated in their production, as well as those relations which the space reproduces, challenges, and changes. However, it is important to note that Lefebvre’s three ‘moments’ of spatial production represent only his most explicit theorization of space. While this three-part dialectic forms the foundation of his theoretical approach to space, his uncut theorization engages with a broad range of philosophy and social theory and is thus more aptly understood as a metaphilosophy (Soja, 1996; van Ingen, 2003). In spite of this and due to limitations discussed at greater length in the following chapter, my analysis primarily hinges on Lefebvre’s conceptual triad; I use his three forms of space to decode the “invisible processes, as well as [the] visible practices of brute force and structural injustice” (Merrifield, 2006, p. 108) that shape the experience of growing old in correctional environments.

Lefebvre’s work is especially useful in spatializing our understanding of aging in the carceral milieu for two main reasons. First, it challenges the privileging of place. Place is conventionally understood as a fixed location or site “where an activity or object is located and

which relates to other sites or locations because of interaction, movement and diffusion between them” (Agnew, 2011, p. 23). Place can also be thought of as comprising sites “transformed and given cultural meaning through human activity” (Cartier, 2003, p. 2292). In this sense, place refers to the occupation of a “series of locales or settings” and is culturally embedded (Agnew, 2011, p. 23). Finally, place can refer to a sense of belonging, “either consciously or as shown through everyday behavior such as participating in place-related affairs” (Agnew, 2011, p. 24).¹⁹ In contrast to these broad conceptualizations, space is something that is abstracted and appropriated *from* place to produce and reproduce particular (socio)spatial forms (Cartier, 2003). Focusing on space as understood by Lefebvre instead of place allows for an exploration of the *transcarceral*, which is not geographically bound. Of course, this is not to say that place is unimportant. Place gives us an idea about the conditions or contexts (given that there can be many “spaces” inside a prison) where it may be appropriate to perform certain acts and others where it may be inappropriate (e.g. emotion zones). Casey (1993) contends that we must first know place because we understand location relationally from the perspective of the body.

Lefebvre’s theoretical framework also centralizes the body, ultimately recognizing that the body, social relations, and space are “mutually-constitutive” (Friedman and van Ingen, 2011, p. 96). For him, everyday life is characterized by pulses and rhythms that not only act upon the body, but are also understood through the body (Simonsen, 2005). More specifically, spatial practice (perceived space) feeds sensual experiences and helps structure the ways in which the body can be used (Simonsen, 2005), while spaces of representation (lived space) is inherently embodied, comprising the reflexive ways in which the body is used (Elden, 2004). Importantly, the lived body is absent in representations of space (conceived space). In this kind of space, the body is reduced to an abstraction, but is nevertheless etched in the space of planners, which is

¹⁹ Placelessness, then, can refer to lacking a fixed location, discernable cultural features, and/or a sense of belonging.

determinative of spatial practice; that is, how bodies are (expected to be) used in the space (Elden, 2004). Ultimately then, Lefebvre's inclusion of the body "encompass[es] both the active, lived body that produces space, and the ways in which the body is constructed and inscribed in the production of space" (Friedman and van Ingen, 2011, p. 97). This centralization of the body is important to the study of aging in correctional environments given that aging is primarily understood in physiological or biological terms and the vast majority of age-related illnesses have physical causes and manifestations. Moreover, this "decline" tends to have enormous implications in terms of mobility. Spatial inquiry provides an inlet for exploring the aged body in particular contexts.

3.2 Explicating Carceral Space

To this point, I have detailed what space is and how it is produced in more general terms. In the following, I trace the lines of spatial inquiry in the study of imprisonment and discuss the ways in which these ideas have been employed to help us understand carceral space. At present, the literature that specifically theorizes carceral space is relatively scarce and largely empirical. Ultimately, our contemporary understanding of the carceral as something that is "spatial, emplaced, mobile, embodied and affective" (Moran, 2015, p. 2) is informed by academic engagements within the disciplines of human geography, environmental psychology, and criminology (Moran and Jewkes, 2015). In order to locate a point of entry in this literature, I follow the lead of Dominique Moran who can be credited with having done considerable legwork in bringing together existing geographical research on the practice of incarceration in an authoritative guide, entitled *Carceral Geography: Spaces and Practices of Incarceration* (2015). Using Moran's work as a starting point, I also draw on other important studies that resituate

classic works by Goffman (1961), Foucault (1979), Clemmer (1958), and Sykes (1958) to deconstruct the notion of the carceral briefly introduced in the above.

3.2.1 Introducing the Carceral and Transcarceral

In large part, our understanding of the lived experience of imprisonment is temporally situated, often expressed in terms of prisoners' adjustment to the "temporal rhythms and restrictions of incarceration" (Moran and Jewkes, 2015, p. 165). Indeed, since the mid- to late-1980s, prison scholarship has tended to draw on an understanding of incarceration as an isolated period of time that can be clearly distinguished from the rest of an individual's life course (Moran, 2013b; Moran and Jewkes, 2015). Research on the temporal dimensions of prison life is not problematic in and of itself; however, its centralization has meant that the spatial dimensions of prison life have been relegated to the shadows. In contrast, the emerging field of carceral geography "foregrounds the experience of carceral *space*, both in terms of...the physical manifestation of the penal institution in space" and "the individual's movement into and out of that space and his or her experience within it" (Moran, 2013b, p. 175, emphasis in original).

As articulated by Morris and Rothman (1998), it is "tempting to think of prisons as permanent and fixed" (p. vii); as ahistorical, "paradigmatic container spaces...in which people are merely contained, separated from the rest of active, productive society" (Martin and Mitchelson, 2009, p. 461). There are, however, a number of problems with conceptualizing prison space in this manner. First, the presumed permanence and fixity of prisons contributes to their taken-for-grantedness, their place in society largely unquestioned and unchallenged (Davis, 2003). This understanding also presupposes that prison space is uniform, that all prisons are architecturally similar, built from the same mould and for identical purposes. Prisons, however,

are not uniform physical spaces. While some are purpose built, others are converted buildings constructed at different times, in different places, and for different purposes (Moran, 2013b).

Perhaps most problematically, this conceptualization also implies a binary distinction between ‘inside’ and ‘outside’, which rests on Erving Goffman’s (1961) notion of the ‘total institution’. However, Baer and Ravneberg (2008) suggest that prisons are not necessarily *outside* the general social order. Rather, they contend that prisons can be conceptualized as “heterotopic” spaces that are indeed quite different from other spaces, but remain “*inside* the general social order” (p. 214, emphasis added). Further to this, Martin and Mitchelson (2009) offer that while spatial confinement intrinsic to imprisonment places a great deal of strain on social relationships, ties are not completely severed, suggesting that Goffman’s (1961) “formally administered round of life” (p. 11) is not fully enclosed. Moran’s (2013a) research on prison visiting supports these claims insofar as “prison visiting spaces represent a liminal indistinction between inside and outside, in which both the physical space and the experience of it are reflexively interrelated” (p. 182). The existence of liminal or ‘between’ spaces *within* prisons (e.g. prison visiting rooms) further blurs the line between inside and outside. There is also a growing body of literature on the “impact of the distribution of places of incarceration on the communities which host or surround them” (Moran and Jewkes, 2015, p. 166), which further negates this binary distinction; what happens in prison has political, economic, and social implications for nearby communities (e.g. prisons introduced in destitute rural America as an economic development solution), which should not be the case if ‘inside’ and ‘outside’ were true binaries (see Mitchelson, 2012a).

Further to these critiques, several key studies demonstrate that mechanisms of carceral control are employed beyond prison walls, permeating different spaces and further blurring the

line between inside and outside. The application of these controls in public places transforms these spaces, a process conceptualized as ‘transcarceration’ (Lowman, Menzies and Palys, 1987). The expansion of the carceral net produces ‘transcarceral spaces’, which increasingly rely on communication, surveillance, and management strategies that resemble those used to maintain order in correctional facilities (Maidment, 2006). For former prisoners, this constitutes a kind of ‘reconfinement’ that is unconstrained by physical boundaries (Allspach, 2010). Others have suggested the (trans)carceral can also exist in embodied forms via the corporeal inscription of imprisonment on the bodies of former prisoners (Kilty 2012; Moran, 2014). For these reasons, carceral space is not something that merely exists inside prison walls. Instead, public spaces are transformed through the extended application of carceral control. For these reasons, Moran (2013b) contends that the notion of the ‘carceral’ is “relevant both within *and* outside physical spaces of incarceration” and is rarely experienced as a discrete period of time (p. 176).

As noted earlier, the material body can be understood as a medium through which power operates (Wahidin, 2002). It is, however, not a passive medium; “it is...interwoven with and constitutive of systems of meaning, signification, and representation” (Moran, 2015, pp. 34-35). With this, bodies can be thought of as sites of “textual inscription” (Johnson, 2008, p. 563). Imprisoned bodies are no exception; penal discourses are “imprinted onto the body” (Robert, Frigon and Balzile, 2007, p. 185), in turn shaping prisoners’ identities and structuring their social relations. Moran (2015) argues that “incarceration has a particular set of prison-dependent, tell-tale inscriptions—and... the stigma prisoners may experience after release is to some extent enabled by the ‘lack of fit’ between these inscriptions” and idealized representations of community spaces (p. 35). In an earlier work, Moran (2014) examined released women’s oral health as a ‘corporeal marker’ of incarceration. Many of these women reported having missing

teeth, citing a lack of proper dental care in prison and the preference of visiting dentists to simply remove teeth, rather than treat an underlying problem in an apparent absence of an ethos of care. Once released, the women explained that “their dental health...[was] the single most noticeable physical manifestation of imprisonment—the most outwardly visible and problematic marker of their status” that reduced their likelihood of successful reintegration (Moran, 2014, p. 42). This stigmatization reflects the expansion of carceral control into spaces traversed by previously incarcerated individuals. In this way, the (trans)carceral spaces “exist not just as physical locales, but also through the [corporeal] inscription of incarceration” (Moran, 2014, p. 35).

3.2.2 The Production of Carceral Space

Carceral space, as described in the above, is produced by the application of various mechanisms of control and surveillance, whether bounded by the walls of the prison or not at all. Of course, this does not imply that the physical design of spaces of confinement is unimportant. Prison architecture is but one component implicated in the production of carceral space; it encompasses the processes that “[determine], in large part, how the goals of the criminal justice system are materially expressed and experienced” (Moran and Jewkes, 2015, p. 164). The architecture of the prison is significantly related to the penal philosophy of a particular time and place; it is, in essence, the translated, material form of the prevailing philosophy of confinement. For this reason, Moran and Jewkes (2015) suggest that “an understanding of prison design can enable a better understanding of the lived experience of carceral spaces” (p. 164). Accordingly, we must think about: what purpose the prison serves, or purports to serve; what message it intends to communicate to prisoners and society more generally; and how these specific aims are achieved through the deployment of architecture. Answers to these questions encompass conceived space or representations of space as conceptualized by Lefebvre.

Prisons—and in similar ways community-based facilities—are not only understood in the specific terms used by planners as material expressions of modern penal philosophy, but also as functional mechanisms of control, surveillance, and ultimately punishment. This implicates Lefebvre’s notion of spatial practice, which comprises both the built environment and the everyday activities occurring within and in relation to it. With respect to the former, prison architecture can dictate the experience of confinement, producing “spatial pains of imprisonment” (Hancock and Jewkes, 2011, p. 611). The modern prison is described as ‘hyper-organized’ and highly compartmentalized in an effort to create a space “that is suitable for all the activities of daily life” in the name of efficiency, security, and cost-efficiency (Hancock and Jewkes, 2011, p. 618). In consequence, these prisons produce a “restricted economy of space” that confines both the physical body and the mind (Hancock and Jewkes, 2011, p. 611). Hancock and Jewkes (2011) also discuss new generation prisons as “[exploring] the value of more open, flexible and indeed even playful, spatial planning and design” for the purpose of creating ‘healthier’ prisons (p. 621). However, these designs “represent a new and potentially more insidious form of control that bring their own distinctive [spatial] ‘pains’” (Hancock and Jewkes, 2011, p. 611). For example, modern, open-concept institutions are indeed “spaces that encourage close proximal relations,” but “that laughter, conversation and camaraderie coexist with humiliation and casual violence” (Hancock and Jewkes, 2011, p. 623).

Routine activities occurring at specific site(s) also contribute to the production of carceral space. In fact, understanding imprisonment as an assemblage of spatial practices (Martin and Mitchelson, 2009; Moran, 2015) is crucial, less we fail to recognize “the continual reworking of disciplinary practices within prisons” and the “struggles over autonomy between prisoners and staff,” which would otherwise point to a “diversity of comings and goings, and the near-constant

reordering of that place” (Martin and Mitchelson, 2009, p. 461). To demonstrate how spatial practices of confinement are discursively produced, “constituted through social, political, cultural, and economic relationships” (Martin and Mitchelson, 2009, p. 470), I use examples from the literature on the pains of imprisonment, disciplined mobility, and embodied strategies.

The Pains of Imprisonment. By the end of the eighteenth century, the prison was no longer meant to punish corporeally as it once was (Sykes, 1958). However, Sykes (1958) argued that the *psychological* pains of imprisonment could be just as cruel as bodily suffering. These pains were believed to arise from the deprivation of liberty, good and services, heterosexual relationships, autonomy, and security, which were characteristic of early twentieth century prisons. Sykes (1958) posited that the ‘inmate subculture’ as originally conceptualized by Clemmer (1958) develops in response to these pains, as a way to fulfill needs implicated in Sykes’ discussion of deprivation. Now into the twenty-first century, scholars are suggesting that modern penal practices produce new pains of a fundamentally different nature.

Crewe (2011) contends that the pains produced by modern prisons, albeit different, are not necessarily *less* painful. In fact, he contends that the “carceral experience is less directly oppressive, but more gripping—*lighter but tighter*. Instead of brutalizing, destroying and denying the self, it grips, harnesses and appropriates it for its own project. It turns the self into a vehicle of power rather than a place of last refuge” (Crewe, 2011, p. 524). While “pain is no longer ‘meted out’ in a calculated way,” it is still intrinsic to imprisonment (p. 524). These new pains include: pains of uncertainty and indeterminacy, of psychological assessment, and of self-government (Crewe, 2011). Crewe (2011) explains that indefinite confinement and its relation to the “capriciousness of parole decisions” (p. 513) and the arbitrariness of the prison bureaucracy is characterized by a great deal of uncertainty and insecurity, which in turn causes prisoners

significant anxiety. This resonates with Crawley and Sparks (2006) work with older prisoners facing release, many of whom expressed significant release and resettlement fears due to the uncertainty of their futures. The pains of psychological assessment on the other hand, derive from the use of actuarial risk assessment tools, which are based on aggregate risk calculations (Crewe, 2011). Prisoners are categorized according to their risk level and become known only in terms of the level of risk that they pose. For older prisoners, this can be particularly problematic given that these scales tend to overestimate recidivism among older individuals (Helmus, Thornton, Hanson and Babchishin, 2012). Finally, the pains of self-government are induced by the relocation and reshaping of the “burden of control” onto the prisoner (Crewe, 2011, p. 519). As such, prisoners are increasingly required to manage their conduct. Crewe (2011) claims that prisoners’ “docility is insufficient to indicate a commitment to addressing one’s offending behaviour” (p. 519). Such responsabilization can be difficult to manage for those who have reduced cognitive, emotional, and functional capacities.

Crewe suggests that the vocabulary of ‘tightness’ can help us in further explorations of punishment. ‘Tightness’, Crewe (2011) argues, “gives us a sense of the way that [penal] power is experienced as both firm and soft, oppressive yet somehow light. It does not so much weigh down on prisoners and suppress them as wrap them up, smother them and incite them to conduct themselves in particular ways” (p. 522). To this end, tightness holds an aspect of both depth and weight, where ‘depth’ refers to the extent to which the prison oppresses and invades the psyche, attacking the self; and ‘weight’ is defined as the degree to which the psychological onerousness of imprisonment bears down on those being (ware)housed. Foucault raised similar concerns, “questioning whether the techniques of discipline and regulation that had replaced physical punishment at the end of the [eighteenth] century were more civilized than their predecessors, or

simply a more efficient and penetrative means of ensuring penal control” (Crewe, 2011, p. 510). These ideas are explored in the ensuing discussion of disciplined mobility.

Disciplined Mobility. Described as the potential for movement (Dunn, 1998), or the construction of a field of possibilities for movement through space and time (Knie, 1997 as cited in Moran, 2015), mobility presupposes an individual’s capacity to move autonomously. Prisoners, however, have little choice but “to conform in their movements, their arrangements of meagre possessions... and their daily schedules, even within their cells, to the rule of the larger institution” (Stoller, 2003, p. 2265). The regulation and restriction of movement is inherent to practices of confinement, constituting one of the primary ways through which social control is exercised over criminalized bodies (Martin and Mitchelson, 2009; Moran, 2015). Prison spaces can thus be characterized in terms of the deliberate and material translation of power relations into the social organization of these spaces and movements within them (Massey, 1995).

To the extent that mobility is a “resource to which not everyone has an equal relationship,” institutional control over mobility “both [reflects] and [reinforces] power” (Skeggs, 2004, p. 49). Power can be conceptualized as the way in which a certain action or set of actions can structure the actions of others (Foucault, 1982). Power does not exist in and of itself; it is, above all, relational and “exists only when it is put into action” (Foucault, 1982, p. 788). Wisniewski (2000) contends that this definition permits a ‘weak’ autonomy, perhaps better understood as ‘agency’, that may be understood as an individual’s ability to choose certain actions within a predefined realm of possible action. Where conditions of highly restricted autonomy and mobility are more commonly applied to criminalized bodies for the purpose of exerting control over them, mobility can be understood as a mechanism of power; it is an enforced and *disciplined* mobility (Martin and Mitchelson, 2009; Moran, 2015).

As mentioned, mobility in prisons is highly restricted. Prisoners are unable to access certain areas of the prison at certain times, or they may be prohibited from visiting certain areas altogether. Entry into and exit out of the prison are even more controlled. In these ways, prisoners have become synonymous with immobility relative to the range of movements permitted in the general community (Mincke and Lemonne, 2014). At the same time, prisoners are subject to an emergent “omni-mobility,” which imposes near constant mobility (Mincke and Lemonne, 2014, p. 539). Not only are prisoners barred from certain areas of the prison, but they are also required to be in certain places at certain times. Daily prison routines, enforced by correctional staff dictate these movements. Importantly, Moran (2015) argues that these mobilities and immobilities are differentially felt by prisoners:

In different facilities, different prisoners serving sentences under different regimes, are afforded different levels of mobility, and according to their personal circumstances (including any physical impairments), are differently able to take advantage of opportunities for movement. Prisons are, by their very design, nested pods of space to which prisoners, guards, other prison staff, prison visitors and so on have different extents and levels of access, at different times, and under different circumstances (p. 76).

For some prisoners then, “imprisonment is not only confinement within the physical institution, but also within their physical bodies, for which the prison setting may be poorly adapted, and for whom mobility is further restricted” (Moran, 2015, p. 78). Especially relevant for older prisoners, this additional level of constrained mobility is thus layered on top of the prescribed imposition of highly securitized and restricted mobility that is intrinsic to carceral systems.

Embodied Strategies. Penal discourses not only act *upon* the material bodies of prisoners, but also operate *through* them (Wahidin, 2002) via embodied strategies (Moran, 2015). Deidre Caputo-Levine (2013) suggests that embodied practice can be partly explained in terms of what she calls the ‘carceral habitus’. The carceral habitus is a particular disposition “inculcated through the disciplines of the prison” that “enables the inmate to respond in [an

adaptive] manner to the high levels of interpersonal violence that are present within the prison” with no prior planning or conscious thought (p. 169). It is, essentially, an adjustment to prison life, inclusive of embodied strategies, that help an individual protect him- or herself in the tumultuous prison environment. Caputo-Levine (2013) notes that these embodied strategies are precautionary behaviours; that is, they are generated by the *threat* of violence, and not necessarily actual physical violence. Examples include protective postures, heightened sensitivity to perceived disrespect, and ‘yard face’, which is described as a blank expression that is often perceived as aggressive. Caputo-Levine (2013) notes that the magnitude of the carceral habitus varies with the length of time served; prisoners serving long-term sentences may present few indicators of the carceral habitus, which can be attributed to earning the respect of other prisoners. The security level of the institution also shapes the carceral habitus; prisoners housed in higher security facilities exhibit more indicators of the habitus (Caputo-Levine, 2013).

Importantly, individuals confined to and constrained by carceral space are not only acted upon, but also act upon these spaces and are thus implicated in the co-constitution of the carceral. In the remaining pages of this chapter, I foreground the lived experiences of prisoners. Moran (2015) contends that in order to develop a deeper understanding of carceral space, we need to pay much closer attention to agentic practice.

While older studies of agency in carceral spaces were often grounded in Foucault’s work on ‘biopower’, ‘docile bodies’, the panopticon, and to a lesser extent, Goffman’s (1961) notion of the total institution and his allowance for ‘secondary adjustments’²⁰, key studies in the field of carceral geography, which reflect a keen interest in the lived experience of carceral space, tend to employ theorizations of spatial ‘tactics’ developed by prominent spatial thinkers like de Certeau.

²⁰ Goffman (1961) conceptualized ‘secondary adjustments’ as prisoners’ improvised use of objects, times, and places in an effort to retain some measure of autonomy.

In doing so, they contest Foucauldian approaches to carceral space, namely “the efficacy of the prison in producing ‘docile bodies’” (Sibley and van Hoven, 2008, p. 198), which are those that may first be analyzed, or objectified, and then “subjected, used, transformed and improved” (Foucault, 1979, p. 136). Dirsuweit (1999), for instance, found evidence of resistance and subversion among women imprisoned in a South African correctional facility. Not only were these women observed trading contraband, forging intimate relationships within prison walls, and engaging in prostitution, they were also found to make use of materials found around the prison to ‘decorate’ or personalize their space (Dirsuweit, 1999).

In similar vein, while conducting research in youth institutions, Baer (2005) found that they would display large quantities of peculiar items, such as shampoo bottles and air fresheners, in their cells. This spatial modification of prison space took on a number of different meanings. Baer (2005) reported that in some cases air fresheners were displayed simply to mask an odour, which is consistent with their prescribed use. Others, however, used these items as decorations, as a way to personalize and exert a degree of control over their space. Baer (2005) also notes that during previous visits to correctional facilities, adult prisoners serving longer sentences tended to care for their spaces more vigilantly, while prisoners with comparably shorter sentences displayed fewer items because their time in the prison was limited. This suggests that spatial modification can be employed as a means to cope with imprisonment.

Taking a slightly different approach to the production of space by individual prisoners, Sibley and van Hoven (2008) studied dormitories in a prison for men and found that in prison dormitories, it is expressly difficult for prisoners to establish personal boundaries and they are thus at risk of sensory ‘contamination’. Because “‘mere flight’ is not an option,” prisoners must “develop strategies to remain pure” (Sibley and van Hoven, 2008, p. 202). Common strategies

included keeping their bunk clean and building ‘mental walls’ so that where contamination is unavoidable its experience is less perturbing (Sibley and van Hoven, 2008).

3.3 Concluding Comments

The intricacies of and the discourses underwriting carceral spaces have yet to be explored in the context of aging prisoners and ex-prisoners. By centralizing space in the experiences of formerly incarcerated older adults, we can develop a better understanding of these spaces and the accessibility of health and healthcare for the aging and aged. This thesis primarily draws upon Lefebvrian ideas about the production of space and empirical research in the field of carceral geography to analyze the health experiences of formerly incarcerated older adults while confined to the institution and during their supervised release into the community. In the next chapter, I discuss the methodological approach I engaged to conduct this research; I outline data collection procedures, including key epistemological, reflexive, and ethical considerations, as well as the analytic process and implications for validity as pertinent to the research design.

CHAPTER 4: METHODOLOGY

To gain an in-depth understanding of the health-related experiences of older ex-prisoners and how they are shaped in carceral spaces, I conducted semi-structured interviews with older adults living in CRFs (n=5) and CRF staff (n=4). In this chapter, I explain how I collected and analyzed the interview data. I begin by outlining the guiding interpretive framework, defining central research questions, and operationalizing key terms and concepts. Following this, I describe my research design, including ethical and reflexive considerations, research location, sample selection, recruitment strategies, sample characteristics, and data-collection procedures. Lastly, I discuss my analytic strategy and its implications in terms of research rigour.

4.1 Epistemological Considerations

Before delving into the on-the-ground logistics of this project, it is important to first explicate how I approached the object of analysis and the assumptions I hold about the nature of this object. Ultimately, my interpretive framework shaped the questions that I asked, the importance that I gave to the role of theorizing, the chosen analytic strategy, and claims of epistemic validity (Rigakos and Frauley, 2011).

Given that this study involves a population that is highly heterogeneous, it was important to adopt an approach that could appreciate these differences. Moreover, because the conceptions of space laid out in the preceding chapter understand spatial forms as both concrete and abstract, and as being both a product and determinant of social life, I sought an interpretive approach that would facilitate an exploration of these complexities. The methodology of this project is thus grounded in postmodern conceptions of knowledge. However, due to limitations associated with postmodern epistemology—or, rather, postmodern epistemologies in light of alternative understandings of postmodernism as a “family of theories and perspectives” about knowledge

(Creswell, 2013, p. 48)—and the more pragmatic aims of this study, I do not engage with this theory of knowledge in a holistic way; rather, I am guided primarily by its interpretivist, constructivist, pluralist, and particularist undercurrents.

While modern conceptions of knowledge aim to “*uncover and explain* the underlying determinants of the world,” postmodern approaches are primarily “motivated by the interpretive task to *deconstruct and understand* the sociohistorically shifting meanings attached to empirical actualities” (Susen, 2015, p. 48, emphasis in original). The former presupposes the existence of an objective reality that simply needs to be unmasked. Conversely, the latter posits that truth is *made* (Grbich, 2013; Susen, 2015). Postmodern thinkers also posit that our relation to the world is highly mediated: we are linguistic, cultural, subjective, and affective beings, and thus how we relate to the world is predicated upon the spatiotemporally specific constitution of our material and symbolic relations (Susen, 2015). We “construct and reconstruct reality by virtue of [our] everyday performances” (Susen, 2015, p. 42). In order to understand social life and to bring “concealed hierarchies...dominations, opposition, inconsistencies, and contradictions to the surface,” these realities must be deconstructed (Creswell, 2013, p. 27).²¹

The constructivist metaphysics that underpin postmodern conceptions of knowledge are evident in Henri Lefebvre’s (1991) theorization of space. In *The Production of Space*, Lefebvre asserts space as both a product and determinant of social life; as much a social and historical construction as it is constructing. In doing so, he builds a critical constructivist argument about the ontology of space (Brenner and Elden, 2009) as something that is never primordially given (Soja, 1989). Constructivism is also inherently pluralist and relativist, subscribing to the notion

²¹ It is important to note that while linking constructivism and deconstruction appears paradoxical, Mark Wigley (1998) explains that the process of “deconstructing” reality is “often misunderstood as the taking apart of constructions,” but instead, “the deconstructive architect is...not one who dismantles buildings, but one who locates the inherent dilemmas within buildings” (as cited in Rose, 1991, p. 131).

that “there are multiple, often conflicting constructions and all (at least potentially) are meaningful. The question of which or whether constructions are true is sociohistorically relative” (Lincoln and Guba, 1985, p. 85). The constructivist recognition of the plurality and relativity of meaning is consistent with the understanding of space as transformational and never permanently fixed (Soja, 1989). The constructivist perspective treats “meaning as a function of the spatio-temporal matrix within which emerges” and thus particular representations or practices have no intrinsic meaning of their own; rather, meaning “lies in the place in which it is produced and the machinery that produced it,” the production of which is “a contingent and heterogeneous process” (Brenner and Elden, 2009, p. 20).²²

While modern approaches locate epistemic validity within the rational subject’s capacity to perceive *objective* realities, postmodern conceptions of knowledge derive from the ‘relativist turn’ in epistemology and are thus rooted in the logic that the validity of all knowledge claims is wholly contingent upon the “spatiotemporal specificity of the sociohistorical context” in which they are raised (Susen, 2015, p. 40). Put differently, postmodernists contend that all knowledge is context-dependent (Agger, 1991; Delanty, 2005; Grbich, 2013; Gubrium and Holstein, 2003; Reed, 2010; Susen, 2015). As such, all “knowledge claims must be set within the conditions of the world today and in the multiple perspectives of class, race, gender, and other group affiliations” (Creswell, 2013, p. 27). For this reason, postmodern approaches oppose the modern alignment towards universality in favour of particularity (Agger, 1991; Heartfield, 2002; Susen, 2015). Supporters of postmodern conceptions of knowledge contend that efforts to generate

²² Intending to place Lefebvre’s (1991) theorization of space (including the three moments of spatial production) at the crux of my analysis, I initially began to think of my project as one grounded in a purely constructivist epistemology. However, working outward from the consistently Marxian approach outlined in *The Production of Space*, I also engaged with the conceptual work of scholars that approach their object of inquiry in more varied ways and in ways that centralize ‘lived’ or ‘embodied’ space, which is more reflective of postmodernism on the whole, and not merely its constructivist foundation.

grand narratives are driven by an *illusion* of order. A postmodern epistemology, on the other hand, is characterized by a certain scepticism toward metanarratives and the “rigorous defence of the ‘non-universal’, ‘the particular’ and ‘the local, as well as—in some cases—of ‘the other’ and ‘the oppressed’” (Susen, 2015, p. 47). To this end, a postmodern epistemology is one that recognizes multiple particularities and thus demonstrates a preference for localized experiences situated within specific contexts without any “pretension of abstract theory, universality or generalisability” (Grbich, 2013, p. 112).

This explicit dismissal of the utility of abstraction and theory, however, is a point of contention. Reed (2010) argues that such a dismissal is untenable citing “the dangers and epistemic naïveté of imagining that the researcher enters the field with a ‘blank slate’ for a mind” (p. 34). Instead, he explains that social actors or subjects are oriented by various local meanings and researchers are oriented by abstract social theories. The meanings that orient each party’s actions intersect and are represented in the meaning-laden context of investigation (Reed, 2010).²³ The juxtaposition of postmodern conceptions of knowledge against modern epistemologies reinforces the notion that emergent perspectives evolve out of previous cultural constructions, and are thus “a part of their historical and cultural context” (Bowker, 2001, para. 11). As a result, positivist research traditions cannot be entirely excluded from a postmodern research agenda, which creates space for theoretical and methodological cooperation (Bowker, 2001). Indeed, Lefebvre is persistent in his “conviction about the necessity of universal concepts for the understanding of social reality, including the concept of space” (Stanek, 2011, p. 133).

It is along this line of argumentation that I hope to reconcile the necessity of remaining true to my chosen theoretical framework and more pragmatic concerns. Given the timeliness of

²³ While the application of abstract theory is acceptable to many postmodern philosophers, Reed (2010) notes that “abstract theory is not—and should not be—strictly testable as to whether it accurately represents ‘society’ ...for, society *as such* does not exist—there are rather a myriad of social contexts of explanation” (p. 37).

the subject matter and the many practical concerns that surround the aging correctional population, part of this project is about exploring “reliable platforms for action” (Hickman, 2007, p. 2). In order to do this, it is necessary to construct *a* narrative, in this case, one that engages theories of space and spatiality to interpret older adults’ experiences and to present some insights from a particular way of thinking that may provide insight into ways of acting even in the absence of absolute truth (Hickman, 2007).

4.2 Research Questions

This research project explores how health, illness, and aging are shaped in carceral and transcerceral spaces by analysing the situated experiences of formerly incarcerated older adults under federal correctional supervision in the community. It asks:

- 1: How do older adults experience health, illness, and aging while incarcerated?
- 2: How do older ex-prisoners experience health, illness, and aging while under correctional supervision in the community?
- 3: What are the health-related needs of older ex-prisoners?
 - 3a: How are these particular needs met?
 - 3b: What barriers exist to their fulfillment?
- 4: How is the experience of health, illness, and aging shaped in/by the carceral milieu?

To answer these questions, I conducted in-depth, semi-structured interviews with older adults residing in halfway houses, as well as halfway house staff, including directors and caseworkers who support formerly incarcerated individuals in community-based correctional settings.

4.3 Key Terms and Concepts

To clarify the intended meaning of important concepts, this section operationalizes key terminology. For the purposes of this research, the notion of *old age* in correctional contexts is used in reference to individuals aged 50 and older. As mentioned in my review of the extant literature, this is the point of demarcation used by the Correctional Service of Canada (Uzoaba, 1998). Because the population of interest consists of older adults following their release from

Canadian federal correctional facilities under the purview of CSC, I adopt this particular definition. To conceptualize *health*, I defer to the World Health Organization (WHO), an international entity providing leadership on diverse health matters. The WHO (2003) describes health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” This particular definition moves away from positivist notions of health that conceptualize it as the opposite of disease and as quantifiable scientific fact (Webb and Wright, 2000). Arguably, the WHO’s definition remains broad enough to facilitate an “engagement with the social complexity and contingency of health...” without imposing a singular, empiricist definition (Webb and Wright, 2000, p. 88).²⁴ Closely related to health is the notion of *accessibility*. Something is accessible when the barriers that prevent persons with disabilities from fully participating in civic life are removed (Altman, 2001). *Disability* is more difficult to conceptualize. Disability is commonly defined as a restricted ability, whether physical, intellectual, psychiatric, or sensory, to perform certain functions (Altman, 2001; Devlin and Pothier, 2005). However, this definition presupposes normal and abnormal structures and functions, privileging the former; it assumes that disability has an essential nature. Alternatively, critical disability theorists prefer to conceptualize disability as a highly contextual, socially constructed phenomenon and as such, they aim to “rid the term ‘disability’ of its pejorative and exclusionary origins” derived from the problematic assumptions of the biomedical model (Devlin and Pothier, 2005, p. 4). Whether or not a person is considered disabled is thus contingent upon how buildings have been constructed, transportation systems are designed, and social expectations imposed. For the purposes of this research, I use the term disability to capture

²⁴ Webb and Wright (2000) explain that within a postmodern mode of inquiry, health must be conceptualized as “a multiply determined, culturally contingent concern...a concept constructed within and dependent upon a chaotic and diverse social reality” (p. 89). However, they note that limits must be placed on postmodernism’s relativity and prioritization of “chaotic social processes” in order to develop “coherent and workable frameworks of analysis” and solidify a basis for establishing epistemic validity (Webb and Wright, 2000, p. 89).

both connotations, choosing to define it as a physiological or psychological *ability* that is not accommodated in particular circumstances.²⁵

4.4 Research Design

Having anticipated difficulties recruiting older adults currently serving time in provincial or federal correctional institutions, I chose to focus this research on formerly incarcerated older adults under correctional supervision in the community. Community supervision can take two forms: it can be used as sentence in and of itself (i.e. probation), or as a period after an individual's release from an institution (i.e. parole). Individuals given probation or who are sentenced to a term of incarceration of less than two years are the responsibility of the provinces/territories. Those sentenced to a term of incarceration of two years or more are the responsibility of CSC. Because there is little data on provincially sentenced older adults, and because older prisoners are more likely to have been convicted violent or sexual offences and are thus more likely to serve federal time (Bouchard, 2004; Grant and Lefebvre, 1994), this research focuses on older, federally sentenced adults following their release from Canadian penitentiaries.

CRFs accommodate adults on conditional release (including day parole and full parole), statutory release, work release, and unescorted temporary absences (CSC, 2015a). Primarily, they house those released on day parole (CSC, 2015a). Reasons for choosing to recruit participants from CRFs are twofold. First, previous research on the spatiality of CRFs describes them as 'transcarceral' as they retain some features that resemble institutional life (Kilty and

²⁵ It should be noted that the alternative conceptualization developed by critical disability theorists does little to address the initial dichotomy between impairment and disability wherein the latter is conceptualized as a "natural defect" thereby idealizing the norm and othering the "defective" (Devlin and Pothier, 2005, p. 7). As such, it does little to challenge the "tyranny of normalcy" and fails to "[denude] grand narratives which disparage bodies and experiences that do not fit" (DePoy and Gilson, 2010, para. 4). Consequently, this particular conceptualization does not fall under the parameters of postmodernism. This was a conscious decision made in light of the fact that postmodernism's "carnavalesque gaze and focus on the nonsense of language and symbol [leaves] too many vacancies when looking to theory to inform human rights and equality of opportunity for groups" that would be necessary to form a coherent framework (DePoy and Gilson, 2010, para. 4).

DeVellis, 2010; Lowman et al., 1987; Maidment, 2006). Secondly, because older ex-prisoners can be seen as a vulnerable population, there were concerns regarding coercion if recruiting through CSC or the Ottawa Parole Office. In contrast, CRFs, while under contract with CSC, are non-governmental agencies and thus are not federally owned and operated (CSC, 2015a).

I chose to interview older residents *and* CRF staff for several reasons. I recruited older residents to learn about their experiences directly; however, the population of older ex-prisoners in the community is disperse and comprises a minority (37%) of the individuals on conditional release (Public Safety Canada, 2016). In light of this, I also chose to interview staff to gain insight into a wider range of experiences. As part of their job, CRF staff (including directors, caseworkers, and relief workers) regularly interact with residents; this entails listening to them air their grievances, struggles, and challenges, as well as helping them connect with community services, including healthcare. In this capacity, staff are able to provide insight into the lives of older residents, describe some of the challenges older adults may face in the community, and draw connections between residents' experiences and underlying social structures (Crouch and McKenzie, 2006). Staff members also work in and move about the CRF space themselves; it was hoped that their lived experience in these spaces would help them think about health, mobility, and aging in different ways from someone who is unfamiliar with the facility. Moreover, staff are implicated in the co-production of social space insofar as they regulate its use.

4.4.1 Ethical and Reflexive Considerations

All Canadian research involving human subjects must adhere to a code of ethics, which guides the collection, storage, and representation of data for the protection of human subjects (van den Hoonaard, 2012). These ethical obligations are laid out in the *Tri-Council Policy Statement 2* (TCPS2). Because this research involves interviews with formerly incarcerated older

adults and CRF staff, I submitted an application to the Social Sciences and Humanities Research Ethics Board (REB) at the University of Ottawa compliant with the TCPS2. REB approval to interview CRF staff was granted on July 9, 2015 (see Appendix F). A Request for REB Approval of Modification to include interviews with residents followed on February 1, 2016.

The informed and voluntary consent of all participants is central to ethical research conduct, a discussion of which helps frame other important ethical considerations. To help interested individuals make an *informed* decision regarding participation, I created recruitment posters (see Appendices A1 and A2) and letters of information (Appendices B1 and B2), as well as consent forms (see Appendices C1 and C2),²⁶ all of which contained information about the study's particular focus and objectives, a description of the role of participants, and information about participants' rights. At the outset of each interview, I discussed the nature of the research with participants and answered any questions they had. All participants were required to sign a consent form prior to commencing the interview, indicating that they understood the purpose of the research; what their participation would entail; the benefits and risks involved; measures to protect their confidentiality and anonymity; that the interview would be audio-recorded with their permission; how interview data would be stored and conserved; how they would be compensated; and their right to withdraw from the study or refuse to answer any questions. While the interviews were not expected to cause psychological distress, each participant was presented with a list of community counselling and crisis services that they could reach out to if they experienced anxiety or discomfort at any time during or following the interview (see Appendix E). While staff-participants were given the consent form to read themselves, I asked resident-participants to read the consent form with me, going section by section, and pausing

²⁶ I created separate recruitment posters, letters of information, and consent forms for each sample group (i.e. staff- and resident-participants).

between each to discuss what they had just read and to ensure that they understood their rights (notably with respect to anonymity and confidentiality, refusing to answer a question, ending the interview, or withdrawing from the study).²⁷ Once signed, I scanned the consent forms and stored a electronic copy on my password protected personal computer, and stored the hardcopies in a locked desk drawer in my home.

Because of the coercive nature of the criminal justice and correctional systems, it was of the utmost importance to ensure that all participants, especially residents, provided consent on a voluntary basis. To do this, I provided my contact information on recruitment materials, encouraging participants to contact me directly. Further, I offered participants the option of attending the interview at an alternate location to the CRF if they were concerned about other staff and/or residents observing their participation in this research. Before the start of each interview, I reiterated the participant's right to refuse any questions, terminate the interview, or to remove themselves from the study at any time without experiencing any negative repercussions. Participants were compensated for sharing their time and insights²⁸ and did not have to return the gift card if they ended the interview and/or withdrew from the study.

In order to ensure that data collection and analysis were conducted ethically, there were considerations that went beyond the scope of a professional code of ethics. Danchev and Ross (2014) explain that formal codes are simply not enough to ensure ethical practice as they place

²⁷ These measures were implemented due to the possibility that some older residents may have mental health or cognitive challenges that may affect their capacity to provide informed consent. While interviews with staff revealed that older adults with significant challenges are typically 'screened out' as applicants for residency due to the unsuitability of halfway houses for individuals with these kinds of challenges, some may develop these challenges during their residency or may be accepted into these residences on an exceptional and temporary basis. Because I was not in a position to assess an individual's cognitive capacity to provide informed consent on the basis of mental health, I adjusted the informed consent process for all resident-participants, which also entailed asking Directors to display and/or distribute copies of the consent form to potential participants ahead of the interviews. This provided participants with the opportunity to read the consent form in advance and formulate questions.

²⁸ Staff were given a \$10 Tim Horton's gift card, while residents were offered a gift card for either Shopper's Drug Mart or Tim Horton's in the amount of \$20. Residents were offered greater compensation than staff on the basis that staff were interviewed during paid working hours and residents were in greater financial need.

the responsibility to behave ethically *outside* of the individual. Instead, ethical research practice is contingent upon our capacity to engage morally. Danchev and Ross (2014) contend that principle-based ethics or “principle ethics” can provide a useful guide for confronting ethical dilemmas that centre on the principles of beneficence, non-maleficence, autonomy, justice, and fidelity (Kitchener and Kitchener, 2009). However, Danchev and Ross (2014) explain that this is still a rules-based approach, emphasising the critical importance of reflexivity in the face of emergent ethical tensions.

Reflexivity can be described as “a heightened awareness of the self in the process of knowledge creation...and how such frames/values as age, gender, ethnicity, religion, social class, [and] education... are impacting on interaction, data collection and interpretation in the research setting” (Grbich, 2013, p. 113). To facilitate reflexivity, Guillemin and Gillam (2004) present the concept of ‘ethics in practice’, which refers to an ‘alertness’ to the “ethical obligations a researcher has toward a research participant in terms of interacting with him or her in a humane, nonexploitative way while at the same time being mindful of one’s role as a researcher” (p. 264). To develop and exercise ethics in practice, I remained conscious of my relative position of power as the interviewer (Yardley, 2000), mindful that the language I used did not reinforce the marginalization of my participants. It was also imperative to be sensitive to participants’ reluctance to explore certain ideas in order to mitigate risk of reproducing the same coercive relationships that exist in the correctional system.

Importantly, reflexive ethical practice extends beyond the direct interaction between researcher and participant; analytic engagement with participant narratives must also acknowledge the co-construction of meaning by researchers and participants. Postmodern researchers contend that researchers and participants “are no longer identifiably separate, they

interweave their constructed meanings in a delicate dance of recognition and interpretation as the same narratives are old and re-told, presented and re-presented” (Grbich, 2013, p. 116). The researcher “cannot be separated from his/her background, life experiences and memories (frames), which inevitably filter impressions of the actions and behaviour of others” (Grbich, 2013, p. 113). For these reasons, postmodern scholars call on researchers to disclose their own positions and biases that may, unpredictably, bear on participants’ narratives; this is a form of reflexivity as self-critique (Grbich, 2013). In order to reflect on and engage with my own preconceptions and how they contributed to the research relationship, I paid attention to the emotive nature of the interview data (Grbich, 2013) by making brief notes following each interview, not only to flag important information (e.g. actionable items) but also to recall especially poignant moments occurring during the interviews.

4.4.2 Research Location and Setting

As a resident of Ottawa, I selected this location as the research site partly out of convenience. A regional case study also allowed for a more penetrating examination of health, illness, and aging in one particular locale converse to previous studies, which aim to be more generalizable. To generate a list of CRFs from which I could recruit participants, I consulted a directory of provincial CRFs provided by the now disbanded Ontario Halfway House Association (OHHA). The directory identified six halfway houses in the Ottawa region: five facilities for men, and one for women. Three of these facilities are affiliated with the John Howard Society of Ottawa (Kirkpatrick House, Ste. Anne Residence, and Tom Lamothe Residence), and one is affiliated with the St. Leonard’s Society of Canada (House of Hope). Maison Decision House is the fifth CRF for men. The only halfway house for women in Ottawa is the Jille-Frances (J.F.) Norwood House, operated by the Elizabeth Fry Society of Ottawa.

Of the six residences noted, five agreed to distribute recruitment materials. House directors distributed materials among staff by inserting posters and letters of information into staff information binders. Additionally, three directors forwarded electronic recruitment information directly to caseworkers for their interest. Directors also assisted with the recruitment of residents by posting recruitment posters, letters of information, and consent forms on house bulletins, while also flagging older residents to the research opportunity at their discretion.

All interviews with staff took place at the CRFs during regular working hours. Each of these interviews was conducted in a designated office space. In all cases, house directors gave me permission to use private and semi-private spaces at the facility to meet with residents. Four residents chose to be interviewed at the CRF and staff helped to arrange these meetings. One resident-participant opted to attend an interview off-site. This interview took place at the University of Ottawa's main campus.

4.4.3 Sample Selection and Recruitment

I recruited halfway house staff using purposive sampling methods. Broadly, this technique involves the intentional selection of research subjects for a specific purpose (Babbie, 2008; Berg and Lune, 2012). Interviewees are chosen “by virtue of characteristics thought by the researcher to be likely to have some bearing on their perceptions and experiences” (Barbour, 2008, p. 52). To this end, I sought participants who had substantive experience working with older adults and indicated this in my initial contact with house directors via email. Specifically, I was looking to recruit staff who had worked closely with older residents (e.g. full-time caseworkers as opposed to occasional relief staff), and those who had been employed at the CRF for a significant period of time and were thus more likely to have interacted with a number of older residents throughout the duration of their employment.

To recruit older halfway house residents, I first employed purposive sampling methods. I also used a variation of snowball, or chain referral, sampling. Conventionally, this approach involves interviewing people with certain characteristics and asking them to provide the names of other individuals that share similar attributes (Esterberg, 2002). Through this informal referral process (Atkinson and Flint, 2001), the intended effect is for the initial sample to “snowball” from a few to many participants (Berg and Lune, 2012). Lee (1993) notes that this strategy is popular among researchers studying deviance and particularly sensitive issues and/or populations that are difficult to reach (as cited in Berg and Lune, 2012). While recruitment materials were posted for all residents to see, some Directors also asked staff to approach older residents who they thought might be interested in participating in order to make them aware of the study. At three of the CRFs, staff that I had interviewed spoke with older residents about my study and referred them to my recruitment materials for more information. Ultimately, three residents were recruited with the assistance of CRF staff; two others contacted me independently.

Purposive and snowball sampling methods are both non-probability sampling methods. The methodological literature documents concern regarding the generalizability of findings obtained from non-probability samples (Barbour, 2008; Berg and Lune, 2012; Esterberg, 2002), which are unlikely to be representative of the larger population insofar as they are selected certain characteristics. As qualitative research is typically not concerned with generalizability, instead aiming to reflect diversity and to generate deeper understanding (Barbour, 2008), it is not a significant limitation or concern for this study.

4.4.4 General Characteristics of the Study Population

The research sample consisted of staff and residents of CRFs in Ottawa, Ontario. The sample was drawn from five of the six CRFs located in this region. Five CRF residents between

the ages of 51-79 participated in this study. This includes two men and three women. All were incarcerated in a federal correctional facility prior to their release to the CRF. Residents spent between three years and two months to nearly 40 years in federal custody. All residents reported being incarcerated in a provincial correctional facility at some point in time. Two were incarcerated for the first time in late-middle age. Three served one or more provincial and/or federal sentences prior to their current sentence, including one whose most recent conviction led to life imprisonment. Residents reported living in their current CRF anywhere from eight to 25 months. While the sample of older residents is relatively small, the dataset is supplemented by staff interviews. Four staff members employed at CRFs that house federally sentenced men participated in an interview, including three caseworkers and one director. The least experienced staff member reported seven years of experience working in a CRF; the most experienced reported 12 years working in this environment. Staff estimated working with 20 to 200 older residents and reported that 20-45 percent of current house residents are age 50 and older.

Overall, the physical and mental health of older adults' following their incarceration was described as poor. However, the present study is unlikely to fully capture the experiences of older adults with critical health conditions. This can be partly attributed to screening practices employed by CRFs when assessing potential "clients." As staff-participant #1 explained, the small number of older residents needing assistance with ADLs is "*a product of our assessment ... anyone with those types of responsivity issues are typically screened out.*" In the next chapter, the health characteristics of the sample are discussed in greater detail.

4.4.5 Data-Collection Procedures

As mentioned, I conducted semi-structured interviews with CRF staff and older residents for the purposes of gaining detailed information about older adults' health-related experiences.

Borer and Fontana (2012) explain that while “there is no such thing as postmodern interviewing per se, postmodern epistemologies have profoundly influenced our understanding of the interview as both a product and a process” (p. 1). Although unstructured interviews are often considered to be the most appropriate for postmodern research endeavours because they create a “spontaneous and free-flowing” dialogue” (Esterberg, 2002, p. 89) and emphasize mutual discovery (Bailey, 2007; Berg and Lune, 2012), they present a number of challenges in terms of sense-making and comparability for novice researchers (Grady, 1998).

Given my lack of experience interacting with criminal justice populations and with formal interviewing of any kind, I opted to conduct semi-structured interviews. Semi-structured interviews consist of predetermined, open-ended, and theoretically motivated questions (Lamont and Swindler, 2014), but also allow for unscheduled questions to explore certain ideas, attitudes, and beliefs that are of particular interest or relevance (Bernard, 1998). In fact, this approach encourages probing “far beyond the answers to...prepared standardized questions” in an attempt to generate more textured accounts (Berg and Lune, 2012, p. 112). A semi-structured approach facilitates comparability across participant narratives (Bailey, 2007). To this end, semi-structured interviews offer novice researchers the support of traditional precepts, while also encouraging open-ended questioning and probing in response to emerging dialogue, which is more characteristic of postmodern ideas (Gubrium and Holstein, 1998; Holstein and Gubrium, 1995).

I created two separate interview guides for staff and resident sample groups, each comprised of three sections (see Appendices D1 and D2). Both guides contained a central subset of questions (‘Section B’) that asked about the health-related experiences of older residents, drawing on key themes that emerged from my review of the topical and theoretical literature. Specifically, Section B of the interview guide for staff asked them to report on older residents’

health experiences in the community based on their observations and interactions. Conversely, residents were asked about their health experiences while incarcerated *and* while living at the CRF. During the interviews, I asked probing questions, engaging participants to discuss their insights, perspectives, and experiences, and to clarify or elaborate upon important points.

Due to the time constraints of the graduate program I aimed to conduct between 8-12 in-depth, semi-structured interviews with residents and staff. This range is in keeping with the research of Guest, Bunce and Johnson (2006), which found that data saturation typically occurs within the first twelve interviews, with key themes emerging as early as six interviews. Recruitment proved somewhat difficult and at the end of five months, I was able to secure interviews with four staff members and five residents. Interviews lasted between 45 and 115 minutes and were conducted in English. Eight of the nine interviews were digitally audio-recorded in order to allow for active listening during the interview and to improve the accuracy of transcription (Berg and Lune, 2012). I took limited notes during the interviews jotting down points that I wanted to clarify and other key ideas that were novel or especially salient. One participant declined to be audio-recorded. During this interview, I took more detailed notes, typing them up immediately following the interview in order to accurately capture as many details as possible. For the digitally recorded interviews I created full verbatim transcripts, which included pauses, corrections, and non-verbal signals/gestures. I removed all identifying information to protect participants' anonymity, including the names of participants, their acquaintances, other CRF staff and professionals that were mentioned; dates of birth; and specific locations, including CRFs, clinics, and hospitals. Each participant was asked if he/she would like to receive a copy of his/her interview transcript. Four participants requested a copy for their review, one of which wished to make minor corrections. Offering participants the

opportunity to review the transcripts was intended to encourage their full involvement in the interview process and to help validate the accuracy of the transcripts and notes.

4.5 Analytic Strategy

To organize and examine the interview data, I conducted a thematic analysis of the transcripts, examining participants' insights and experiences. In addition to the aforementioned research questions, two theoretical questions guided the analysis:

- 1: What do the difficulties that incarcerated and formerly incarcerated older adults face in these settings reveal about the nature of carceral space?
- 2: What contribution does the way in which older adults navigate health and healthcare (due to or in spite of these challenges) make to the production of carceral space?

More pointedly, I used these questions to structure how I coded the data in the later phases (discussed below) to consider the theoretical contributions of the thematic findings.

Broadly, Braun and Clarke (2006) describe thematic analysis as a “foundational method for qualitative analysis...that can be applied across a range of theoretical and epistemological approaches” (as cited in Barbour, 2014, p. 261). Specifically, it is defined as the systematic examination and interpretation of data, typically a text, for the purpose of identifying themes or patterns (Bailey, 2007; Grbich, 2013; Joffe and Yardley, 2004). This analytic strategy presupposes that meaning emerges from the interpretive process relative to context (Bailey, 2007; Joffe and Yardley, 2004). The decision to conduct a thematic analysis is partly based on the need for an analytic approach that would allow me to access latent meaning, particularly the ways in which carceral space shapes the experiences of health, illness, and aging. It was not anticipated that the spatiality of older adults' experiences, nor the service providers' knowledge of abstract spaces, would be revealed manifestly. Accordingly, thematic analysis can be used to examine both manifest and latent meaning; while it can be used to document meaning that is easily categorized with little or no interpretation, it also enables consideration of the deep

meaning conveyed by the message that is not immediately apparent (Berg and Lune, 2012; Joffe and Yardley, 2004). Thematic analysis also allows for inductive coding wherein codes or categories are derived from the data (Joffe and Yardley, 2004). Inductive methods are consistent with postmodern epistemologies; they oppose modernist deductive methods that sort data into predetermined categories to ‘test’ whether a theory accurately represents reality (Susen, 2015).

Thematic analysis typically consists of three coding phases (Strauss and Corbin, 1990), which often overlap.²⁹ The first phase is known as *open* or *initial coding* (Strauss and Corbin, 1990). After transcribing the interviews, I read through each transcript in full. During this first read, I indexed only a few interesting bits of data in each transcript by inserting comments throughout each Word document, in order to get a better sense of the texts as a whole given the extended period of time over which I was intermittently transcribing the interviews. Following this, I began combing through the transcripts case-by-case, flagging seemingly important sentences and paragraphs (i.e. units of analysis) in order to signal the data’s contextual meaning (Berg and Lune, 2012; Elo and Kyngas, 2007).³⁰ I attended to every line of text and digitally highlighted whatever appeared as though it might be potentially useful for analysis with full awareness that more codes would be added, altered, or left unused (Bailey, 2007; Berg and Lune, 2012). I created a separate Word document and highlighted textual labels with a corresponding colour to track emergent codes. After reading through half of the transcripts for a second time, I reviewed my list of codes, which were quite literal and numerous. After revising to eliminate repetitive and less meaningful codes, I continued coding the remaining transcripts. I then

²⁹ Through each of these phases, I wrote memos. Memoing involves reflecting on one’s progression through coding, categorizing, and theme generation (Glaser, 1978). To this end, I recorded ideas about the formation of various codes and categories, how they might be related, and/or why they might differ.

³⁰ Units of analysis can be words, sentences, paragraphs, pages, or documents (Elo and Kyngas, 2007); they must be small enough to be manageable but large enough to avoid fragmentation (Graneheim and Lundman, 2003). While coding, I found that single words held little meaning, but whole pages contained multiple topics. As such, I primarily coded sentences and short paragraphs.

revisited my initial coding frame and then began a third read through the transcripts. I continued to reread the transcripts and revisit the codes until few, if any, new codes emerged. At the end of this phase, I had generated a daunting list consisting of approximately 60 to 70 codes.

I then began *axial* or *focused coding*, which involves identifying and merging initial codes in order to develop conceptual categories (Strauss and Corbin, 1990; Bailey, 2007). To do this, I opened a separate Word document and copied my existing list of codes and began looking for similarities and differences between individual codes. As I drew connections between certain codes, I shifted the order of the codes to group similar ones together. Based on commonalities between the codes with a given group, I developed larger conceptual labels. For instance, I had generated several codes such as ‘trauma,’ ‘victimization,’ and ‘physical/mental toughness,’ which could be subsumed under what I called ‘safety/security.’ Through this exercise, I was only able to marginally reduce the data. I became concerned that due to the plurality of participant perspectives (having interviewed both staff and residents), as well as having asked participants about their experiences in two different settings, that perhaps some concepts were not relevant to both spaces. To mitigate this, I created two separate Word documents, one as relevant to institutional settings and another for community-based settings. I then identified key codes and concepts in relation to one of two broad topics: the conditions of confinement and locating/receiving health services. This helped me narrow the conceptual focus according to the topical literature and develop a more manageable list of concepts, the most notable of which included: bedspace, placelessness, scarcity, accessibility, disclosure, gatekeeping, delays/waiting, luck, fragmentation, jurisdiction, rapport, equivalency, efficacy, and sustainability.³¹

³¹ It is worth noting that because of my broad definition of health, and thus the nature of the questions asked during the interviews, some significant concepts were only loosely related to health and healthcare (i.e., adjustment, support, opportunity, and occupation) and were therefore excluded from the analysis presented in the next chapter.

Following this, I entered the *selective coding* phase (Strauss and Corbin, 1990). Strauss and Corbin (1990) explain that this involves identifying core categories around which others revolve, relating categories to a central one, and refining categories that need further thematic development. I created yet another Word document and copied the now refined list of concepts and supporting codes. I then began to rearrange this list to reflect the interrelatedness of key concepts to develop three key themes: bedspace, both in its material forms and as a practice or set of related practices; accessibility of health services; and standard of care. I then proceeded to create three separate Word documents for each major theme and located the most compelling quotes in relation to each theme and supporting concept.

4.6 Discussion of Validity

Traditional notions of internal and external validity, reliability, and objectivity are largely inappropriate for assessing qualitative studies (Elo et al., 2014; Graneheim and Lundman, 2003; Grbich, 2013; Lincoln and Guba, 1985; Popay, Rogers and Williams, 1998; Shenton, 2004; Yardley, 2000). For instance, ‘validity’ and ‘reliability’ suggest an implied comparison, indicating the extent to which individually constructed views are similar to or different from others in the study population (Grbich, 2013). This is especially problematic for researchers who have adopted a postmodern epistemology, which emphasizes the spatiotemporal specificity of knowledge claims and criticizes the privileging of one perspective over another, claiming that all are ‘valid’ (Grbich, 2013). In response to these concerns, scholars developed evaluative criteria that are more appropriate for qualitative methodologies and associated epistemologies.

Yardley (2000) presents one such framework, which, in keeping with the research philosophies that guide many qualitative methods, consists of four open-ended and flexible principles. The first principle, *sensitivity to context*, comprises many facets. To ensure the

‘quality’ of the research, Yardley (2000) underscores the importance of remaining perceptive to the context of topical and theoretical understandings generated by other investigators and acknowledging how this awareness affected the direction of the analysis. In a similar vein, sensitivity to context might also involve an awareness of the sociocultural backgrounds and understandings of the researcher and participants alike. It could also involve consideration of the social context of the research relationship between the interviewer and interviewees, and the inherent power dynamics that grant the researcher the authority to initiate, control, and benefit from the research (Yardley, 2000). To demonstrate this principle, researchers may corroborate theoretical projections and/or actively seek out contradictory findings for thorough examination (Yardley, 2000). They may also engage in reflexive practice, part of which involves disclosing the sociocultural factors that may influence the interview relationship (Grbich, 2013).

The second set of criteria, *commitment and rigour*, refers to the ‘thoroughness’ and ‘completeness’ of data collection, interpretation, and analysis (Yardley, 2000). A researcher’s prolonged engagement with the topic of interest in various capacities can demonstrate commitment. In this way, my sustained interest in working with the elderly population—through my past work in the field of home health care and more recent contributions to the development of non-for-profit policy positions with respect to the aging prison population—can be perceived as a form of commitment that may produce a more informed interpretation and analysis. Rigour can be demonstrated by the ‘completion’ of data collection and depth and/or breadth of analysis, both of which are dependent upon the ‘adequacy’ of the sample; that is, its ability to supply enough information for a comprehensive analysis (i.e. data saturation) (Yardley, 2000). Conducting between eight to twelve interviews, a range identified as able to generate saturation (see Guest et al., 2006), serves this purpose.

Transparent and coherent data presentation is also important to ‘good’ qualitative research (Yardley, 2000). Qualitative researchers do not merely describe reality; rather, they construct social reality through its representation. To achieve transparency, Yardley (2000) suggests that researchers consider detailing every aspect of data collection, organization, and analysis so that readers can come to understand how investigators arrived at particular findings and discern patterns for themselves. Openly reflecting on the decisions I made and how they affect the product of the investigation creates research transparency (Yardley, 2000). To achieve coherence, researchers may work on the fit between the research questions, philosophical underpinnings, and methodologies employed in order to ‘keep things plumb’ (Chenail, 1997).

Lastly, Yardley (2000) suggests that the quality of a qualitative research project can be derived from its practical, theoretical, and/or sociocultural *impact and importance*. Pragmatically, this research may be impactful in two ways. First, in speaking with CRF staff about older residents, they may form a heightened awareness of the challenges this group faces. Given that staff were unlikely to have received training related to the care of older adults, the interview provided them an opportunity to reflect upon their experiences and the needs of this population. Secondly, given that older ex-prisoners often report loneliness and lacking meaningful occupation (Snyder et al., 2009), the opportunity to participate in an interview may constitute an interactive and meaningful experience. In terms of theoretical importance, this research applies spatial theory to a particular problem that has not yet been spatialized.³² This may open up new ways of understanding how aging and, more broadly, how health is experienced in carceral space. Finally, the sociocultural importance of this research rests on its understanding of participant experiences as they relate to spatial (and therefore social) processes.

³² One notable exception is the work of French academic Caroline Touraut (2015a, 2015b) who studied older prisoners’ constrained mobility in French prisons, with a focus on those convicted of sexual offences.

4.7 Concluding Comments

In this chapter, I outlined the techniques and underlying methodology I used to conduct a spatial analysis of aging in correctional settings. Using data obtained through interviews with four CRF staff and five older residents, I examined formerly incarcerated older adults' spatialized experiences of health and healthcare. In the next chapter, I present the central analytic findings organized around three themes, namely the availability of appropriate bedspace suited to older adults' needs; disproportionate barriers to accessing health services due to exclusionary practices; and the formation of carceral spatialities of care characterized by non-equivalence and competing logics of care, cure, and control.

CHAPTER 5: RESEARCH FINDINGS

In this chapter, I provide an analysis of formerly incarcerated older adults' health and healthcare related experiences in institutional and community-based correctional settings. I draw on participant testimony, presented in the format of summary descriptions and direct quotations from interviews with CRF staff and residents in Ottawa, to demonstrate how the experience of health, illness, and aging unfolds in carceral space. I begin by describing the health status of older ex-prisoners as reported by participants. Then, I explore the three key themes that emerged during the coding process, namely bedspace and related practices, accessibility of health services, and standard of care. This analytic discussion is guided by Henri Lefebvre's theorization of space, including the three 'moments' of spatial production, and findings are further contextualized using the complementary literature on carceral space. While this chapter highlights the spatial in relation to major themes and draws inferences about these spaces, a more pointed theoretical discussion is provided in the concluding chapter.

5.1 Situating Older Adults' Health Experiences

5.1.1 Understanding Old Age in Correctional Settings

Given the many ways of defining old age in correctional settings and the diversity of health challenges older adults face, it is important to delineate the ways in which participants talked about aging. For instance, some participants were hesitant to describe themselves or certain residents as "old" citing the absence of life-threatening medical conditions, while others considered a lessened ability to manage physical labour to be a marker of old age in the absence of serious illness. Generally speaking, participants' understanding of what it means to be old consistently referenced deteriorating health. This was evident in interviews with both staff and residents. Consistent with the literature (Aday, 2003; Kerbs and Jolley, 2007; Stojkovic, 2007),

some staff agreed that CSC's definition of old age, which designates those aged 50-plus as "older offenders," was a valid point of demarcation given that the life histories of many criminalized people are characterized by structural and material disadvantages that take their toll on the body and mind. Others disagreed. For instance, one staff member noted that if a resident were aged 70 or older, only then would they be considered "old" or "geriatric." Regardless of whether they agreed with this age cut-off, staff recognized that the notion of old age is tied to health status:

We never really think of it as old age. It's more if they have health issues related to age then we would think of them as old age [clients]. We have plenty of sixty-year-olds or fifty-year-olds who don't have a lot of health concerns that are fine and active in the community (staff-participant #4).

In this sense, CRF staff perceived old age as being marked not only by an increase in the number or severity of ailments, but also the presence of illnesses that become more prevalent with increasing senescence (i.e. aging-associated diseases). But, as this staff member's statement may imply, old age is not merely defined by compromised health; it is also based on how ill health affects a person's capacity to participate in civic life. Residents were more likely to describe themselves as older if they had major health challenges that had a significant impact on their day-to-day lives, including the experience of chronic pain and/or dependence on mobility aids. They also tended to associate old age with life-threatening conditions such as stroke or cancer. Typically, residents only expressed 'feeling old' when they faced these challenges.

5.1.2 Reporting on Older Adults' Health

By and large, the physiological health of older adults' following their incarceration was described as poor. Participants described a number of health conditions afflicting formerly incarcerated older adults. Common physical ailments include: substance-related health issues (e.g. addiction, cirrhosis of the liver); diabetes and diabetic complications; gastric problems (e.g. irritable bowel syndrome, Crohn's disease, gastritis, reflux, colitis); chronic and acute respiratory

problems (e.g. emphysema, pneumonia); cardiovascular illnesses, including hypertension and hypercholesterolemia; hearing and vision problems; musculoskeletal conditions and injuries (e.g. arthritis, tendonitis, osteoporosis, fibromyalgia, ligament and tendon injuries, and chronic pain including back and hip pain); infectious diseases, namely Hepatitis C; and cancers.

As mentioned, staff characterized older residents as having numerous and severe medical conditions, including age-related illnesses, as well as greater healthcare needs requiring more frequent medical attention than their younger counterparts.³³ Some staff indicated that older residents were likely to have received treatment for these conditions while in custody, but noted that these issues are “*not addressed inside as well as they could be*” (staff-participant #1). Others added that health issues may be “overlooked” particularly among prisoners with histories of substance abuse. Another noted that health problems might be associated with weight gain inside as the result of “*high carbohydrate diets and high fat meats*” (staff-participant #4).

Similarly, a majority of residents described their physical health upon release from custody as being in a state of disrepair.³⁴ Some residents ascribed their ill health to the conditions of their confinement, in some cases coupled with their participation in health-averse behaviours. As one resident explained: “*you put that crap in your system, you put the dope in your system, you’re not eating right, and no matter how much you pump the iron, your insides are rotting out*” (resident-participant #1). Others explained that while their illness was not necessarily caused by their incarceration, their symptoms worsened under these conditions. For instance, resident-participant #3 explained that he began to experience severe, intermittent joint pain while

³³ Some staff articulated that health, illness, and aging could be experienced differently, describing the health of older residents as “*all over the place*”, varying on a case-to-case basis (staff-participant #4).

³⁴ One participant described his health as “good” and explained that he had not experienced any life-threatening illnesses (e.g. stroke, cancer), but also noted that he was experiencing gastric problems and had cataracts, and would need treatment for both issues. He also alluded to feeling depressed and isolated.

incarcerated, but his condition went undiagnosed and untreated until his release. Four residents reported that their physical health improved after receiving care in the community.

Upon release from custody, older adults' mental health is typically in comparable disrepair to their physical health, if not worse. CRF staff cited anxiety disorders and bipolar disorder as the most common mental health challenges among older residents.³⁵ Staff also explained that depressive symptoms are also highly prevalent among this group.³⁶ One staff member indicated that he is beginning to see more older residents with dementia, describing these cases as "*the most difficult...we've had*" (staff-participant #4). Importantly, some staff observed differences in mental health status between older and younger residents to be minimal, agreeing that any differences in the prevalence of mental health issues are usually "*a factor of time inside*" (staff-participant #1). By this logic, some staff members suggested that symptoms may be more common among "long-term, first-time offenders" and "chronic recidivists" (Metzler, 1981 as cited in Goetting, 1984). As staff-participant #2 remarked, residents who have spent a great deal of time inside tend to harbour feelings of shame and guilt, and they experience isolation if they have few connections on the outside. Moreover, it can often be difficult for older residents to grapple with the desire to "*make up for lost time*" (staff-participant #2).

Mental health was more frequently discussed by residents than by staff and in more varied ways. Residents readily shared experiences related to the mental health challenges they faced while incarcerated and in the community. Pointed questions about how these different spaces affected their health were typically met with discussions surrounding their mental health

³⁵ One staff member explained that residents are not required to disclose mental illness to their case management team because of health privacy laws. As such, their knowledge of prevalence is limited.

³⁶ Staff-participant #3 noted that while depression might be more prevalent among older residents, it is difficult to "isolate" in these contexts.

and emotional well-being, rather than physical health.³⁷ All but one resident reported experiencing mental and/or emotional hurt or abuse during their youth.³⁸ Resident-participants also reported experiencing substance abuse, depression, insomnia, social anxiety, agoraphobia, auditory hallucinations, and suicidal ideation during their incarceration. One reported attempting suicide prior to and during their incarceration. Additionally, four of five residents indicated that they had either experienced or witnessed traumatic or emotionally charged events while incarcerated (e.g. violent victimization, self-injury, attempted suicide). Because of this, most residents highlighted the necessity of mental “toughness” to survive prison life.

Immediately following their release from custody, a majority of residents described their mental health as “not O.K.” or having gone “down the tube” and noted feeling “depressed,” “isolated,” and “discouraged.” One participant reported that she felt she had to capitalize on her newfound freedom and seize every opportunity to engage in community life; however, she explained that this quickly became overwhelming, so much so that she began taking antidepressants to manage her symptoms. Another resident felt a great sense of loss coming out of the penitentiary, as well as the weight of trying to rebuild her life following decades of incarceration. In spite of these challenges, all residents observed at least some improvement in their psychological health in the weeks and months following their release from custody; as they adjusted to life in the community and became connected with care professionals, they reported experiencing fewer and less severe mental and emotional stresses.

5.2 Spatializing Our Understanding of the Aging, Carcerally-Situated Body

Broadly, space can be understood as something that is “actuated by the ensemble of movements deployed within it... occur[ing] as the effect produced by the operations that orient

³⁷ Because of this, I found myself asking comparably more probing questions when discussing their physical health.

³⁸ The exceptional resident did, however, report experiencing abuse in an intimate relationship during her adult life.

it, situate it, temporalize it, and make it function...” (De Certeau, 1984, p. 117) and in turn reproduces these operations. For Lefebvre, movement is inherent to the production of space, which can be described as having a “pulse” (Merrifield, 2006, p. 105). The significance of movement is further reflected in his conceptualization of spatial practice. Mobility, on the other hand, is described as the potential for movement (Dunn, 1998) or the construction of a field of possibilities for movement (Knie, 1997 as cited in Moran 2015). As discussed in Chapter Three, mobility in prisons is strictly regulated. In custodial settings, individuals are unable to access certain areas at certain times, or they may be prohibited from visiting some spaces altogether. Entry into and exit out of secure facilities are highly controlled. For these reasons, prisons have become synonymous with immobility. At the same time, prisoners are subject to “omni-mobility,” meaning practices that impose near constant movement, as they are required to be in certain areas of the prison at certain times according to the daily routines enforced by correctional staff (Mincke and Lemonne, 2014, p. 539). These observations can be extrapolated to CRFs where conditions are enforced by correctional staff through policies, rules, and interactions that shape residents’ daily routines (e.g. curfews, strict prohibition of fraternizing with other residents, expectations of pro-social community engagement). In these settings, mobility becomes disciplined and as such, is intrinsic to the production of carceral and transcarceral space (Martin and Mitchelson, 2009; Massey, 1995; Moran, 2015).

In the following, I discuss each of the aforementioned themes in relation to movement and mobility. Whether participants talked about health in terms of the availability of accommodations that promote well-being, the accessibility of health services, or the quality of care, these discussions can be interpreted as centering around the ‘comings and goings’ of carceral life. By focusing my analysis in this way, health, illness, and aging in carceral space can

be understood as something that is experienced through the flows of people (e.g. corrections staff, medical personnel, other prisoners, and members of the “free” population); flows of material goods (e.g. food, contraband, hygiene products, medication); and flows of information (e.g. the release of medical records, prescription renewals, and disclosure of criminal records).

5.2.1 Bedspace and “Bedspacing”³⁹

For prisoners of all ages, the prison milieu is recognized as fundamentally unhealthy (Christie, 2006). The literature reviewed in Chapter Two identifies environmental and sociostructural determinants of health as they pertain to the experience of aging in prison and recognizes that the circumstances that bring about ill health in institutions are reproduced in community-based settings, reflecting the expansion of the carceral net and the permeability of inside/outside transcarceral boundaries (Allspach, 2011; Kilty and DeVellis 2010; Lowman et al., 1987; Maidment, 2006; Moran, 2013b). Unsurprisingly, a majority of participants indicated that the conditions of confinement and transcarceral surveillance have negative health implications. Most staff indicated that these conditions can have a more pronounced effect among older individuals during and following their incarceration. This was similarly evident in residents’ testimony regarding their health experiences in both settings. These experiences can be understood as being mediated by bedspace and related practices. Staff-participants repeatedly referred back to the availability of accessible beds, especially in CRFs, and a majority of resident-participants situated their health, particularly their mental health, as symptomatic of their living arrangements, whether incarcerated (on a cell block or in group accommodation houses) or living in a CRF (in self-contained bachelor units or communal living environments).⁴⁰

³⁹ Lui, Griesman, Nisenbaum and Bell, 2014.

⁴⁰ Participants discussed bedspace and related practices in a number of different ways, varying according to whether they were referring to beds in federal and provincial correctional institutions, halfway houses, hospitals, long-term care facilities, low-income housing, and other residential facilities.

The term “bedspace” is commonly used to indicate the accommodation capacity of a particular facility and can additionally refer to the geographical area in which an individual bed is (or is intended to be) placed; this space, including items normally adjacent to it (e.g. personal effects such as hygiene items and clothing stored in and on surrounding furniture within the enclosed area), is regarded as one that *belongs* to the bed’s occupant and conventionally offers some modicum of privacy (Mitchelson, 2012b). In such terms, bedspace is understood as “inanimate architectural infrastructure” (Mitchelson, 2012b), while “bedspacing” may be understood as practice. This verbiage is conventionally used in hospital settings to describe the practice of placing patients in a different ward than they would normally be admitted because the number of incoming patients exceeds the number of department-allotted beds (Lui, Griesman, Nisenbaum and Bell, 2014). Here, I use this term to denote a similar phenomenon observed in the correctional system, where the demand for adapted bedspace, if exceeding supply, results in the placement of high needs individuals in non-designated beds. Together, these broad conceptions reflect Lefebvre’s (1991) notion of spatial practice, a referent to the built environment and routine activities within it, insofar as they help to identify what places are accessible, the boundaries that define a given space, the types of interactions that occur within them, as well as structuring material flows in and through space (Friedman and van Ingen, 2011).

5.2.1a “There’s nowhere for them to go”

The relative absence of designated facilities and/or specialized units within existing facilities that serve the aging correctional population was a central concern for participants and contributes to current debates surrounding the segregation versus integration of older adults in correctional facilities (see Blowers et al, 2014; Kerbs and Jolley, 2009). This is a source of unease for many older adults at all points along the carceral continuum, from custody, to

supervised community-based residency, and following warrant expiry. Accordingly, the first area of focus I consider in relation to bedspace is participant perceptions of placelessness.

Staff articulated numerous concerns surrounding an older adult's release from custody. Specifically, they discussed some of the difficulties that older adults face in terms of securing a bed at a CRF and completing their residency condition due to screening practices and ongoing assessment. Three of the four staff members revealed the likelihood that their facility would exercise the "*right of refusal*" upon receiving an application for residency on behalf of a high needs client. They indicated that many existing CRFs are not architecturally designed to accommodate those experiencing physical disabilities given that many CRFs are repurposed buildings, typically featuring stairs and narrow passageways while lacking accessibility equipment. As staff-participant #1 explained: "*Aside from the five steps from the street you have to take to get into the front door...all our rooms are on the second and third floors. We don't have ramps and based on the building codes and our own contract...our existence pre-dates [accessibility] requirements.*" Consequently, physical inaccessibility often forms the basis for refusal. Staff also indicated that the decision-making process for accepting new clients involves careful consideration of available human resources. If there is the possibility that an incoming resident requires the help of personal support workers (PSWs) and/or nurses, this will bear on the selection process. As staff explained, PSWs are not included under contract with CSC; instead, funding for PSWs is granted on an ad hoc basis, without which a CRF's capacity to responsibly accept high needs clients requiring assistance beyond what CRF staff are able to provide is limited. As one staff member offered:

So, if I've got a guy who needs nursing care, um, I have to be very careful...If he's brought here, the Parole Board and the Correctional Service might want to keep him, and I quote 'parked here'...when what this person may actually need is nursing care, and then we're stuck with an offender who needs a huge amount of care that we might not be

able to provide. At the same time, we and the Service may not be able to get him into a, uh, a facility that would better fit his needs.

Because these facilities reserve the right to deny applicants on the basis of health status and exercise that right for fear of high needs clients being placed in their care in the absence of more appropriate accommodations, older adults are likely to be left in limbo. The practice of accepting new residents is thus guided by an acute awareness of the built environment, as well as human resources (and fiscal constraints implicated therein). This assessment process works against older adults who are more likely to have significant illnesses requiring additional care. As non-profit organizations under contract with CSC to provide bedspace with limited resources, CRFs are not well positioned to accommodate high needs individuals.

CRF staff also discussed the practice of transferring residents with significant health needs to “*more suitable accommodations*” should they experience medical challenges that are too great to be managed at the halfway house.⁴¹ However, this can be enormously challenging given the need for a facility that not only provides more intensive care, but also correctional supervision. As staff-participant #2 noted, these kinds of transfers have “*been a little more difficult since we’ve actually become a full halfway house, because [clients] have to stay at a halfway house*” and cannot be placed in an unsupervised environment. As a result, staff look to the only CRF in Ottawa with fully accessible units for available beds; or, at the very least, to a less inaccessible CRF in the city (for instance, one with fewer stairs).⁴² Expectedly, transferring clients to accessible CRFs is not always possible. Ottawa’s only fully accessible CRF for men is

⁴¹ Although most staff indicated that it was unlikely for a resident with severe health and mobility issues to be admitted to the CRF, they explained that in exceptional cases, not necessarily involving older adults, residents arrived with or developed debilitating conditions that could not be managed at the residence.

⁴² In contrast, staff-participant #3 described a situation involving a resident who broke both legs in an accident. Given these injuries, the house was no longer accessible for the resident. Staff worked with the resident’s parole officer (PO) to arrange for the resident to recover at home where family could assist with his care. Arrangements were made for the PO to visit the client at home and for the client to do call-ins with house staff as opposed to in-person check-ins. This suggests that some agencies are more flexible than others in accommodating special needs.

a facility that caters to high-risk and high-needs individuals, including older adults with more significant health concerns or mobility issues. As staff-participant #2 explains, there may be some hesitation to transfer a resident to this location due to concerns of appropriating bedspace available to high risk clients to accommodate clients with significant healthcare needs: *“If we put somebody over there, um, it would be taking away a bed from a high-risk client...that would probably get more out of a place like that.”*

When a resident’s health needs can no longer be managed at the CRF, staff consider placement in a long-term care facility. Gaining entry to these facilities can be expressly difficult for older adults with a criminal history. Staff-participant #4 reported seeing *“rejection after rejection”* in applying for long-term care on behalf of residents. Staff-participant #1 offered that this could be because these facilities perceive older ex-prisoners as a threat to the safety of residents and staff, even if they have no history of violence. Nevertheless, that *“information of [their] past still has to be disclosed”* (staff-participant #1). Ultimately, grave implications can result from difficulties securing a bed in a nursing or long-term care facility. One staff member discussed a case in which he and his colleagues searched in vain for a nursing facility that was willing to accept their client. This search lasted two years, ending when the individual *“self-sabotaged”* and was reincarcerated, dying 14 months later:

Uh, we were trying and unfortunately the man was being denied on the basis of his past, which was horrendous...he was physically unable to be the security risk that he was, but because he has to disclose that...so we were settling in for the long run, but, you know, we had no end game (staff-participant #1).

Because *“there’s nowhere for them to go”* (staff-participant #4), some residents deliberately violate their conditions of release or reoffend in order to return to the institution, suggesting that despite dire conditions on the inside, formerly incarcerated older adults experience prison as place; that is, they derive a sense of belonging through their occupation of that particular setting

and cultural activities in which they participate (Agnew, 2011; Cartier, 2003; Maidment, 2006). They do not necessarily experience community life in the same way.

In the preceding paragraphs, I focused on staff perceptions of placelessness, which centered on practices of refusing high needs applicants and transferring residents to other facilities when their needs cannot be managed. By contrast, residents did not report being denied residency or transferred to more supportive facilities on the basis of their health status. Instead, residents experienced placelessness as dangerous, isolating, and/or contaminating, suggesting that in the absence of age-designated spaces, older adults are (mis)placed in facilities that are ill-equipped to accommodate their needs.

Similar to the literature that identifies older adults as more prone to victimization in prison than their younger counterparts (Cohen and Taylor, 1981; Fattah and Sacco, 1989; Kerbs, 2000a; Kerbs and Jolley, 2007; Mann, 2012; Snyder et al., 2009; Tarbuck, 2001), residents experienced some form of victimization while incarcerated, namely assault, exploitation, and threats.⁴³ For instance, resident-participant #3 reported that he had been “*brutally attacked*,” sustaining an injury to his head and a broken ankle. He also experienced “*intimidation*” by younger prisoners when trying to access the gym, forcing him to find an alternative means of exercise. In similar vein, resident-participant #2 recalled his younger cellmates exploiting him for canteen money and resident-participant #1⁴⁴ underscored the importance of staying in good physical shape in an effort to prevent victimization, noting that this becomes exceedingly difficult as one grows older.

Like prison, participants experienced community-based settings as psychologically or emotionally gripping. Isolation was a common experience among older adults in community-

⁴³ Similar experiences of victimization were not reported in community-based settings.

⁴⁴ This participant self-identifies as a woman; however, her insights are drawn from her experiences in correctional facilities for men.

based correctional settings, particularly facilities that have bachelor units in which residents are discouraged from interacting with other residents. One resident with dementia experienced considerable isolation: *“You know what, I get destroyed eh... all alone. But, I try to keep myself occupied, you know. Sometimes they can’t get a volunteer; sometimes they’re alone in the office”* (resident-participant #2). Another explained that while this setup *“cuts down on a lot of...negative actions and interactions”* and affords her time alone when she needs it most, *“it would be nice once and a while to have somebody to eat with”* (resident-participant #1).

In communal living settings, participants were less likely to experience isolation and more likely to experience ‘contamination’. When confined to a correctional institution (and, arguably, when residing at a community-based facility), Goffman (1961) contends that individuals can experience “contaminative exposure” as a “mortification” of the self via the “violation of one’s informational preserve” (p. 23), “besmearing and defiling of the body” (p. 25), and/or forced social contact and/or relationship. Primarily, residents reported interpersonal contamination, explaining that *“you had to adjust yourself to”* the other people with whom they were forced to live in close quarters. All resident-participants residing in a communal living environment reported at least one negative interpersonal interaction with another resident. Consequently, residents proposed keeping to themselves as a viable means of avoiding conflict. This “quest for isolation” is unsurprising given that the prison environment is one in which a person is seldom alone (Munn, 2009, p. 200). Solitude provides a means to “protect themselves by attending to the perils of propinquity which result from having too great a proximity to certain others” (Munn, 2009, p. 179). In this sense, spatial isolation is a tactic employed by participants to gain a sense of psychological security; this is in contrast to the preceding discussion where involuntary isolation led to feelings of vulnerability.

5.2.2b “We do our best with what we have”

This research demonstrates that the demand for both accessible beds and care beds often exceeds supply. Due to the lack of accessible bedspace, older adults are likely to find themselves in facilities that are neither designed nor operated in a way that meets their needs. Contingent efforts to accommodate these individuals are often made in a reactive fashion, sometimes introduced only temporarily. Staff and residents alike acknowledged that the availability of fiscal, human, and material resources have an enormous impact on a facility’s capacity to accommodate high needs clients. As staff-participant #2 explained: “*we do our best to help them out,*” but “*there’s not really too much we can do individually to accommodate them*”.

Staff and residents frequently discussed changes made to the built environment of the CRF in order to accommodate those facing health and mobility challenges. According to staff, one thing that facilities can do with limited resources is to provide “*static elements*” such as safety equipment, including grab bars, handrails, and anti-slip mats. As mentioned by one staff member, organizations, including many halfway houses, established prior to the introduction of accessibility standards in the province of Ontario are not required to retrofit existing buildings under the *Accessibility for Ontarians with Disabilities Act*. Instead, building accessibility is regulated by the *Ontario Building Code*, under which barrier-free design requirements need only be included “when a new building is constructed, when an existing building undergoes an extensive renovation, or when a building is renovated because of a change to how the building is used” (Accessibility Ontario, n.d.). Otherwise, the agency is “*grandfathered in.*” Adaptive measures tend to be taken on an “*as needed*” basis and/or when mandated by a higher authority:

Where the contract changes or the requirements change, [and] we can...make the changes, we’ll make them, right. So, when it came to the, uh, handle bars in the showers for instance, we installed them, shortly after [one resident] arrived...so...it’s a lot of knee-

jerk reaction, right...When John Howard tells us we need to make the change, we make the change and when CSC does, the same thing: we have to (staff-participant #1).

In this vein, three residents indicated their need for environmental supports to safely navigate their living quarters; of these, two reported that their units were retrofitted prior to their arrival, while one expressed some concerns about her unit and the shower in particular: *“it’s...sort of a half a hexagon with three glass walls, and if you grab a hold of the top if you’re going to slip, the whole thing would come down with you...it’s not a safety area”* (resident-participant #1).

Staff also discussed their efforts to place residents experiencing mobility challenges in more accessible beds at the house. For instance, staff-participant #3 described a situation involving a resident with a severe heart condition who needed to be placed on the second floor of the building to limit how many stairs he would have to climb; to accommodate this resident’s needs, another resident was displaced to the third floor. Similarly, one resident who had been living on the third floor of the CRF despite experiencing mobility issues, recalled being offered a room on a lower floor when another resident moved out. The resident refused the offer, later submitting a complaint about the inaccessibility of the building and the house’s limited capacity to implement an satisfactory solution: *“I gotta do three flights of stairs. And when I complained...[the staff said] ‘well we offered him the ground floor, but he wouldn’t take it.’ The ground floor is the second floor...”* (resident-participant #1). Interestingly, one staff member discussed the *creation* of a temporary bed in a more accessible location in order to accommodate a resident who endured double bypass surgery and was unable to manage the stairs during his recovery. As staff-participant #1 explained: *“We put him—we actually used the sofa bed in this very room [on the first floor] and that was his room for about two months... Um, if we can accommodate, we will—we’ll use this room if we have to. But if it’s a long-term permanent change, we have to look for alternative resources.”* By creating bedspace on the first floor, staff

were able to better accommodate the accessibility needs of the resident temporarily. To do so, however, staff appropriated a space conventionally used for casework meetings due to the privacy it offers, effectively forcing that work to another, less suitable location within the house.

Where modifications to the built environment may be insufficient or largely impossible, staff members also highlighted some of the ways that they rallied fiscal and human resources to accommodate high needs residents. Once again, staff reiterated the difficulty in these situations. As staff-participant #2 articulated: *“We would do everything we could to accommodate them, but it’s always difficult. There’s only so much we can do in these situations.”* Staff-participant #2 explained that in cases where a resident is experiencing mobility issues, he and his colleagues would do their *“best to help them up and down the stairs.”* He provided an example where one resident required the use of a walker to get around: *“what we had to do was he would go up and down the stairs very slowly and then we’d—he’d leave his walker at the top and we’d bring it down the stairs for him, and same for when he’d come back... .. But there was never an issue getting up and down.”* Interestingly, a resident facing similar issues and who was placed in a house where there were no beds located on the ground floor, reported having issues ascending and descending the stairs: *“I gotta do three flights of stairs...Yeah, I mean it’s such a height. I gotta go up one step at a time, I can’t go up boom, boom, boom”* (resident-participant #1). Because these buildings are not retrofitted and there are no mechanical supports, staff become a resource for safe mobility. Nevertheless, assistance provided by staff is often limited due to their lack of training specific to the care of older adults. As one participant explained:

There’s not really much out there, unfortunately... If we have a health seminar, it’s a health seminar for offenders... If we have program seminars, it’s for offenders, it’s...it’s not age-targeted. So, there’s very little out there specifically for older offenders. You’re sort of out there fending on your own (staff-participant #2).

This limits what staff are able to do to assist residents with significant age-related challenges. Staff-participant #4 discussed the needs of a geriatric resident who “*needed assistance with showering, getting dressed, cutting his toenails*” and other ADLs, but clarified that “*there’s only so much we can do, we’re not trained for these things.*” He added that “*support workers would assist with the cooking, household chores*” and so on, suggesting that volunteers and other staff are available to assist with IADLs, but not ADLs. As mentioned earlier, funding can be solicited for the hire of PSWs to assist older residents with ADLs, but this is difficult to secure. Where a PSW cannot be secured, one staff member indicated that “*more likely we’d try to get like a volunteer maybe from either [our overseeing organization], like if there was a student looking for extra experience, um... we’d try to find something in place to do that*” (staff-participant #2).

5.2.2 Accessibility of Health Services

In the previous section, I discussed participant perceptions of placelessness and provisional efforts to accommodate special needs in relation to the lack of appropriate and accessible bedspace for older adults, especially those facing serious health challenges. Whether institutionally or community-based, these spaces are produced and reproduced through the application of carceral controls. Not only are they defined by the activities occurring within and through them, but they also structure the experience of everyday life. To this end, these spaces determine access to health services and quality of care. In this section I focus on the former.

Throughout the interviews, participants raised concerns regarding the accessibility of health services calling attention to significant barriers to care. Participants zeroed in on issues of proximity, gatekeeping, and discontinuity, concepts that are intimately related to movement and mobility. Movement is inherent to the process of locating and receiving care in both institutional and community-based settings.

5.2.2a Geographical Proximity

In Chapter Three, I discussed the notion of ‘disciplined mobility’ as first conceptualized by Moran, Pallot and Piacentini (2011). Where mobility presupposes an individual’s capacity to move autonomously, *disciplined* mobility can be understood as punitive power expressed through the regulation and restriction of movement (Moran et al., 2011). These practices create “terrains of exclusion” beyond the radii within which ex-prisoners are permitted to circulate (Munn, 2009, p. 212), ultimately inhibiting access to healthcare services—especially those that are not proximate—and in some cases, create dependencies on supports that will not be available to older adults following warrant expiry. All the while, the individual faces the threat of shouldering the “burden of control” (Crewe, 2011, p. 519) under the neoliberal expectation of self-regulation. Ultimately, participants discussed the location of medical services as a determinant of care access, revealing that geographical proximity is mediated by conditions of confinement, the availability of suitable transportation, and the availability of escorts.⁴⁵

Providing insight as to how the conditions of confinement and transcarceral surveillance may impede access to healthcare, staff discussed access to public health facilities in certain locations as partly determined by the conditions of release. For instance, one staff member explained that an individual convicted of a sexual offence might be prohibited from entering certain facilities, including fitness centres, public health facilities, community centres, and shopping centres (i.e. places where minors congregate). Should a clinic be attached to or located within one of these facilities he or she may not be permitted to access services at that location. Staff-participant #1 explained that this creates a “*significant barrier*” to care:

If he finds a medical doctor who’s willing to take him—in a mall—he needs an escort every time he goes to that mall. He also needs permission from the Correctional Service

⁴⁵ In this subsection, I mainly discuss participants’ experiences as they relate to community-based settings, as issues of proximity were most salient in these narratives.

and the National Parole Board to see his doctor because it is located in a place that geographically, he is forbidden to go.

There are also policies and rules imposed by the CRF under contract with CSC that residents must comply with. For example, residents are required to “check-in” at regular intervals and this activity is recorded in the duty log. Staff reported that residents are allowed off the premises for a maximum interval of four hours. This allotment may be shorter for residents who are assessed to be at a higher risk level.⁴⁶ This can be problematic for some older residents experiencing mobility issues who may find it difficult to get to and from medical appointment(s) in the allotted time. This suggests that activities undertaken to help manage health can contribute to noncompliance, including risking failure to report. Moreover, staff indicated that older residents typically have a high volume of medical appointments. Attending multiple appointments in different locations may further conflict with correctional priorities, as staff-participant #2 suggests: *“They might have more medical appointments too that would take up more time so it can be challenging for them to schedule things. Like a lot of times the parole officer will want to meet with them, but they have a doctor’s appointment.”*

The availability of suitable transportation can also affect access to health services. Where health services are not proximate or convenient, older adults can be deterred from accessing specific services. Staff-participant #4 described his experience with an elderly client diagnosed with dementia, explaining that *“[he]won’t go out if it’s cold or if he doesn’t have a drive. If there isn’t a staff [member] here that has a car, he won’t go.”* Similarly, resident-participant #5 explained that she had previously accessed culturally sensitive medical services at a centre for Indigenous health. She reported being highly satisfied with the care she received there, *“but*

⁴⁶ Residents may also be allowed “out” for longer periods under exceptional circumstances (e.g. attending a medical appointment in another region). One staff-participant explained that employment can affect a resident’s ability to comply with these check-in regulations and that there are ways to accommodate (e.g. calling in on breaks).

because it's too far out...way out there" and her primary means of transportation include bus transit and para-transportation services, she stopped going. These examples contrast with the experience of resident-participant #3 who owned a car, making it easy for him to travel within the city. This, however, is rare; staff explained that very few residents have their own transportation following incarceration. Staff noted that using public transit systems can be a significant stressor for older residents, particularly those who were incarcerated for long periods of time, because *"the concept of timing the buses, understanding the schedules, um, knowing where they go, um...knowing that when you get on you have to go the back, you ring the bell, who sits and who doesn't sit...the informal protocols"* are foreign to them (staff-participant #1). Consequently, older adults may be hesitant to use public transit and may not access healthcare in locations that they cannot easily get to by other means. Staff-participant #3 indicated that in some cases, it might not be safe for a resident to use public transportation if they are experiencing significant physical or mental health issues, further limiting healthcare options.

The availability of escorts is also an important determinant of access to care. In the institution, access to healthcare for those experiencing physical disabilities can be complicated by the unwillingness of other prisoners—who are often tasked with supporting older prisoners by correctional workers—to assist with transport to the on-site clinic. Resident-participant #3 explained that while incarcerated, the clinic was located across the prison grounds, requiring outdoor travel between two buildings. While confined to a wheelchair during the wintertime, this participant was not able to get to the infirmary independently. Instead, he had to rely on the help of other prisoners: *"Sometimes you would wait, you know. They would say: 'Well, we'd like to see you at ten o'clock'... Well the guy wouldn't show up until eleven and you get there: 'Well, the doctor is gone'"* (resident-participant #3). In the community, escorting can also complicate

access to health services. Resident-participant #5, who, at the time of the following incident, was not permitted to leave the grounds of the CRF without a volunteer escort, described her experience travelling to and from medical appointments with a volunteer:

We got stranded out at, um, the General (hospital) when Para-Transpo was supposed to be picking us up and they said they'd be there for four and we were there till about four-thirty/quarter-to-five... and I had to take a cab back down...to where I live and switch my volunteers...there was a shift over... So, by the time we got here, she got out of the cab, the other lady got in the cab, so we just zoomed it down to the [clinic].

This participant's stressful experience demonstrates the complexity of trying to balance healthcare needs while ensuring compliance with correctional policies.

5.2.2b Gatekeeping Practices

Gatekeeping refers to the act of controlling another person or group's access or rights to something, which may include: information, locales, opportunities, services, and communities and/or identities. In the context of healthcare, gatekeeping typically functions as a mechanism of care referral and a family physician or nurse practitioner is typically the first point of contact; this is known as primary care (Macinko, Starfield and Shi, 2003). Should a patient require secondary care, including laboratory services, specialist care, or hospital admission, the patient relies on their primary care provider to make the appropriate referral(s).⁴⁷ As such, primary care is coordinating care (Macinko et al., 2003). Gatekeeping is intrinsic to the correctional system in similar ways. Characterized by the exercise of regulatory control over individuals within and across geographical boundaries (Moran, 2015), carceral space is something that is in part produced and reproduced by various spatial practices. This includes gatekeeping practices enacted through designated correctional personnel. Navigating healthcare systems within correctional settings is thus inevitably centered around gatekeeping. For individuals who are in

⁴⁷ Subsequent referrals to tertiary care (i.e. a higher level of specialty care following hospitalization) and quaternary care (e.g. highly specialized surgical procedures and experimental medicine) are possible, depending on the complexity of the case (Macinko et al., 2003).

custody or under community-based supervision, access to health services is mediated by the activities of others, namely correctional and residential facility staff and medical personnel.

Correctional personnel as gatekeepers. The literature reviewed in Chapter Two highlighted the gatekeeping role played by correctional staff in mediating access to many programs and services in institutional settings and the potential for strained relations between staff and prisoners to obstruct a prisoner's access to institutional health services (Bretschneider and Elder, 2014; Stoller, 2003). While participants infrequently discussed the gatekeeping function performed by institutional staff⁴⁸, it formed a significant part of their discussion around accessing health services in the community; therefore, I contrast participant experiences in this regard with institutionally based experiences reported in the literature.

Halfway houses operate under contract with CSC and are, among other things, mandated to “assist residents to secure services appropriate for their needs or for public safety requirements” including medical, dental, and mental health services (CSC, 2015b, p. 3). Given this, CRF personnel are responsible for facilitating residents' access to primary health services in the community by helping them to obtain a health card and by referring them to specific health services. Some residents expressed appreciation of staff efforts; as resident-participant #3 explained, he perceives staff to play a “*supportive*” role in the maintenance of his health, often expressing “*concern*” for his well-being and helping to make sure he gets to his medical appointments: “*If I have an appointment, they'll always remind me... You don't have to let them know, but I like to let them know so I remember and they keep track of it*”. Some staff expressed frustration over constraints that limit their capacity to help. For instance, because residents are not permitted to have prescription medications in their possession, their medications are kept in a

⁴⁸ Residents shed light on this practice in the institution, but staff did not talk about this practice in the institutional context. Thus, this section focuses on access to community services as informed by both groups of participants.

main office space and are dispensed by staff who monitor whether “*residents are starting to get low on their medication or haven’t taken it in a couple of days*” so they can “*talk to them about it...especially if they have anything with mental health or...something that they should be taking daily and shouldn’t be missing, we’ll follow up on that*” (staff-participant #2). However, because residents’ compliance with their medication regimens is voluntary, some staff members lamented their inability to “*ensure*” that clients were taking their medications.

Medical personnel as gatekeepers. As mentioned, nursing staff and primary care physicians act as gatekeepers to specialized services. Participants highlighted significant differences between institutional and community-based health services in terms of the likelihood and expediency of a referral to secondary care. A majority of staff and residents indicated that access to specialist care in closed custody is expressly difficult; as one staff member offered, “*the concept of a referral...is non-existent*” (staff-participant #1). While some residents reported delays in gaining access to specialized services following a visit with the nurse or, more rarely, the physician, others reported being refused specialist care altogether, often on the basis that their condition was not severe enough. As resident-participant #4 explained, “*If it’s major, you go out. If it’s not, you stay in;*” otherwise, “*it was like trying to pull teeth to see somebody on the outside*”. Because of this, some participants suggested that “*you really had to fight for it; you had to really push*” to gain access to needed services, as staff would reportedly “*wait until you complained enough that finally they’d send you*” (resident-participant #3). Resident-participant #3 reasoned that this reluctance is due to fiscal restraint: “*It’s because the doctor is told that wherever possible...don’t make outside appointments because it costs them money*”.

By contrast, residents reported few issues in accessing specialized care through their primary care physicians with whom all residents reported having a strong rapport.⁴⁹ However, some staff noted difficulties in this regard.⁵⁰ For instance, staff-participant #4 discussed his experience working with a resident who, to him, very clearly had dementia; he indicated that despite the resident's deteriorating condition, "*no clinic would refer him to any type of specialist for Alzheimer's or dementia*". Upon learning that the hospital staffed a geriatric emergency response (GEM) team, the staffer was able to connect the resident with a referral to the geriatric day hospital. This incident underscores the importance of securing a primary care practitioner in order to locate an entry point to the broader healthcare system and a suite of different services.

5.2.2c Bridging Needs

The literature reviewed in Chapter Two with respect to the release and reintegration needs of older prisoners suggests that older adults face a number of unique barriers to reentry (Crawley, 2005; Crawley and Sparks, 2006; Jamieson et al., 2002; Maschi et al., 2014; Sapsford, 1978; Stewart, 2002, Stojkovic, 2007). Moreover, older prisoners expressed uncertainty about whether they would be able to access the healthcare they need in the community (Crawley and Sparks, 2006). Notably, those with severe health problems are most likely to experience these apprehensions due to their greater dependence upon the formal and informal provision of healthcare in prison (Davies, 2011). Participants discussed the continuity of care across two planes, namely bridging care between correctional institutions of the same or different security level, and between institutional and community-based settings. Because the vast majority of

⁴⁹ All residents reported being registered with a family doctor and claimed "*no problems*" in gaining access to community healthcare. This could be due to the makeup of the resident subsample. First, none of the residents disclosed a severely limiting health condition or they did not perceive their health issues in this way. Second, three residents were first incarcerated later in life and spent relatively little time incarcerated. As such, two residents who were registered with a family physician prior to their incarceration returned to their doctor's care upon release.

⁵⁰ This may be attributable to the fact that staff often recalled more salient experiences involving clients that faced severe health conditions, which resident-participants largely denied having.

these experiences involve bridging service delivery at the juncture between the institution and the community, the ensuing discussion will focus on transitions to community-based care.

Throughout the interview process, most staff recalled cases involving disruptions in health service delivery to older adults upon their release into the community. They revealed several contributing factors to the discontinuity of care centering around inadequate pre-release planning. As one staff member explained, prisoners are often “*cut loose*” from the institution without a well-considered community strategy:

Um, what happens is they, like, once they're (CSC) no longer responsible for the offender, they wash their hands of it. There's very little pre-release work. I mean, with the volume of offenders and the resources that are just not there, there's simply no time or energy to do it (staff-participant #1).

As a result, pre-release planning largely consists of generic, “*cut and paste*” community strategies that gloss over an individual's specific healthcare needs, which are often not a component of community strategies (staff-participant #3). Parole officers and CRF personnel generally do not get health-related information about the clients they supervise, limiting their capacity to properly receive them in the community and coordinate case planning with other service providers. For instance, staff-participant #1 described a situation resulting from failure to communicate critical health information about an incoming client:

He had a massive infection in his knee from an injury he sustained inside. Um, he was released to us without any information... without anyone telling us just how bad this was, without any follow-up, without any medication... He actually wound up losing that leg. And, uh, you know...there's a professional courtesy to let us know because...we need to be able to say whether we can fulfill the needs of this client. In this case, we could not.

Staff discussed other earmarks of inadequate release planning, virtually leaving some residents to “*start from scratch.*” For example, nearly all staff noted that some incoming residents are released without any formal identification, including health cards, which can prevent them from accessing services. Consequently, staff have to “*really scramble to get them a health card as*

soon as possible and it can be difficult because a lot of times they need other ID, they might need a birth certificate to get that, or something else to get the health card” (staff-participant #2). Accessing institutional health records is another challenge. Staff members encourage residents to obtain their medical file to share with care providers in the community “because they do keep fairly adequate files inside of medical follow-up” (staff-participant #4). However, in order to do this, they must submit a formal *Access to Information* request to CSC and wait “months for a medical file of their own” (staff-participant #4). Obtaining prescription medication is another ordeal and because individuals are typically released with a short supply of medication (normally two weeks’ worth), they need to act fast in order to prevent a disruption in their medication regimen. Insufficient ID and/or an absent medical file hinders this process. If an individual is not registered with a family doctor, this too will impede access to prescription medications.⁵¹ As one staff member explains: “You need to find someone who’s going to, uh, renew those prescriptions very quickly, which can be difficult to do because if you have a doctor who is unfamiliar with the client, they might be reluctant to issue, uh, heavy, heavy prescriptions, not knowing that client” (staff-participant #1). As a last resort, staff will “send people to the ER for simple follow-up or simple prescriptions” (staff-participant #1). In such cases, a person will only receive a few doses and they will need to return again and again until a family doctor can prescribe the medication. As a result, some residents stop taking their medications, which can have negative implications.

Conversely, residents perceived the transition from institutional to community-based care as a fairly seamless process. There are a few possible explanations for this. First, staff tended to

⁵¹ Staff reported different experiences in terms of securing a family doctor for older, high needs clients. Some indicated that finding a physician is more difficult for older residents due to the complexity of their cases and more generally, high demand “because the family doctors, the family practices, are I mean, they’re so stretched for time, resources, that to take on a client who is going to need a lot of—comparatively—a lot of time and resources or just management of health, they’re reluctant to take them on” (staff-participant #1). Others noted that doctors are more likely to take on complex cases, indicating that registering an older client with a family doctor is no more or less difficult than it would be for anyone else.

refer to cases involving older adults living with debilitating conditions. By contrast, residents interviewed for this research, while facing serious ailments, did not necessarily perceive these conditions to be debilitating. Furthermore, all residents reported being registered with a family doctor and reported “*no problems*” in gaining initial access to healthcare in the community. As discussed in the preceding section, primary care physicians are gatekeepers to the healthcare system and are thus instrumental to accessing health services in the community and maintaining continuity of care following release from prison. Given that all resident-participants secured access to a primary healthcare provider, they were more readily connected with needed services and treatments. Interestingly, some participants (including staff) attributed these successes to luck. Two residents reported that following their incarceration, they learned that they were “*still on file*” with their family physician and resumed seeing their provider once released. For those who did not yet have a family physician, staff-participant #4 credited luck when a nearby clinic began accepting new patients and CRF staff were able to send a few residents over to register: “*it all depends on how lucky we get*”. This suggests that residents and staff alike perceive gaining access to community-based health services following release as something that they have little control over. Alternatively, or perhaps complementarily, it could also suggest that successfully achieving continuity of care in this context is the exception and not the rule.

5.2.3 Standard of Care

For individuals of all ages, the quality of healthcare provided in correctional settings is disreputable (Christie, 2006; Condon et al., 2007; Stojkovic, 2007). However, due to their needs, older prisoners are likely to experience even larger gaps in service delivery (Kerbs, 2000a; Potter et al., 2007; Snyder et al., 2009). Unsurprisingly, the majority of participants described the quality of institutional health services as substandard, while indicating a strong preference for

community-based services generally regarded as higher caliber. This partiality suggests that the nexus of care matters deeply; that there is something about the character of carceral space that bears on service delivery standards and, in turn, disproportionately affects the quality of care that older adults receive. Two key subthemes emerged with respect to the quality of care: (a) the competing logics of care, cure and control, and (b) the principle of equivalency. I discuss the nuances of these subthemes as manifested in participant experiences of institutional and community-based care. In this regard, I refer to participant experiences in both the federal and provincial correctional systems collectively, making important distinctions where necessary.

5.2.3a Carceral Care: Curing Disease and Controlling Disorder

Healthcare services are deeply affected by the carceral milieu in which they are provided. As Stoller (2003) explains, the spatial organization of the prison reflects management goals that are incompatible with the “putative goals of a committed healthcare provider” (p. 2265). The provision of effective, patient-centred care is thwarted via two primary means: first, and perhaps most prominently, as the result of a heavy preoccupation with maintaining order by enforcing institutional rules and regulations (Stoller, 2003; Wright et al., 2014), and second, as a consequence of reactive, disease-centred efforts to cure (Christie, 2006; de Viggiani, 2006; Stoller, 2003). Both phenomena were salient in residents’ care-related experiences while incarcerated. For instance, resident-participant #1 described a situation involving her psychologist, a well-liked figure in the institution, who expressed opposition to the institutional rules constraining how she cared for her patients:

In all the years I tried psychology, there was [one doctor] and another (psychologist)... But all the rest of the psychologists were as crazy as we were...And, uh, but [the first psychologist], when they started telling her what they should be writing about us, she quit and she had lasted about five years. They started pushing her these sort of half-assed rules. Some of us started getting write-ups and she said no and away she went...

This particular incident illustrates how healthcare personnel are expected to conduct themselves—that is, in accordance with the guiding carceral logic that prioritizes control and management above all else—and the consequences of stepping outside these bounds to deliver services to prisoners in a manner that protects and promotes human dignity.

While medical caring is the responsibility of trained healthcare providers, correctional staff are also implicated in the provision of care. Crawley (2004) conceptualizes the prison as a “quasi-domestic sphere” (p. 103), in that all aspects of daily life are confined to a particular location. As such, the work that correctional officers perform has a domestic component. A responsibility to ensure that the domestic needs of prisoners are met thus involves a particular kind of caring that intersects with and lends support to the provision of actual medical care.⁵² At the same time, correctional staff are responsible for the maintenance of order. Where the operation of prisons is based upon “principles of exclusion, separation, and confinement” and thus “demands discipline and the stripping of identity, possessions, affection, and touch” (Stoller, 2003, p. 2265), correctional staff are tasked with administering the processes implicated therein. This role complexity manifests in their interactions with prisoners, particularly among older prisoners who are likely to have high needs, while presenting low risk (Crawley, 2005), and is highly evident in participant experiences with institutional staff.

Generally speaking, resident-participants perceived institutional staff as failing to see prisoners as human; rather, they felt as if they were treated “*like a number*” and characterized staff as having “*a lack of concern*” for the well-being of prisoners. Importantly, most resident-participants acknowledged that there were exceptional officers who treated them with dignity and respect, but noted that they had high turnover. Residents also reported negative perceptions

⁵² This responsibility can sometimes fall on the shoulder of other prisoners. Several resident-participants explained that other prisoners with whom they were close would often help in times of need, taking over daily chores as necessary, offering items from Canteen, making sure they got something to eat, and transporting them, for instance.

of correctional staff as caretakers. Following a violent attack that left him with a broken leg, resident-participant #3 described his experience with correctional staff during his recovery:

They put me in a cell where they deliver your food to the door. I had no crutches. I had to hop to get my plate...and on a couple of occasions I ended up putting pressure—weight—on it [and] it made the break even worse, to the point where I had to get a metal plate with nine screws put in... They just... the guards don't know what to do... So, they just say 'ok, well, this is where he goes, he goes in this room, that's what he's been assigned to, that's what he gets and they have to get their own food from the door'. No special instructions 'well, you have to open the door and give him his food on his desk'.

This can be likened to what Crawley (2005) termed “institutional thoughtlessness,” which arises out of efforts to treat prisoners similarly and results in the failure to recognize prisoners’ individual needs. In this particular case, the officer’s blind adherence to institutional rules and the resulting inattention paid to the prisoner’s needs actually exacerbated his condition.⁵³

Different from mere negligence, however deleterious, correctional staff were also perceived to actively defend the institutional order when under threat, which included neutralizing those perceived to pose a risk of harm to themselves or to others. Institutional responses to these incidents are predominantly control-oriented. One elderly resident recounted his experience in solitary confinement after expressing suicidal ideation: “*I was in the hole for seven days. I told someone I was going to commit suicide, they went and told the guard, and they put me in the cell—the hole. Nothing—no clothes on or nothing. They didn't want to take a chance eh*” (resident-participant #2). By placing prisoners in segregation, correctional staff attempt to neutralize the threat of suicide. While correctional policy “prohibits segregation placements for the purpose of managing suicide risk” in the Canadian penitentiary system, Howard Sapers (2014) reports that “the Service continues the dangerous practice of long-term

⁵³ Similar manifestations can be observed in community-based correctional settings. For brevity’s sake, the discussion focuses on institutionally-based experiences.

segregation of mentally disordered inmates at elevated risk of suicide and/or self-injurious behaviour.” Similarly, resident-participant #1 shared her experience following a suicide attempt:

Like the night I cut up they gave [one of my friend’s] the key to...my cell door. They had locked themselves in their bubble and they said if you can get him over to the hospital then the nurse will see him. So, he took me over to this hospital and... there’s over three hundred stiches inside and outside. They wouldn’t give me no more so I ripped em out thinking I would get more of them, but they just threw me in the hole. Locked the door and that was it till the next morning.

Here, the use of segregation emerges as a disciplinary practice. Given that the participant was placed in segregation with an open wound, it would seem that isolating her was no longer about protecting her well-being; rather, the institutional response to the participant’s distress is grounded in the assumption of wrongdoing and the consequent need for discipline.

In light of their strained relationships with institutional staff, residents reported relying on other prisoners to meet their care needs. For instance, resident-participant #5 explained that because she had trouble walking, the other girls would allow her to skip the lunch line. On days when she was experiencing immobilizing pain, she gratefully noted that “*they brought my...uh, plate to me because I couldn’t walk.*” Resident-participant #1 delineated her caretaking role early on during her long-term incarceration: “*My job was to get [an elderly prisoner] up to...SIS where you got your soap, shampoos, clean clothes and all that sort of stuff. Other guys made sure—with him being diabetic—that he’d get over to get something to eat. Uh, some other guys did his laundry and checked on him during the day*”. For her, caring for others in this environment is “*no different than you taking care of your grandmother or grandfather out here,*” explaining that “*it’s our world*” and when someone is in need, there is what resembles a familial obligation to help that differs from the duty bestowed upon correctional staff that is often neglected.

5.2.3b Negotiating Equivalent Care from a Position of “Double Disadvantage”⁵⁴

The second area of focus I consider in relation to the standard of care provided to incarcerated and formerly incarcerated older adults is the principle of equivalency in medical caring. As mentioned, equivalent care refers to the obligation to provide “ethically and legally acceptable standards of health care” for prisoners (Bretschneider and Elger, 2014, p. 320). With respect to the aging correctional population, the matter of equivalency is two dimensional. Not only is it a matter of providing equivalent care to that received in the community, it is also about providing equivalent care to that which is available to younger cohorts while incarcerated. In Canada, CSC is responsible for the delivery of healthcare to those incarcerated in federal institutions. The CCRA (1992) stipulates that the “essential” care provided in these facilities must match “professionally accepted standards.”⁵⁵ In spite of this benchmark, participants tended to describe institutionally based care as “*less than adequate*”, often providing only the “*bare minimum*,” if at all, in some cases failing to appropriately address serious health concerns, especially among older prisoners.⁵⁶ Not only are older prisoners unlikely to receive equivalent care to their community counterparts, but they are also unlikely to receive equivalent care to their younger correctional counterparts (Bretschneider and Elger, 2014; Stojkovic, 2007). As resident-participant #3 articulated, there is “*a lack of concern when it comes to elderly people. They don’t know how to treat elderly people and their health concerns...and they don’t provide the resources for it*,” adding that medical staff treated “*older people just like they treated the younger people*” despite the “*difference between being an elderly gentleman than a young guy*”.

⁵⁴ Uzoaba, 1998.

⁵⁵ Federal institutions are also required to provide “non-essential mental health care that will contribute to the inmate’s rehabilitation and successful reintegration” (CCRA, 1992).

⁵⁶ It is important to note that participants (namely residents) described the care they received in provincial institutions as significantly worse than that which they received in federal custody.

Non-equivalent institutional care is largely characterized by “rushed” service and a prevailing focus on acute-incident response in the absence of preventative care. Incarcerated older adults typically have complex care needs due to their markedly poorer health (Aday, 2003; Bretschneider and Elger, 2014; Rutherford and Duggan, 2009; Stojkovic, 2007). Consequently, it is imperative that healthcare practitioners treat the individual and not merely their illness. In order to do this, health practitioners must have detailed knowledge of patient medical histories, which is demanding of their time and relies on patient-practitioner rapport. However, participant testimony indicates that the conditions of confinement are not conducive to the provision of complex care as required by many older adults. Most residents reported feeling that healthcare staff had not spent enough time with them to fully understand their condition and provide proper treatment. As resident-participant #3 grieved: *“You get to see the doctor, he comes in and it’s like a two-minute discussion and then: ‘oh, go’, you know. Nothing done!”* Resident-participant #5 added: *“They just write down what they need to write down and they shove you out the door,”* speculating that *“it’s almost like they don’t want to take the time because they have so many people.”* Where institutional health services are overburdened and stretching already limited resources in order to process requests for service, patient care suffers. Arguably, providing individualized care that upholds human worth and dignity is impossible in carceral settings.

Feeling valued as a human being is something that occurs by way of a genuine caring relationship, as opposed to a machinated and distanced practice. As one resident explained, *“it has to do with, uh, the doctors and the staff around you, um, to treat you like a human and not just: ‘Ok, next! Ok, next!’”* (resident-participant #4). Resident-participant #1 perceived her physician in similar ways: *“That loon that was the doctor, she just didn’t care. She didn’t care about me or anybody else. She... we were a dollar sign to her.”* Receiving equivalent care is

further complicated by policies such as that which allows patients to raise only one medical issue per visit. This particular policy was mentioned by two residents, one indicating that this was a particularly salient concern in the provincial system: *“In jail...if you had a problem, it was for that problem. You can’t discuss something else; you had to wait. And if you had seen the doctor one week, you weren’t gonna see him the next week; he’s able to see only so many girls”* (resident-participant #4). Participants primarily understood rushed, uncaring service to be a consequence of limited resources. For instance, resident-participant #3 explained that the medical staff at the institutions *“just didn’t have the time or the resources. You know, I don’t blame the staff...They didn’t want to hire more doctors”*. This line of reasoning is consistent with Christie’s (2006) assertion that the operation of prisons tends to be dominated by economic thinking, resulting in the prioritization of fiscal efficiency.

As mentioned, equivalent care in the institution is also encumbered by a narrow focus on disease-centered, acute incident response. This is particularly problematic for incarcerated older adults because managing their complex needs typically demands a holistic approach, inclusive of both preventative and responsive measures. This theme was salient in interviews with both CRF staff and residents. Once again, many participants attributed the focus on acute-incident response to cost-cutting measures that affect the availability and quality of health-related services. For instance, one resident explained that while incarcerated, he saw a psychologist on a regular basis, but due to fiscal cutbacks, virtual psychiatric care was introduced, albeit with fewer benefits:

We used to see a psychologist face-to-face, but they cut that out and the psychologist that I was seeing was through the Internet... It was very bizarre, you know. So, you didn’t feel you were really getting anything out of it, you know... It saves them money, you know... And, uh... so I wasn’t really getting what I really needed (resident-participant #3).

This narrative demonstrates the importance of direct contact and human connection as integral to the healing relationship. Virtual spaces can impede this, particularly for those who have limited

experience with such technology. Staff and residents alike acknowledged that these constraints affect even esteemed professionals, expressing similar sentiments to that of staff-participant #1 who reasoned that virtual caring is not *“over the willingness of staff, it’s money, right?”*

Disease-centered care is further characterized by a preoccupation with pharmacological interventions (de Viggiani, 2006). In many cases, residents went without diagnosis and subsequent treatment while incarcerated. When they were treated, it usually consisted of prescription medication. More problematically, many participants reported issues with their medications. For instance, resident-participant #1 indicated that she was prescribed Toradol in the institution to help manage pain: *“you’re supposed to be on it two weeks. It’s a top-of-the-line painkiller. And they left me on it for four years. It burnt holes in my esophagus and in my stomach lining.”* Resident-participant #4 explained that while she was incarcerated, there were *“a lot of mix up[s]”* with her medications, including one instance where she was mistakenly given a double dosage of prescription grade sleeping pills. Following this, she paid more careful attention to the medications she was given each day, *“afraid”* of suffering adverse effects.

The overreliance on drug interventions was particularly pronounced in participants’ experiences with mental health services. As staff-participant #3 noted, there is a tendency for mental health practitioners to pass clients a pill in the absence of other supports, especially in the institution. Resident-participant #1 was highly perceptive of this machinated, un-individuated prescription of psychotropic medications to prisoners which were *“handed out like candy”*: *“So, it uh, there was always a good psychologist there ... ‘we’ll add and subtract and we’ll multiply ... oh, this is what you are here with this final number. So, do you want this type of pill or that type of pill or do you want a mixture of both?’”* Of course, these interventions are contingent upon the detection of a mental health problem. Staff-participant #4, who reported working with clients

experiencing dementia, indicated that diagnosing and addressing cognitive difficulties, particularly among older adults, is rare. Referring to a client who was diagnosed with Alzheimer's while living at the CRF, he explained that the client faced these issues *"for a long time. [He] had it in prison, they just never took care of it... he came out here and we could tell right away that something was wrong... there was no diagnosis; he was on no meds"*.

In the absence of adequate care, residents underscored the importance of engaging in self-care practices. For example, one resident described her experience involving overmedication. During her incarceration, resident-participant #4 lost a significant amount of weight, which she attributed to depression. Consequent to this weight loss, her blood pressure dropped dangerously low and the medications she was prescribed aggravated this condition. She explained that only one of the prison nurses expressed concern about this: *"She told me 'you know, with the meds you're taking and everything, it's not really good for you...I think that's why your blood pressure is getting so low.'" While nothing was done to address these concerns, the participant stopped taking some of her medications in fear of the potential health implications:*

I decided to cut down my meds by myself and the psychiatrist came and saw me and asked me why I was cutting down my meds like that and I told her that it wasn't good for me and that I came in as an alcoholic, now I'm going to get out as a pill-popper. And she said I couldn't do it that way and um, she said 'don't get off your meds like that, you're going to be sick. You can't cut it off, you have to go slowly' (resident-participant #4).

Other residents relied on the help of incarcerated individuals. As one resident described, some healthcare practitioners in prison were competent, while *"other ones you've got, uh... it, uh, you're better off being sewed up by one of the inmates if you got stuck, which happened quite a bit. I sewed some guys up in my day"* (resident-participant #1). Residents also spoke of the need

to campaign for proper care while in prison. For instance, one resident explained that while incarcerated he was prescribed a cervical pillow⁵⁷, but faced months of delays in receiving it:

I had to finally go to the warden and say, ‘...this has been going on for fourth months, you know, you’ve taken my money already out of my account for this...’ She phoned purchasing...she gave them hell and...the next day the pillow was there... That’s the kind of care, you know, that you get and if you don’t speak up for yourself, I probably would have never got the pillow (resident-participant #3).

When an individual is released from a federal correctional facility, the provision of medical care becomes the responsibility of the healthcare system of the province or territory in which they are located (Standing Committee on Public Safety and National Security, 2010). This holds true for those who remain under federal correctional supervision, whether released conditionally or statutorily. However, once older adults have secured access, the standard of care they receive in the community can be markedly better than that which they receive in the institution. In this regard, three residents expressed a strong preference for community-based health services⁵⁸, describing the difference as “*night and day*” and lauding their healthcare practitioners by articulating that they “*couldn’t ask for any better,*” suggesting that the quality of care received in the community following their incarceration is significantly better than the institutional care they received. Staff expressed similar sentiments, but shared some criticisms of the provincial healthcare system more broadly, frequently citing a lack of family physicians with the capacity to accept new patients, a common complaint amongst Canadians (Canadian Institute for Health Information, 2012). Ultimately, the quality of community-based care is largely understood in relation to accessibility, which is constrained by their status as wards of the Crown under the care of CSC and the limitations imposed by forms of care assured by the Service.

⁵⁷ Used to promote proper neck alignment.

⁵⁸ Two residents had relatively positive experiences with institutional health services and as such, did not explicitly comment on their preference for community-based services in similar ways to the other participants.

5.3 Concluding Comments

To this point, I have primarily discussed the structural barriers to health and healthcare that incarcerated and formerly incarcerated older adults face. These challenges emerged in relation to three central concepts, namely bedspace, accessibility, and quality. Through exploring these themes, I demonstrated that carceral space, as inherent to institutional and community-based corrections, creates boundaries that constrain older adults' access to healthcare. In the next chapter, I provide a more explicitly theoretical discussion of these themes, further abstracting the interview data to infer about the nature of space that produces and is produced by participant experiences in a more categorical manner.

CHAPTER 6: CONCLUSION

To this point I have demonstrated how carceral space shapes older adults' access to health and healthcare. This chapter examines the carceral logic that underwrites the spaces that incarcerated and formerly incarcerated older adults occupy and offers a more theoretically engaged discussion of the research findings. To do this, I examine how key concepts presented in the theoretical framework operate in relation to my interpretation of the interview data and its likeness to the extant literature on aging in prison. I conclude this chapter by acknowledging the limitations of this thesis and identifying areas for future research.

6.1 Interrogating Carceral Experiences of Old Age

The three overarching themes presented in Chapter Five can be understood in relation to specific intersections where access to health and healthcare is negotiated. This includes: securing accommodations that promote well-being, locating and gaining access to needed health services, and receiving care. Where my findings highlight structural barriers to health and healthcare for incarcerated and formerly incarcerated older adults at these junctures, I deconstruct these observations to reflect on the nature of carceral space by asking two questions:

- 1: What do the difficulties that incarcerated and formerly incarcerated older adults face in these settings reveal about the nature of carceral space?
- 2: What contribution does the way in which older adults navigate health and healthcare (due to or in spite of these challenges) make to the production of carceral space?

Taken together, these two questions open my line of inquiry to the three kinds of space conceptualized by Lefebvre (1991): representations of space (conceived space), spatial practice (perceived space), and spaces of representation (lived space). By situating these three moments of spatial production within the context provided by each thematic discussion, I hope to highlight tensions in how the aging body is negotiated and renegotiated in carceral space.

In the preceding chapter, I illustrated how the problems encountered by older adults in institutional and community-based correctional settings have relatively little to do with the physicality of space; instead, the problems participants noted are inherently social, stemming from the practices that produce and are reproduced by carceral space. An examination of these practices invokes consideration of the applicable correctional legislation (i.e. the CCRA), regulations (i.e. Corrections and Conditional Release Regulations [CCRR]), and policies (e.g. the CRF's contractual obligation to comply with Commissioner's Directives [CDs]) that contribute to the production of carceral space. I explored how some of these guidelines operate in relation to older adults' carceral health. I elaborate on these findings, revealing a problematic relationship between the space of legislators and policymakers (conceived space) and the space of frontline practitioners and other users (perceived and lived space). This disconnect bears heavily on older adults' access to health and healthcare in institutional and community-based settings.

6.1.1 Procuring Apt and Accessible Bedspace

Placelessness (*"there's nowhere for them to go"*) and contingency (*"we do our best with what we have"*) emerged as major subthemes in relation to the concept of bedspace. Participant narratives suggest that the absence of designated spaces for older adults in prisons and halfway houses, as well as the lack of forensic beds in nursing homes and other residential facilities, means that older adults are (mis)placed in facilities that are ill-equipped to accommodate their needs, which can result in negative experiences (i.e. victimization, isolation, and contamination).

In community-based correctional settings in particular, there are a number of regulations that dictate the allocation and management of bedspace. These are constitutive of conceived space, which encompasses formal communications such as rules, policies, and other directives that are established by administrators (Friedman and van Ingen, 2011). The regulatory

framework that governs CRF operations is dictated by a contractual relationship with CSC. As revealed throughout the interviews, attempting to circumvent some of the challenges that older adults may face in spaces that are poorly adapted to their needs—or, at least in part, to prevent overburdening already strapped resources—CRFs engage in one or more of the following practices: refusing clients with needs that exceed the facility’s capacity to accommodate, transferring clients to better equipped facilities, or making contingent efforts to accommodate.

Staff frequently cited the right of first refusal; this is a contractual right that affords a contractor, in this case the CRF, the liberty to choose whether or not to enter into an agreement. Each CRF is responsible for “specifying the conditions of eligibility for its services, admission criteria, and program availability” (CSC, 2015b, p. 2). Accordingly, CRFs reserve the right to deny applicants on the basis of health status if they are not in a position to meet the needs of the ‘client’ in question. Similarly, the practice of transferring clients to more accessible facilities is mediated by legal requirements stipulating that federally incarcerated persons who are released with a residency condition be placed in a supervised environment (CCRR, 2015). By and large, this excludes long-term care facilities where some older adults may be more aptly placed. Alternatively, transfers to more accessible facilities are contingent upon the availability of accessible bedspace; for men in Ottawa, only one residence offers fully accessible bedspace. This facility is specifically designed for ‘high risk’ individuals whose needs are understood as ‘criminogenic’ first and foremost. Older ex-prisoners, who typically ‘age out’ of criminogenic risk (Aday, 2003; Kerbs and Jolley, 2009; Rikard and Rosenberg 2007; Snyder et al., 2009; Williams, Goodwin, et al., 2012; Yates and Gillespie 2000), are marginalized as an afterthought. These (spatial) practices tend to reinforce carceral discourses insofar as they typically work within the provisions of the contractual agreement with CSC, operating in accordance with

principles of risk management and compliant with applicable legislation and policy (CSC, 2015b). Ultimately, in the context of aging prisoners facing conditional release, CRF admissions and the practices that fall within this framework are exclusionary.

Importantly, both staff and residents emphasized contingent efforts to accommodate. Many cited alterations to the built environment on a case-by-case or “*as needed*” basis. These adaptations are mediated by legislation such as the AODA and directives from operating agencies (e.g. John Howard-affiliated CRFs), operating within a broader regulatory framework. In addition to these top-down adaptations, CRFs took action to accommodate residents facing significant health and mobility challenges by working around certain conventions when faced with few, if any, alternative arrangements. For instance, staff created temporary bedspace in otherwise inaccessible facilities by transforming the living spaces or appropriating existing CRF beds. Some CRFs provided human supports in exceptional circumstances. CRF staff (and more rarely PSWs)⁵⁹ acted as a resource for residents’ safe mobility and maintaining some modicum of independence through providing assistance with ADLs and IADLs. These practices reflect changes to the routine activities of CRF life more reminiscent of representational space, but that do not exist completely outside of ordered (or perceived) space.

These policies and practices disproportionately affect older applicants who are more likely to have high *health* needs and contribute to older adults’ experience of placelessness. Placelessness is experienced in relation to Lefebvre’s (1990) spatial practice, at once comprising the built environment and routine activities occurring within it. As demonstrated in the literature, prisons are not designed to suit the needs of older adults (Moran, 2015; OCI, 2011; Potter et al., 2007; Trotter and Baidawi, 2015), and according to CRF staff and some residents, community-

⁵⁹ The hire of PSWs for ADL support is not included under contract with CSC. As mentioned, funding for PSWs is granted on an ad hoc basis.

based facilities are no better equipped. As such, older adults seldom have access to appropriately built space, which inhibits their ability to independently move about these facilities. They are expected to navigate institutional and community settings in prescribed ways; however, the routine activities that govern them in and through these spaces and which they are expected to perform are not necessarily matched to the interests and abilities of older adults. For instance, older adults living in halfway houses that feature individual bachelor units are expected to “*keep busy*”, avoid contact with anyone with a criminal record (including those residing in the same facility), and engage with ‘pro-social contacts’ outside of the halfway house, demonstrating productive civic engagement. Where there are few opportunities to connect with those their own age in the community, and as many older adults have lost contact with family and friends, forging these kinds of relationships is exceedingly difficult. This can result in a “sense of disaffiliation,” negatively affecting an individual’s ability to be “in-place” at the halfway house and in the community more broadly (Munn, 2009, p. 180).

6.1.2 Locating and Securing Health Services

In Chapter Five, I explored proximity, gatekeeping, and discontinuity as major subthemes in relation to the overarching theme of accessibility.⁶⁰ I described older adults’ access to healthcare as being mediated by material flows between sites of care. In correctional settings, various policies, economies, routines, and “spur-of-the-moment decisions” bear on how individuals, groups, and commodities move through space (Stoller, 2013, p. 2263). The policies and practices that delimit carceral space, as determined by correctional priorities, can interrupt

⁶⁰ Unlike my earlier analysis of participant experiences linked to bedspace, which refers to the physical accessibility of custodial and non-custodial correctional environments, this theme focuses on older adults’ attempts to locate and gain access to health services exclusive of the built features of care sites; participants expressed few concerns about the physical accessibility of care sites beyond proximity.

these flows along routes to care, ultimately affecting the accessibility of healthcare. Where movement and mobility are inherent to accessibility, older adults are disproportionately affected.

As discussed, older adults' health-seeking behaviours are partly dictated by proximity. Conditions of release and various CRF policies, if applied without exception and without consideration for individual health needs and mobility challenges, often act as barriers to accessing health services. For instance, limits on unescorted time in the community are ignorant to the CRFs proximity to needed services, as well as to the older adult's physical capacity to travel to and from these locations in a timely manner. As a result, older adults may face difficulty scheduling medical appointments and risk non-compliance in attending scheduled appointments. In a similar vein, limited availability of preferential forms of transportation can engender significant stress and may result in delayed care or forestall treatment altogether, as was the case for resident-participant #5 who discontinued her care at a centre for Indigenous health because it was "*too far out*". Policies and practices that are not sensitive to these circumstances are effectively immobilizing.

Together, corrections and medical personnel act as gatekeepers, controlling access to care sites. The pairing of these two systems creates impediments to accessing these services making healthcare more difficult to navigate. As explained, correctional staff are a first point of contact in attempting to access medical services. In the institution, correctional staff decide whether a prisoner will be permitted to travel to the clinic based on their assessment of the prisoner's health and formal request(s) to see a doctor. For prisoners of all ages, this can be circumspect, but for older adults, the issue is compounded by "institutional thoughtlessness" arising out of the need to treat all prisoners equally (Crawley, 2005). In the community, CRF staff are not accused of institutional thoughtlessness. CRF employees are not corrections staff whose powers are outlined

in the CD regarding Peace Officer Designations (CD 003). Instead, CRF staff are employed by the organization contracting with CSC. The contractual agreement stipulates that CRF staff are assigned to a resident's Case Management Team, participating in "the development of, and updates to, an offender's release plan (Community Strategy) and Correctional Plan" (CSC, 2015b, p. 3). They must also develop a Resident Action Plan that aligns with the resident's Correctional Plan and review progress in relation to the Resident Action Plan at least once per month (CSC, 2015b). CRF staff are also responsible for referring older adults to appropriate services and assisting them with the requisite procedures as needed (e.g. obtaining Ontario Health Insurance Plan coverage). CRF staff also mediate repeated access to these services, for instance, by ensuring that residents are well aware of their appointments. Ultimately, their efforts are hindered by systemic issues reminiscent of conceived space (discussed below); however, this discrepancy highlights a point of demarcation with respect to health service accessibility in custodial and non-custodial settings. Residents suggested that CRF staff play a more supportive role; of course, they have management responsibilities, but the on-the-ground practices enacted by caseworkers are comparably less control-oriented.

Institutional medical staff facilitate access to secondary health services, including laboratory services, specialist care, or hospital admission. Participants reported significant delays in gaining access to these services, while others reported being refused specialist care altogether if their condition was not severe enough; otherwise, *"it was like trying to pull teeth to see somebody on the outside"* (resident-participant #4). Interviews suggested that prisoners must be persistent in advocating for their health. However, the literature reports that older adults may be less likely to do so in institutional settings (Aday, 2003; Crawley, 2007). Importantly, some participants suspected that access to specialized care is heavily influenced by fiscal restraint, and

not necessarily a lack of concern on the part of medical practitioners: “*It’s because the doctor is told that wherever possible...don’t make outside appointments because it costs them money*” (resident-participant #3). By contrast, participants reported few issues in accessing specialized care through consultations with their primary care physicians in the community with whom all residents reported having a strong rapport.

Expectedly, discontinuity is also experienced in relation to spatial practice, specifically in terms of procedural disruptions to the flow of health information, which compromises the adequacy of pre-release planning. Specifically, this subtheme deals with the transfer from institutional to community-based care. Because institutional care is provided by CSC, and community care is provincially operated, there is significant disconnect. Inadequate pre-release planning results from a number of factors identified by participants, including: generic community strategies, lack of formal identification, and limited access to health information including institutional health records and prescription information. First, community strategies, which map out an individual’s reintegration to the community, often neglect the health needs of individuals. This is common across all age groups, but disproportionately affects older adults whose health is more likely to negatively impact their successful reintegration. Lack of formal identification is also an issue. Community spaces, and health services located therein, are difficult to navigate for individuals who have spent a significant period of time in prison and are less likely to possess formal identification. This is compounded by the fact that despite the institution’s adequate health files, individuals do not have ready access to their health records (instead having to file an *Access to Information* request) and they are not released with prescription information. This means that in order to continue receiving their medications, they must find a family doctor immediately upon release. Familiarizing a doctor with their history

would be made easier by access to their institutional medical file. Where these factors do not impede access to health services, participants attributed success to luck.

6.1.3 Receiving Healthcare

In the preceding chapter, I discussed different types of care experienced in the institution, namely formal care, which includes care provided by trained health professionals (i.e. medical care) and by corrections staff (i.e. domestic care), and informal care, encompassing care provided by other prisoners and self-care. By and large, participants reported negative experiences with formal institutional care, which is characterized by competing logics of care, cure, and control. Ultimately, these tensions have significant repercussions for equivalent care.

While provincial and territorial governments are primarily responsible for the delivery of healthcare services, the federal government, specifically CSC, is responsible for providing the federal custodial population with healthcare that is commensurate with that which is widely available in the community (CCRA, 1992). The literature suggests that prisons largely fail in this regard, resulting in negative health consequences for the incarcerated population (Bretschneider and Elger, 2014; Lines, 2006; Stojkovic, 2007; Stoller, 2003).⁶¹ This can be attributed to the fact that the prison serves, or purports to serve, several functions. As such, the prison is obliged to be many spaces at once. First and foremost, it is alleged to be a rehabilitative space, though it is frequently determined to be a punitive or disciplinary space (Mathiesen, 2006). Prison is also a clinical and therapeutic space, a psychiatric or forensic space, and a palliative or hospice space. The institution cannot conceivably do all of these well, especially in times of fiscal constraint (Christie, 2006). Moreover, these spaces do not operate independently of one another. Instead,

⁶¹ Notwithstanding, this arrangement creates additional barriers for incarcerated individuals upon release; the entity responsible for the provision of care changes hands, while CSC still retains some responsibility for the well-being of the individual until they reach warrant expiry. These struggles are especially common among older adults. However, the implications of this weigh more heavily on service accessibility.

these care spaces are physically nested within the broader disciplinary space, whose governing logic and associated practices permeate and structure all care activities.

In particular, participants characterized institutional healthcare as being heavily preoccupied with policy and procedure. To this end, participants described institutional healthcare as primarily reactive, lacking any pretence of holism. Consistent with the literature, many participants attributed these shortcomings to limited resources and suggested that this issue is exacerbated by overcrowding, which places increased demands on available services despite the lack of adequate resources. This issue is further compounded by the increased costs associated with caring for elderly prisoners, who tend to place greater strain on health systems (Snyder et al., 2009; Stojkovic, 2007; Tarbuck, 2001; Williams, Goodwin, et al., 2012; Williams, Stern, et al., 2012).

As a result, carceral healthcare is experienced as rushed and acute. Medical staff have limited time to spend with patients and deal with a high volume of patients on a daily basis. This leaves little room to attend to older adults' complex care needs. Instead, it forces medical staff to focus on acute-incident response and present generic treatment options. Furthermore, staff and residents alike reported that prison physicians typically prescribe pharmacological interventions, which can have grave implications. Residents in particular noted that medications are often (over)prescribed and errors are frequently made in distributing them. Ultimately, cost-cutting measures and related policies and practices dictate the actions of staff whose practices define the care space in penal institutions. Together, these activities change the nature of care and prevent the space from being therapeutic; instead, it is strictly curative and inadequately so.

Correctional personnel are also implicated in the provision of care given the “quasi-domestic” nature of prison spaces (Crawley, 2004). With few exceptions, resident-participants

described staff as indifferent to or deliberately negligent of their needs, health-related and otherwise. Specifically, some resident-participants reported being treated “*like a number*” and feeling as though staff lacked concern for their well-being. Once again, these experiences reflect “institutional thoughtlessness”—that is the institution’s blindness to individual circumstances in a broader attempt to treat all prisoners equally, which actually denies the possibility of equitable care. Beyond this, resident-participants shared a number of experiences where staff deployed a disciplinary response instead of a care response in order to neutralize what they perceived as a threat to the individual’s safety. Recall resident-participant #1’s experience following a suicide attempt where the uses of segregation emerges as a disciplinary practice: “*Like the night I cut up...there’s over three hundred stiches inside and outside. They wouldn’t give me no more so I ripped em out thinking I would get more of them, but they just threw me in the hole. Locked the door and that was it till the next morning.*” This demonstrates that correctional staff were also perceived to actively defend the institutional order when under threat, which included neutralizing those perceived to pose a risk of harm to themselves or to others. Institutional responses to these incidents are predominantly control-oriented.

These practices change what should be a rehabilitative or therapeutic setting into one that is primarily disciplinary and that responsabilizes the individual in the provision of their own care. The spaces are disciplining insofar as negligent formal care forces prisoners to rely on informal mechanisms of care, which discipline the self and the pseudo-caretaker (i.e. other prisoners). In the place of formal care providers, younger prisoners are tasked with providing informal care to their aging counterparts; as Crawley (2005) suggests, correctional staff distance themselves from their caretaking identity and expect younger cohorts to take on the responsibility of caring for their elders. This is a form of administratively-sanctioned care. Older adults facing significant

health and mobility challenges have little choice but to accept this help regardless of quality. At the same time, older adults engage in self-care (e.g. exercising, being vigilant with respect to taking their medications) where formal mechanisms may fail them. However, participants also reported relying on less permissible forms of informal care. For instance, resident-participant #1 described occasions where she stitched other prisoners' wounds, and times when prisoners would pull each other's teeth out to relieve pain in light of limited access to dental care. Similarly, resident-participant #4 cut her medications on her own accord, fearful of the adverse effects she was experiencing. These practices are a reaction to perceived space producing inadequate care systems and are thus reminiscent of representational (or lived) space.

By contrast, the care available to older adults following their release from the penitentiary is described as markedly better. This is in spite of the difficulties that older adults are prone to experience in attempting to access healthcare following their release into the community. Specifically, these challenges tend to arise prior to and leading up to their securing a primary care provider. When taken together, these findings suggest that the issues plaguing carceral healthcare standards are predominately place-based.

6.2 Concluding Thoughts

The purpose of this thesis was to explore how the health of incarcerated and formerly incarcerated older adults unfolds in the spaces to which they are confined. Through in-depth, semi-structured interviews with CRF staff and older residents at halfway houses in Ottawa, Ontario, I identified three major themes that represent different moments where health, illness and aging are negotiated; these themes center around procuring apt and accessible bedspace, locating and securing access to care, and receiving care. Through an exploration of these themes, I illustrated how institutional space not only inhibits older adults access to health and healthcare,

but also renders inept the healthcare provided within. By contrast, while older adults access to health and healthcare in the community is constrained by carceral practices, the quality of the care they receive is preferable to that which is available inside.

Ultimately, by hinging this thematic analysis on the spatiality of health and healthcare using Lefebvre's (1991) ideas about social space in particular, I have demonstrated that the problems encountered by older adults in institutional and community-based correctional settings have relatively little to do with the physicality of space; rather, they are fundamentally social, being tied to the everyday practices that produce and are reproduced by carceral and transcerceral space. This is especially salient in the lived experiences reported by older adults, but less so in the insights offered by staff who were more likely to focus on challenges arising from the built environment. These differences suggest a disconnect between older adults' needs and systematic responses to these needs. Ultimately, this thesis contributes to the debate surrounding the best course of action in addressing the aging correctional population. The proposed solutions are inherently spatial, essentially boiling down to which correctional environment older adults are best kept. Given the expansion of the carceral net, it is demonstrated that community-based settings also pose significant problems for older adults. As such, it is not only the physical confines of the prison environment, but rather carceral/spatial practices that inhibit older adults' access to health and healthcare in institutionally and community-based correctional settings.

6.2.1 Study Limitations

When considering the validity of this research, there are notable limitations that I discuss in relation to two broad categories. First, there are several limitations stemming from the chosen data-collection procedure. Restricted access to federal penitentiaries and privacy concerns at

CRFs meant that ethnographic methods were unfeasible. This is problematic because ethnography is integral to understanding how space is produced and reproduced. I was also unable to speak to older adults during their incarceration; instead, participants were drawn from community-based settings and asked to reflect on their experiences while incarcerated and following their release from prison. It is possible that participants' recollection of their institutional care experiences was more erroneous and less thorough than their reports of community-based care experiences.

To sidestep delays in obtaining permission to speak with older adults under community supervision, I decided to draw my sample from CRFs. For convenience, I limited this further by selecting the Ottawa region as my sole research location. By focusing only on CRFs, I potentially excluded participants with the most severe health challenges. Speaking with POs in Ottawa may have allowed me to tap into a larger sample with a more diverse range of experiences. Anticipating that few staff members would have enough expertise working with older adults to speak about their challenges, and anticipating that few older adults would be willing to participate, I interviewed from both samples. While this helps generate some data triangulation, neither subsample was large enough to reach data saturation or to get a diverse range of experience from each perspective. Due to the small sample, the present study lacks analysis of the intersections between incarceration, age, health, gender, and race. A larger, more representative sample would have permitted an exploration of these differences (e.g. a gendered analysis) and how they shape the experience of health, illness, and aging in these settings.

There are also limitations associated with my spatial interpretation of the interview data. As explained, I draw heavily on Lefebvre's three moments of spatial production to guide the analysis and discussion. While this tripartite conceptualization comprises a useful interpretive

framework, it is not meant to stand alone (Merrifield, 2006; Soja, 1996; van Ingen, 2003). While I integrate theoretical literature relevant to carceral space, due to space and time constraints I could not fully mobilize Lefebvre's complete theoretical and methodological enterprise.

6.2.2 Future Directions

As the correctional population ages and older adults (especially those experiencing cognitive and psychological symptoms associated with dementia) continue to become entangled in the criminal justice system, sustained research and policy interest in this area will be crucial. Specifically, the present study focuses on the spatial dimensions of older adults' health experiences while incarcerated and following their release from prison. Considering the limitations of this thesis, as well as secondary themes that emerged during the interview but lacked relevance to the health-focused analysis and discussion, I suggest that there a number of areas of inquiry that would benefit from further research.

First and foremost, this thesis does not purport to have fully captured the health experiences of criminalized people. Due to the small sample derived from CRFs in a single Canadian city and the tendency of CRFs to refuse high needs clients, older adults living in the direst circumstances are excluded. Future research might attempt to develop a more comprehensive understanding of incarcerated and formerly incarcerated older adults' health needs in Canada. Information about a wider range of health experiences, especially more serious and debilitating conditions, holds the potential to illuminate other spatial features implicated in the experience of health, illness, and aging, or highlight differences in the lived reality of these spaces for differentially aged, gendered, and raced bodies. Comparative research that examines health and healthcare experiences in provincial prisons would also highlight these differences.

Secondly, participants frequently alluded to difficulties adjusting to community life and noted a lack of support, both social and material. In this thesis, I only briefly mention these issues as pertinent to their reported health experiences. Consequently, participants' experiences relating to institutionalization, loss, self-identity, financial hardship, motivation and the like are largely absent, but no less important. Of course, these experiences have implications for health given that many constitute significant emotional stressors and can bear on access to and quality of healthcare, but they also raise broader questions about older adults' wellness that are not explicitly bound to mental or physical health.

Finally, participants expressed concerns about the lack of suitable programming and/or being screened out of certain opportunities that might have otherwise provided meaningful occupation. Instead, they are merely "kept busy" or placated. Moreover, participants discussed expectations of productivity (including participation in the labour market) and engagement in civic life following their release; this is in spite of having reached an age when "free" older adults are permitted to retire from these responsibilities. Participants also cited limited access to any entitlements that come with old age because their chronological age underestimates their biological age. Moving forward, research in this area might apply Lefebvre's work by focusing on the ways in which contemporary capitalist discourse underwrites the health and healthcare experiences of this diverse and marginalized group.

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APPENDICES

APPENDIX A1: RECRUITMENT POSTER**PARTICIPANTS NEEDED FOR
RESEARCH ON COMMUNITY CORRECTIONS**

We are looking for volunteers to partake in a study that will explore the health-related challenges faced by older former prisoners from the perspective of those who support them in the community.

If you choose to participate, you will be asked to attend one interview lasting approximately 30 to 90 minutes. During this interview, you will be asked a series of questions about your experiences working with older adults under community supervision. Please note that participants will be selected on a first come, first served basis and that interviews will be conducted in English only.

In appreciation for your time, you will receive a \$10 Tim Hortons gift card.

If you are interested in participating in this study or would like further information, please contact:

Meagan Strasser

MA Student, Department of Criminology, University of Ottawa
at

Mobile: [REDACTED]

Email: [REDACTED]

OR

Dr. Jennifer Kilty

Associate Professor, Department of Criminology, University of Ottawa
at

Phone: 613-562-5800 ext. 1931

Email: Jennifer.Kilty@uOttawa.ca

APPENDIX A2: RECRUITMENT POSTER**PARTICIPANTS NEEDED FOR
RESEARCH ON COMMUNITY CORRECTIONS**

We are looking for volunteers to take part in a study that will explore the health-related experiences of older former prisoners who are now under community supervision.

To participate in this research, you must be at least 50 years of age and currently reside in a halfway house in the Ottawa region.

If you choose to participate, you will be asked to attend one interview lasting approximately 45 to 90 minutes. During this interview, you will be asked a number of questions about your health experiences while incarcerated and while under supervision in the community. Please note that participants will be selected on a first come, first served basis. Interviews will be conducted in English only.

In appreciation for your time, you will receive a gift card valued at \$20.00 for either Shopper's Drug Mart *or* Tim Hortons.

If you are interested in participating in this study or would like more information, please contact:

Meagan Strasser

MA Student, Department of Criminology, University of Ottawa
at

Phone: [REDACTED]
Email: [REDACTED]

OR

Dr. Jennifer Kilty

Associate Professor, Department of Criminology, University of Ottawa
at

Phone: 613-562-5800 ext. 1931
Email: Jennifer.Kilty@uOttawa.ca

APPENDIX B1: LETTER OF INFORMATION

Dear Interested Participant,

I would like to invite you to take part in a research study entitled “Health, Illness and Aging in Carceral Spaces,” which will explore the health-related, post-release experiences of older former prisoners under community supervision. This research will be conducted by Meagan Strasser, a graduate student in the Department of Criminology at the University of Ottawa, under the supervision of Dr. Jennifer Kilty.

The purpose of this study is to learn how older adults experience health and illness in community correctional settings following their release from prison. With this research, we hope to develop a greater understanding of the extent to which the health needs of older ex-prisoners are being met. This information will become evermore critical as this population continues to grow. To learn about the experiences of older adults in the criminal justice system, in-depth interviews will be conducted with service providers who support these older ex-prisoners in the community.

Your role in this study is completely voluntary. Should you choose to participate, you will be asked to attend one interview with the researcher, which will explore your experiences in dealing with older adults following their release from prison. This interview will last approximately 30 to 90 minutes and will be scheduled at your convenience. With your permission, the interview will be audio recorded so that it can be transcribed at a later time. The information that you share during the interview will be kept confidential and your anonymity protected. All identifying names, places and events will be changed in the interview transcripts and any published material.

If you are interested in participating in this study, or would like more information, please contact the researcher, Meagan Strasser, or her supervisor, Dr. Jennifer Kilty, indicating your interest.

Thank you for your consideration,

Meagan Strasser

MA Student
Department of Criminology, University of Ottawa
Mobile: [REDACTED]
Email: [REDACTED]

Jennifer Kilty, Ph.D.

Associate Professor
Department of Criminology, University of Ottawa
Phone: 613-562-5800 ext. 1931
Email: Jennifer.Kilty@uOttawa.ca

APPENDIX B2: LETTER OF INFORMATION

Dear Interested Participant,

I would like to invite you to take part in a research study entitled “Health, Illness and Aging in Carceral Spaces,” which will explore the health-related experiences of older former prisoners under community supervision. This research will be conducted by Meagan Strasser, a graduate student in the Department of Criminology at the University of Ottawa, under the supervision of Dr. Jennifer Kilty.

The purpose of this study is to learn how older adults experience health and illness in correctional settings, which includes experiences while incarcerated and following release from prison. With this research, we hope to develop a greater understanding of the health needs of older ex-prisoners. To learn about the experiences of older adults in the criminal justice system, in-depth interviews will be conducted with older residents (ages 50 and over) at halfway houses in Ottawa, Ontario.

Your role in this study is completely voluntary. If you choose to participate, you will be asked to attend one interview with the researcher, which will explore your health experiences while involved in the correctional system. This interview will last approximately 45 to 90 minutes and will be scheduled at your convenience. With your permission, the interview will be audio-recorded so that it can be transcribed at a later time. The information that you share during the interview will be kept confidential and your anonymity protected. All identifying names, places and events will be changed in the interview transcripts and any published material. If you choose to participate, you will receive a gift card valued at \$20.00 for use at either Shopper’s Drug Mart or Tim Hortons (your choice) in appreciation for your time. Please note that participants will be selected on a first come, first served basis and interviews will be conducted in English only.

If you are interested in participating in this study, or would like more information, please contact the researcher, Meagan Strasser, or her supervisor, Dr. Jennifer Kilty, indicating your interest.

Thank you for your consideration,

Meagan Strasser

MA Student
Department of Criminology, University of Ottawa
Mobile: [REDACTED]
Email: [REDACTED]

Jennifer Kilty, Ph.D.

Associate Professor
Department of Criminology, University of Ottawa
Phone: 613-562-5800 ext. 1931
Email: Jennifer.Kilty@uOttawa.ca

APPENDIX C1: CONSENT FORM

Title of Study: Health, Illness and Aging in Carceral Spaces

Principal Researcher:

Meagan Strasser

MA Student

Department of Criminology

University of Ottawa

Mobile: [REDACTED]

Email: [REDACTED]

Thesis Supervisor:

Jennifer Kilty, Ph.D.

Associate Professor

Department of Criminology, University of Ottawa

120 University Private, Ottawa ON, K1N 6N5

Phone: 613-562-5800 ext. 1931

Email: Jennifer.Kilty@uOttawa.ca

Invitation to Participate: I am invited to partake in the above-named research study conducted by Meagan Strasser under the supervision of Dr. Jennifer Kilty. This research will be used for the Principal Researcher's MA thesis.

Purpose of the Study: The purpose of this study is to explore the health-related, post-release experiences of older former prisoners under community supervision. It will provide an in-depth examination of the challenges faced by older adults in the criminal justice system from the perspective of halfway house staff. It is hoped by learning about how older ex-prisoners experience health and illness following their release from prison, we can ascertain the extent to which this population's health needs are being met in the community, and determine how these needs might be better served.

Participation: My participation in this study will consist of taking part in one interview, lasting approximately 30 to 90 minutes. During this time, I will be asked a number of questions about my own thoughts and experiences working with older ex-prisoners. This interview has been scheduled for: _____ (date) at _____ (time), taking place at _____ (location).

Risks: My participation in this study will entail that I volunteer personal information about my thoughts, feelings and experiences. This may cause me to feel uncomfortable and/or to experience anxiety before, during, or after the interview. I have received assurance from the researcher that every effort will be made to minimize these risks and I have been provided with a list of organizations and the services they provide. I can access these services should I experience any negative feelings. This research may also involve social repercussions in the form of negative judgement or suspicion from colleagues and/or residents. The researcher has assured me that my participation will only be known to the researcher and her supervisor and that I may attend the interview at an alternate location to my place of work if I have concerns in this regard.

Benefits: My participation in this study will contribute to current knowledge about older adults' experiences in the criminal justice system. In particular, it will explore older adults' health-related experiences after prison, generating a more nuanced understanding of their needs in context. This information will become evermore critical as this population continues to grow and could be used to help communities respond to the challenges faced by older ex-prisoners.

Confidentiality and Anonymity: I have received assurance from the researcher that the information I share will remain strictly confidential. I understand that the contents of my interview will be used only for the purposes of the current study. All identifying information will be anonymized in the interview transcripts and any published material. While quotations, or paraphrased quotations, that I share during the interview may be published, my identity will not be revealed in doing so. Further, my participation in this study will not be disclosed to any other person or participant; however, I understand that this cannot be guaranteed if I have chosen to be interviewed at my place of work where supervisors, colleagues, and/or residents may notice my attendance to an interview. Should I wish to review the contents of my interview, I may request a paper copy of the audio recording once it has been transcribed. If I would like to revise or delete any of my responses, I will be able to meet with the researcher for a follow-up interview at which time I may provide clarification or further information.

Conservation of Data: I understand that the data collected from the interview will be audio-recorded, transcribed, and electronically stored on a password-protected personal computer. Recordings of the interview and a printed copy of transcripts will be kept in the researcher's home in a locked desk drawer, to which only she has access. An additional electronic copy of the interview transcripts will also be kept on a USB storage device in a locked cabinet in Dr. Jennifer Kilty's office at the Department of Criminology, where only the researcher and Dr. Kilty will have access to it. Following the defence of the Principal Researcher's Master's thesis, paper copies of transcripts will be shredded. Audio files and electronic copies of interview transcripts will be transferred to USB devices and stored in locked drawers in the Principal Researcher's home and Dr. Kilty's office; all other copies will be securely deleted. Information contained on both USB keys will be conserved for a period of five years after the defence, after which time it will be securely deleted.

Compensation: I will be offered compensation in the form of a \$10 Tim Hortons gift card in appreciation for my contribution to the current study. Should I choose to remove myself from the study, the compensation I have received will not have to be returned.

Voluntary Participation: I understand that I am under no obligation to participate in this study, and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, I understand that I have the choice to refuse any data gathered until the time of withdrawal from being used in the study, at which point the data will be destroyed.

Acceptance: I, _____, agree to participate in the above research study conducted by Meagan Strasser of the Department of Criminology at the University of Ottawa, under the supervision of Dr. Jennifer Kilty.

Audio-Recording: I understand that, with my permission, this interview will be audio-recorded. The purpose of this is to facilitate the accurate transcription of my interview. All identifying information will be anonymized in the transcript. I give permission to be audio-recorded for the duration of the interview (please check one of the following):

- Yes, I give permission.
- No, I do not give permission.

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions or concerns regarding the ethical conduct of this study, I may contact:

Protocol Officer for Ethics in Research, University of Ottawa
550 Cumberland Street, Tabaret Hall, Room 154
Ottawa, ON K1N 6N5

Telephone: 613-562-
5387^L_{SEP}
Email: ethics@uottawa.ca

Two copies of the consent form will be completed, one of which is mine to keep. The other will be kept in the possession of the Principal Researcher.

Participant's signature: _____ Date: ^L_{SEP} _____

Researcher's signature: _____ Date: _____

APPENDIX C2: CONSENT FORM

Note: Before starting each interview, participants were asked to read the consent form with the researcher section by section (note that an ellipsis marks the end of a section), pausing between each to discuss what they have just read and to ensure that each participant's understanding of their rights (notably with respect to anonymity and confidentiality, refusing to answer a question, ending the interview, or withdrawing from participating in the project) was clear.

Title of Study: Health, Illness and Aging in Carceral Spaces

Principal Researcher:

Meagan Strasser

MA Student

Department of Criminology

University of Ottawa

Mobile: [REDACTED]

Email: [REDACTED]

Thesis Supervisor:

Jennifer Kilty, Ph.D.

Associate Professor

Department of Criminology, University of Ottawa

120 University Private, Ottawa, ON, K1N 6N5

Phone: 613-562-5800 ext. 1931

Email: Jennifer.Kilty@uOttawa.ca

Invitation to Participate: I am invited to take part in a research study carried out by Meagan Strasser under the supervision of Dr. Jennifer Kilty. This research will be used for the Principal Researcher's MA thesis.

Purpose of the Study: The purpose of this study is to explore the health experiences of older adults who were incarcerated, but are now under supervision in the community. It will examine the health challenges faced by older adults in the correctional system. By learning about how older adults experience health and illness both in prison and in halfway houses once they are released, we hope to determine whether older adults' health needs are being met, and how these needs could be better served.

Participation: If I choose to take part in this study, I will be asked to attend on one interview that will last approximately 45 to 90 minutes. During the interview, I will be asked questions about my health experiences in the correctional institution and in the halfway house. I will be asked how living in these spaces has affected my health. This interview has been scheduled for _____ (date) at _____ (time), and will take place at _____ (location).

...

Risks: If I choose to participate in this study, I will be asked to volunteer personal information about my thoughts, feelings, and experiences. This may make me feel uncomfortable and/or anxious before, during, or after the interview. The researcher has assured me that every effort will be made to minimize these risks. I have been provided with a list of organizations and the services they provide and I can access these services if I experience any negative feelings. By taking part in this research, it is possible that I may face negative judgement or suspicion from other residents, halfway house staff, or other correctional personnel. The researcher has assured me that only the researcher and her supervisor will know about my decision to participate in this study and that I can be interviewed at a different location if I choose.

•••

Benefits: If I take part in this research, the information that I provide will help develop current knowledge about older adults in the criminal justice system. In particular, it will explore older adults' health experiences during incarceration and while under community supervision, to gain a better understanding of their needs in context. This information may be used to help correctional administrators respond to challenges faced by older adults.

•••

Confidentiality and Anonymity: The researcher has assured me that the information I share will be kept strictly confidential. I understand that the information I share during my interview will be used only for the purposes of this study. All information that could identify me or other people will be anonymized in the interview transcripts and any published material. While quotations, or paraphrased quotations, that I share during the interview may be published, my identity will not be shared. My participation in this study will not be disclosed to any other person; however, I understand that this cannot be guaranteed if I have chosen to be interviewed at the halfway house where residents and/or staff may notice that I am attending an interview. If I would like to review the contents of my interview, I may request a paper copy of the audio recording once it has been transcribed. If I would like to change or delete any of my responses, I will be able to meet with the researcher for a follow-up interview to provide clarification or more information.

•••

Audio-Recording: I understand that, with my permission, this interview will be audio-recorded. The purpose of this is to help ensure that my interview can be accurately transcribed. All identifying information will be made anonymous in the transcript. I give permission to be audio-recorded for the duration of the interview (please check one of the following):

- Yes, I give permission.
- No, I do not give permission.

Conservation of Data: I understand that the data collected from the interview will be audio-recorded, transcribed, and electronically stored on a password-protected personal computer. Recordings of the interview and a printed copy of transcripts will be kept in the researcher's home in a locked desk drawer, to which only she has access. An additional electronic copy of the interview transcripts will also be kept on a USB storage device in a locked cabinet in Dr. Jennifer Kilty's office at the Department of Criminology, where only the researcher and Dr. Kilty will have access to it. Once the Principal Researcher has defended her Master's thesis, paper copies of transcripts will be shredded. Audio files and electronic copies of interview transcripts will be transferred to USB devices and stored in locked drawers in the Principal Researcher's home and Dr. Kilty's office; all other copies will be securely deleted. Information contained on both USB keys will be conserved for a period of five years after the defence; it will be securely deleted after this time.

•••

Compensation: I will be offered a \$20.00 gift card for use at either Shopper's Drug Mart or Tim Hortons in appreciation for my contribution to the current study. If I decide that I no longer want to take part in this study, I will not have to return this gift card.

Voluntary Participation: I understand that I am not obligated to take part in this study. If I choose to participate, I understand that I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, I understand that I have the choice to refuse any data gathered until the time of withdrawal from being used in the study, at which point the data will be destroyed.

Acceptance: I, _____, agree to participate in the research study conducted by Meagan Strasser of the Department of Criminology at the University of Ottawa, under the supervision of Dr. Jennifer Kilty.

•••

If I have any questions about the study, I may contact the researcher or her supervisor.

If I have any questions or concerns regarding the ethical conduct of this study, I may contact:

Protocol Officer for Ethics in Research, University of Ottawa
550 Cumberland Street, Tabaret Hall, Room 154
Ottawa, ON K1N 6N5

Telephone: 613-562-5387
Email: ethics@uottawa.ca

Two copies of the consent form will be completed, one of which is mine to keep. The other will be kept in the possession of the Principal Researcher.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

APPENDIX D1: INTERVIEW GUIDE

Note: I began each interview by reading the statement below. This was followed by questions posed in Sections A, B, and C of this guide. Additional questions that emerged from the dialogue were asked to elicit further information from participants.

I am interested in discussing your experiences working with older former prisoners. In particular, I would like to learn about the health-related needs of older adults under community supervision and any barriers to meeting these needs. Please keep in mind that during this interview, I will be using the term ‘older’ to describe former prisoners over the age of 50.

During this interview, I will ask you a series of questions to learn about the health of older adults following their release from prison. In the beginning, I will ask you a few brief questions that pertain to your work in the halfway house in order to gain a sense of the work experience you will be drawing on to answer the central subset of questions. The main series of questions will require more detailed responses and will focus specifically on what you have observed about the health of older residents at the House. At the end of the interview, you will have the opportunity to discuss any experiences and ideas that have not been addressed.

SECTION A: Working in the Halfway House: Sample Characteristics

1. When did you begin working at this facility?
2. Could you provide a description of your regular duties at the House?
3. How many residents in this facility are currently over the age of 50?
 - a. Are there generally fewer or more older residents than this at any given time?
 - b. Approximately how many men over the age of 50 have you worked while employed here?
4. Were there any opportunities to receive training specific to the care of older adults?
 - a. If yes, could you describe what this training entailed?
5. As noted, I will be using the term ‘older’ to describe offenders over the age of 50. The Correctional Service of Canada uses this designation. Can you describe whether this designation is consistent with how old age is conceptualized in the halfway house?
 - a. What does old age look like in the halfway house?
 - i. How do you identify residents who are older from those who are younger?
 - ii. How are older residents the same or different from older adults not involved in the justice system?

SECTION B: Participants’ Experience Working with Older Adults

1. How would you describe the physical health of older residents?

2. How would you describe the mental health of older residents?
 - a. Have you worked with any older residents who have had or were suspected to have had cognitive impairments such as Alzheimer's or other dementias?
 - i. If yes, can you describe how these individuals were dealt with (or would be dealt with) in the halfway house?
3. What impact do you think living in a halfway house has on the physical and mental health of older residents?
 - a. How accessible is the living space for older adults?
 - i. Are there stairs? Are there lifts or elevators?
 - ii. Are hallways/doorways wide enough to accommodate walkers/ wheelchairs?
 - iii. Do washrooms have safety equipment like grab bars and no-slip mats?
 - iv. Is the space adequately warm in the winter and cool in the summer?
 - b. Where the space is not accessible, how do older residents adapt?
 - c. What sorts of things have house staff done to make these spaces accessible to overcome barriers to accessibility?
4. What routines or what daily tasks are all residents typically expected to perform? This includes tasks related to personal hygiene as well as those related to house maintenance (e.g. chores).
 - a. Would you say that older residents able to complete these tasks independently?
 - b. Are there environmental supports in the House that help them complete these tasks independently?
5. How would you describe older residents' ability to follow house rules and their correctional directives/conditions?
 - a. Are they more or less compliant than younger residents?
 - b. Can you describe any difficulties older adults have had meeting these demands?
6. What services and/or programs, health-related or otherwise, are offered *at* the halfway house (e.g. substance abuse programs, life skills development, employment assistance, recreational activities)?
 - a. Do older adults often make use of these services/participate in these programs?
 - b. What kind of feedback have you received from older adults about these services and/or programs?
 - c. Are there any services and/or programs specifically for older former prisoners?
7. Can you identify healthcare services available to older adults outside of the halfway house? This includes diagnostic testing, medications, and other treatments.
 - a. How accessible are these services for older, formerly incarcerated individuals?
 - i. Where do residents go to access these services?
 - ii. Can you recall any particular instances where an older resident had difficulty obtaining medication, treatment, and/or other health services?

- b. What kind of feedback have you received from older adults about these services and/or programs?
8. What do you think could be done, if anything, to better serve the health needs of older adults following their release from prison?

SECTION C: Other Relevant and Administrative Questions

1. Would you like to share any other relevant experiences that have not yet been addressed, or that you may feel were inadequately addressed?
2. Would you like to receive a copy of your interview transcript?

APPENDIX D2: INTERVIEW GUIDE

Note: I began each interview by reading the statement below. This was followed by questions posed in Sections A, B, and C of this guide. Additional questions that emerged from the dialogue were asked to elicit further information from participants.

I am interested in discussing your health experiences in the correctional system. In particular, I would like to learn about any health-related challenges you have faced while incarcerated and that you now experience residing in the halfway house, and how the space in which you live has affected your health.

During this interview, I will ask you a series of questions to learn about your experiences. In the beginning, I will ask you a few brief questions that pertain to your involvement in the correctional system in order to gain a sense of the experiences you will be drawing on to answer the central subset of questions. This second series of questions will require more detailed responses and will focus specifically on your health-related experiences while incarcerated and at the halfway house. At the end of the interview, you will have the opportunity to discuss any experiences and ideas that have not been addressed.

SECTION A: Sample Characteristics

1. What is your age?
2. When were you incarcerated?
 - a. How long were you incarcerated for?
3. Were you sentenced to a provincial and/or federal correctional institution?
4. What institution(s) did you serve your sentence(s) at?
5. How long have you been living at this facility (halfway house)?
 - a. Have you been a resident of any other facility prior to this?
 - i. If yes, for how long were you a resident?
 - ii. If yes, could you share your reason for leaving?

SECTION B: Participants' Health-Related Experiences

Part I – Health-related experiences while incarcerated.

1. How would you describe your physical and mental health:
 - a. Prior to your incarceration?
 - b. During your incarceration?
2. What impact did being in prison have on your physical and mental health?
 - a. Can you explain what about the physical environment affected your health?

- i. How accessible was the living space for you? (e.g. stairs, lifts, elevators)
 - ii. Can you recall whether there was mobility and/or safety equipment in the institution? (e.g. shower mats, grab bars, door levers instead of knobs)
 - iii. What sorts of things did staff or other prisoners do to make these spaces accessible?
 - iv. What sorts of things did you do to overcome barriers to accessibility?
 - v. Did you find the space to be adequately warm in winter and cool in summer?
3. Can you describe your daily routine while in prison (i.e. a typical day)?
 - a. What tasks were you required to complete on a daily basis?
 - b. Were you able to complete these tasks independently?
4. Can you describe whether your health affected your ability to follow institutional rules? (e.g. not being able to hear instructions, not being able to complete tasks in allotted times)
5. What health-related services were offered at the institution? (e.g. medical clinics, prescription distribution, substance abuse programs)
 - a. Did you make use of these services/participate in these programs?
 - b. What kind of feedback would you give about these services and/or programs?
 - c. Were there any services and/or programs specifically for older prisoners?
6. What kinds of healthcare services did you have access to outside the prison? (e.g. specialist care, emergency medical services)
 - a. How accessible were these services for you?
 - b. Can you recall any particular instances where you had difficulty obtaining health services outside the institution?
7. What do you think could be done, if anything, to better serve your health needs?

Part II – Health-related experiences while living at the halfway house.

1. How would you describe your physical and mental health since you have been at the halfway house?
2. What impact do you think living at the halfway house has on your physical and mental health?
 - a. Can you explain what about the physical environment affects your health?
 - b. How accessible is the living space for you? (e.g. stairs, lifts, elevators)
 - c. Is there mobility and/or safety equipment in the House? (e.g. shower mats, grab bars, door levers instead of knobs)
 - d. What sorts of things have staff or residents done to make these spaces accessible?
 - e. What sorts of things have you done to overcome any barriers to accessibility?
 - f. Do you find the space to be adequately warm in winter and cool in summer?

3. What daily tasks are all residents expected to perform? (e.g. chores, tasks related to personal hygiene)
 - a. Are you able to complete these tasks independently?
4. Can you describe whether your health has affected your ability to follow house rules and/or conditions of your release?
5. What services and/or programs, health-related or otherwise, are offered *at* the halfway house? (e.g. substance abuse programs, life skills development, employment assistance)
 - a. Do you often make use of these services/participate in these programs?
 - b. What kind of feedback would you give about these services and/or programs?
 - c. Are there any services and/or programs specifically for older residents?
6. What kinds of healthcare services do you access outside of the halfway house? (e.g. diagnostic testing, over-the-counter and prescription medications, treatments)
 - a. Where do you go to access these services?
 - i. How accessible are these services for you?
 - ii. Can you recall any particular instances where you have had difficulty obtaining medication, treatment, and/or other health services?
 - b. What kind of feedback would you give about these services and/or programs?
7. What do you think could be done, if anything, to better serve your health needs?

SECTION C: Other Relevant and Administrative Questions

1. Would you like to share any other relevant experiences that have not yet been addressed, or that you may feel were inadequately addressed?
2. Would you like to receive a copy of your interview transcript?

APPENDIX E: LIST OF RESOURCES

Should you experience any anxiety or emotional upset at any point during the research, the organizations listed below can assist you.

For immediate support, please contact:

Distress Centre Ottawa and Region

Distress Line: 613-238-3311

Available by phone 24 hours a day, 7 days a week (in English only)

Mental Health Crisis Line

Crisis Line: 613-722-6914 or 1-866-996-0991

Available by phone 24 hours a day, 7 days a week (in both English and French)

For longer-term support, please contact:

Centretown Community Health Centre

420 Cooper Street
Ottawa, ON
K2P 2N6

Phone: 613-233-4443

Website: www.centretownchc.org

Hours: Mon - Fri: 8:30 a.m. to 4:45 p.m.

Sandy Hill Community Health Centre

221 Nelson Street
Ottawa, ON
K1N 1C7

Phone: 613-789-1500

Website: www.sandyhillchc.on.ca

Hours: Mon - Thurs: 8:30a.m. to 4:30p.m.
Fri: 8:30a.m. to 4:00p.m.

Somerset West Community Health Centre

55 Eccles Street
Ottawa, ON
K1R 6S3

Phone: 613-238-8210

Website: www.swchc.on.ca

Hours: Mon - Wed: 9:00a.m. to 5:00p.m.
Thurs: 1:00p.m. to 8:00p.m.
Fri: 9:00a.m. to 4:30p.m.

Vanier Community Service Centre

290 Dupuis Street
Vanier, ON
K1L 1A2

Phone: 613-744-2892

Website: www.cscvanier.com

Hours: Mon - Tues, Thurs - Fri: 8:30a.m. to 4:30 p.m.
Wed: 8:30a.m. to 8:00p.m.
Sat: 10:00 a.m. to noon

APPENDIX F: ETHICS APPROVAL CERTIFICATE

File Number: 06-15-21

Date (mm/dd/yyyy): 07/09/2015



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Social Sciences and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Jennifer M.	Kilty	Social Sciences / Criminology	Supervisor
Meagan	Strasser	Social Sciences / Criminology	Student Researcher

File Number: 06-15-21

Type of Project: Master's Thesis

Title: Health, Illness and Aging in Carceral Spaces

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
07/09/2015	07/08/2016	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:

N/A

File Number: 06-15-21

Date (mm/dd/yyyy): 07/09/2015



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

