‘Nobody Wants to Die in Prison’: Limited Access to Healthcare and Obstacles to Early Release for Federally Incarcerated Persons in Canada

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Prisons were never intended to be nursing homes, hospices, or long-term care facilities. Yet increasingly in Canada, they are being required to fulfill those functions.

Correctional Investigator of Canada and Canadian Human Rights Commission (2019)

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List of Abbreviations

ADL…….. Activity of Daily Living
ALS…….. Amyotrophic lateral sclerosis
CanLII…… Canadian Legal Information Institute
CIC……..…….. Correctional Investigator of Canada
CHRC…….. Canadian Human Rights Commission
CSC……..……...…….. Correctional Service of Canada
DO……...……Dangerous Offender
IP……. Incarcerated Person
IPCSO……..……..…..Incarcerated Person Convicted of Sexual Offences
MAiD……...……. Medical Assistance in Dying
PBC……..……..Parole Board of Canada
SIU……..……...…… Structured Intervention Unit
UCCO…….…… Union of Canadian Correctional Officers
VRAG……..…….. Violence Risk Appraisal Guide
VRS……..…….. Violence Risk Scale
VRS-SO…….……Violence Risk Scale-Sexual Offence

Abstract

The Canadian federal prison population is aging, with facilities operated by the Correctional Service of Canada struggling to adequately meet the healthcare needs of these incarcerated persons. The Correctional Investigator of Canada and the Canadian Human Rights Commission recommended that expanded access to early forms of release, including compassionate release, for aging incarcerated persons would address many of these deficiencies. This study recruited 13 current and former Correctional Service of Canada staff members across four professions (nurses, psychologists, physicians and correctional officers) for qualitative interviews to discuss access to healthcare and obstacles to compassionate and other forms of early release for aging incarcerated persons. Additional focus was placed on access and obstacles for aging incarcerated persons convicted of sexual offences, a large and growing proportion of the aging federal prison population in Canada. A poststructuralist theoretical framework guided the research question, methodology and analysis. A thematic analysis methodology permitted interrogation of the power relations of the correctional system and the production of incarcerated person subjectivities. Results indicated that the healthcare needs of aging incarcerated persons often go unmet, and that reliance of regional hospitals and psychiatric facilities is required to address these needs. Access to early release is complicated, lengthy, and often not approved. Power relations and subjectivities figured prominently in the prioritization of risk management above all other measures in the consideration of early release. As a result, many aging incarcerated persons die in prison. Improved access to healthcare and expediting and expanding access to early release offer opportunities to better meet the healthcare needs of aging incarcerated persons, and permit death with dignity outside of correctional institutions.

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I am indebted to several individuals in the completion of this dissertation and research project. First and foremost, I am endlessly grateful to the participants in this study, and those who facilitated recruitment. Correctional settings are notoriously difficult to study, and the participants in this project graciously stepped outside an opaque culture to explore their experiences, despite potential personal risk. Such acts take courage, and I hope that the results of this work will affect the change so many of them wished to see.

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I would like to dedicate this project to the staff working within CSC facilities working hard to make a difference in the lives of their patients, and to those who may never experience a taste of life outside of prison walls ever again.

Chapter 1: Research Problem

Of growing concern in Canada is the increasing number of older incarcerated persons (IPs) in federal correctional institutions. In Canada, any convicted individual sentenced to two years or longer is placed in a federal institution under the authority of Correctional Service of Canada (CSC). According to the Correctional Investigator Canada and the Canadian Human Rights Commission [CIC & CHRC] (2019) and Public Safety Canada (2023), over 25% of federally incarcerated persons are over the age of 50, and this segment of the incarcerated population has increased by 50% over the past decade. Although there is no universal definition of what constitutes 'old', many consider age 50 and older to fit this definition (CIC & CHRC, 2019; Stevens et al., 2017; Turner et al., 2018). Though the age of 50 is not considered 'old' amongst the general population, incarcerated persons are found to experience 'accelerated aging', in which exposure to various stressors, including while incarcerated, results in IPs to present as 7 to 15 years older physiologically than their chronological age (Burles et al., 2016; Maschi et al., 2012; Williams et al., 2012). In Canada, it has been argued that, for Indigenous IPs, the age of 45 constitutes 'old', given racial disparities in health related to colonialism (Stoliker et al., 2022). The average age of death in federal custody is 60 years of age (CIC & CHRC, 2019). Those over the age of 50 are more likely to be serving longer or indeterminant sentences, including life sentences (CIC & CHRC, 2019). Incarcerated persons convicted of sexual offences (IPCSOs) make up a growing proportion of this aging prison population. An increase in historical convictions, attributed to improved investigatory technologies, has increased the age of admission of this particular group of IPs. Furthermore, IPCSOs are more likely to be serving lengthy or indeterminant sentences. As of 2019, nearly 25% of federal IPs aged 50 to 64, and nearly 38% of those aged 65 and older had convictions of sexual offenses.

This aging federal prison population places considerable strain on the resources and clinical staff within correctional institutions. “Prisons were never intended to be nursing homes, hospices, or long-term care facilities. Yet increasingly in Canada, they are being required to fulfill those functions” (CIC & CHRC, 2019, p. 3). Inadequate infrastructure, such as stairs and steep ramps, doors not wide enough for wheelchairs, inaccessible showers, uneven floor surfaces, and a lack of call bells in IP rooms highlight the many deficiencies of an aging prison infrastructure that was never intended for an aging population (CIC & CHRC, 2019). Staffing is also an issue, where some institutions lack 24-hour nursing care, and security and healthcare staff are not adequately trained to meet the needs of aging IPs. When adequate care cannot be provided within a CSC facility, IPs are typically escorted to civic hospital or other healthcare settings, requiring the supervision of correctional officers at all times, which proves costly. The average cost of maintaining an IP in a federal institution in 2020/2021 was $126,253 per year (Public Safety Canada, 2023), and this cost is significantly higher for aging IPs with complex medical needs (CIC & CHRC, 2019). The increasingly complex medical needs of aging IP cannot adequately be met, yet compassionate and other forms of release – the transfer of an IP to a long-term or palliative care facility where their healthcare needs are better met –is rarely utilized (Officer of the Correctional Investigator [OCI], 2020). The OCI (2020) has called for increased access to, and utilization of compassionate release for aging IPs to community-based care facilities, where the dignity and complex medical needs of aging IPs can be better met, at significantly lower cost.

Access to compassionate release, however, has been described as a slow and complex process (Burles & Peternelj-Taylor, 2019), requiring input from multiple professions and jurisdictions. Ultimate approval of compassionate release for the purpose of seeking palliative or

end-of-life healthcare services is provided by the Parole Board of Canada (PBC), though according to the OCI (2020), few applications for compassionate release are pursued by CSC, and even fewer are granted. When early release, either through compassionate release or other means cannot be secured for aging – and often dying – incarcerated persons, these individuals are left to die in prison. As Shaw and Driftmier (2021) indicated, few aging IPs in CSC facilities want this to be the case. Most would prefer to die outside of prison walls, what is considered a more meaningful and dignified death (Burles et al., 2016).

A primary consideration in the granting of parole, compassionate release or other forms of release by the PBC is the question of risk: does this individual present a risk to reoffend if released into the community (CSC, 2019a). Depending on the nature of an IPs conviction, access to early release may be limited. Those serving life sentences, serving mandatory minimum sentences, or those serving indeterminate sentences (including those deemed dangerous offenders) have limited or no access to parole or other forms of early release (CSC, 2019a). In these cases, compassionate release at end-of-life may present the only option for release into the community to receive healthcare services, including palliative and end-of-life care. Yet even in these cases, the PBC considers the level of risk the individual presents to reoffend. Empirically, an inverse relationship exists between the age of an IP and their risk to reoffend (Cornelius et al., 2017; Ray & Jones, 2023). What has been described as ‘aging out’ (Auerhan, 2013), this concept indicates that as IPs age, their level of risk to recidivate declines, with IPs over the age of 50 representing the lowest risk to reoffend. This trend also applies to aging IPCSOs, who are among the least likely IPs to reoffend as they age (Ambroziak et al., 2021; Crookes et al., 2022). Despite this empirical evidence, aging IPs continue to face obstacles in securing release to access healthcare services (CIC & CHRC, 2019; OCI, 2020).

Aging IPs who do receive early release continue to face obstacles in accessing healthcare services. Poulin et al. (2023) examined a Canadian halfway house setting for aging IPs and those with more considerable healthcare needs and indicated that accessing placements in non-correctional long-term care facilities presented significant challenges. As the authors indicated, these facilities were hesitant to accept IPs, even if they had been granted release. Issues of stigma and fear dominated the concerns expressed by these facilities. Despite the empirical evidence of 'aging out' for aging IPs, considerable stigma remains, particularly for those convicted of sexual offences (Harris & Socia, 2016).

Nurses provide healthcare for IPs within CSC facilities, both primary and mental health services. They are highly familiar with the needs of their patients, and adept at providing care typical of this population (Burles & Peternelj-Taylor, 2019). However, much of the focus of typical nursing care within correctional facilities is on the needs of a younger patient population (Burles et al., 2016; Burles & Peternelj-Taylor, 2019; CIC & CHRC, 2019). Knowledge and skillsets related to the needs of aging and geriatric patients is lacking in most CSC facilities, particularly for those individuals requiring palliative or end-of-life care. Much like the physical design of prisons is focused on a younger population, so is the provision of healthcare services. Yet nurses are in a unique position to advocate for the needs of their patients, both within CSC facilities and in accessing appropriate community-based services.

This issue of an aging prison population is not unique to the Canadian context. Increasing proportions of aging IPs are found in jurisdictions across the Western nations, including the United States, the United Kingdom, and Australia (Baidawi et al., 2011; Hayes, 2017; Psick et al., 2017; Stevens et al., 2017; Turner et al., 2018). In all these jurisdictions, challenges are documented in adequately meeting the healthcare needs of an aging prison population, based on

similar concerns as in Canada: prisons built for younger populations, lack of healthcare services and lack of healthcare knowledge in the provision of care to aging IPs. Furthermore, other jurisdictions such as Spain, France, Germany and Switzerland (Handtke et al., 2017) provide forms of release similar to compassionate release in Canada, yet such release is also rare in these nations. The simple question of how to meet healthcare needs of an aging prison population exist across the globe and are not unique to Canada.

Within prison settings, the operation of various forms of power shape both the practices of institutional staff and the production of IP subjectivities (Holmes, 2002, 2005; Perron & Holmes, 2011). Explored most extensively by French philosopher Michel Foucault (1997, 2006), multiple forms (or operations) of power exist within the prison environment, and their operation affects how the identities – or, more specifically, the subjectivities – of IPs are produced. Simultaneously, the production of these subjectivities affect the practices of prison staff and may affect the types of care provided (Perron & Holmes, 2011). Within this research project, it is necessary to consider how the operations of power and the production of IP subjectivities affect access to healthcare services and early release for aging IPs in Canadian federal institutions.

Beyond a recognition that this aging prison population poses significant concerns for nurses in Canada (and beyond), and a similar recognition that this issue has received minimal attention in the nursing literature, the motivation for conducting this research is also based on personal experience. Having worked clinically for several years in forensic mental health settings, specifically a forensic hospital environment, I worked closely with a number of aging patients. Many of these individuals had a designation of Not Criminally Responsible on Account of Mental Disorder for crimes committed and were being held indeterminately within the hospital environment due to concerns of risk. Even in this hospital environment, appropriate care

for aging patients proved difficult, but options for community-based care were challenging to access. The question of what could be done for this population remained unanswered. Furthermore, in the fall of 2019 I attended the Custody and Caring: International Conference on the Nurse's Role in the Criminal Justice System conference in Saskatoon, Saskatchewan. A keynote address at this conference was by Dr. Ivan Zinger, the Correctional Investigator of Canada, who was presenting on his recently released report with the Canadian Human Rights Commission (CIC & CHRC, 2019) on this topic of aging IPs in CSC facilities. Much of Dr. Zinger's presentation resonated with my own experiences in the forensic hospital setting, and this topic of aging IPs in federal facilities became of considerable interest. Of note in his presentation was the considerable challenges faced in studying this population, as well as the resistance he faced during questions from some of the conference attendees. These experiences motivated me to pursue this research.

Research Aim

The aim of this research is to better understand the healthcare needs of aging IPs, including aging IPCSOs, and the obstacles they face in accessing compassionate or other forms of early release. Despite the recognition that aging IPs face significant obstacles in obtaining appropriate healthcare services within CSC facilities, few studies have examined this issue, particularly the Canadian context. Conducting research within correctional facilities and about IPs proves challenging, and limited research on this topic in Canada has been pursued. As Waldram (2009) described, correctional facilities are particularly opaque settings; those working within them are resistant to participating in research and allowing the day-to-day realities of the setting to be exposed. Furthermore, CSC itself may present obstacles in conducting and disseminating research. As Waldram (2009) further described the Canadian context, even if

access to research within institutions is permitted, that permission may be revoked at any time, without reason provided. Prison staff are reluctant to participate in observations or interviews, concerned of the sanctions they may receive – official or unofficial – for participating in research. Recently, few studies (Iftene, 2017b; Shaw & Driftmier (2021) have examined this issue of the healthcare needs of aging IPs within CSC facilities. The aforementioned obstacles presenting difficulties in the successful study of this topic. Nonetheless, those CSC staff who work with aging IPs and who are involved in the application for early release best understand these issues. Through interviews with these individuals, an exposition of the obstacles to accessing appropriate health services and early release of aging IPs is presented, with subsequent recommendations for future improvements to better meet the healthcare needs and dignity of this growing prison population.

Research Questions

The following questions are addressed in this study:

1. According to CSC staff, what are the healthcare needs of aging IPs? Do these needs differ for IPCSOs?
2. Do aging IPs and aging IPCSOs have appropriate access to healthcare services in CSC facilities? If not, how are these services provided? How do power relations and the production of subjectivities affect access to services?
3. What obstacles do aging IPs face in application for and granting of compassionate and other forms of early release? Do these obstacles differ for aging IPCSOs? How might power relations and the production of subjectivities affect access to early release?

Chapter 2: Literature Review

In 2019 the Correctional Investigator of Canada and the Canadian Human Rights Commission released the report *Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody*, a scathing indictment of the treatment of aging IPs within Canadian federal prison institutions operated by CSC. This expansive document outlined the poor health status of aging IPs, lack of infrastructure suitable to meet the needs of this population, challenges faced in providing end-of-life care, and lack of release options for these aging individuals. In particular, aging incarcerated persons convicted of sexual offences were highlighted as a large – and growing – proportion of this prison population. To better meet the complex medical and mental health needs of these aging individuals, the CIC and CHRC (2019) issued a call for expanded access to compassionate release, a form of early release or parole typically only accessed for aging IPs who are nearing end-of-life. These early forms of release, often granted outside the allowed parameters of an individual IP's sentence, see IPs transition to community-based care outside the authority or jurisdiction of CSC, such as long-term or palliative care facilities, hospitals, or with family members, and is granted by the Parole Board of Canada [PBC] (Iftene, 2017a). However, early forms of release are rarely granted by the PBC, with compassionate release the most rarely granted. In 2019, for instance, according to the OCI (2020), only seven requests for compassionate release were reviewed by PBC, with only four releases granted.

This phenomenon of aging prison populations, comprised of growing proportions of aging IPCSOs, is not unique to Canada. Multiple factors, driven by an overall aging of the general population, have contributed to similar situations across western nations, including Australia, New Zealand, the United States and United Kingdom (Maschi et al., 2012; Stevens et

al., 2017; Turner et al., 2018). This chapter will review the current data and literature on this aging prison population in Canada, with consideration of literature from other western jurisdictions. Literature collected and considered in this review was gathered from several sources and databases, including CINAHL Plus, JSTOR, and APA Psycharticles, as well as Google Scholar. Keywords such as 'aging prison population,' 'compassionate release,' 'aging sex offenders,' and 'prison research' served as initial starting points in the literature search. Articles were reviewed primarily for relevance to the Canadian context, whereas additional articles were considered for jurisdictions outside of Canada. The reference lists of relevant articles were reviewed for additional sources not captured in the initial searches, and articles which subsequently cited these sources – as indicated in Google Scholar – were also considered. For additional Canadian context, figures and statistics, reports prepared by the Office of the Correctional Investigator were reviewed, as were several Government of Canada websites, including CSC, Statistics Canada, and Public Safety Canada. The healthcare needs of aging IPs, including those convicted of sexual offences, is examined, including access – or lack thereof – to appropriate care. Forms of early release, including compassionate release are explored. Concerns of risk and recidivism within these aging IP populations are reviewed, with their effect on access to community-based resources. And finally, the unique challenges of conducting research within prison environments are considered.

Aging in Federal Institutions: The Canadian Context

In Canada, any individual convicted of a crime and sentenced to two years or longer in prison is relegated to a federal penitentiary operated by the Correctional Service of Canada (CSC). Individuals sentenced to less than two years are relegated to correctional facilities under the jurisdiction of Canadian provinces or territories and are not considered in this research. The

CSC operates 43 institutions classified as maximum, medium, and/or minimum security across Canada, 14 community correctional centers, and 5 regional psychiatric facilities. The CSC also partners with other agencies that operate community residential facilities across the country (CSC, 2021a). All newly convicted individuals are assessed and classified, based on determined security level, and placed within an institution of corresponding security (CSC, 2018a). Individuals may be transferred "to an environment consistent with their security requirements" (CSC, 2018b, para 1), either within multi security level institutions or to separate institutions, when deemed appropriate. The vast majority of federal IPs in Canada are men. According to Public Safety Canada (2023), in 2020-2021, 4,795 males were admitted into CSC facilities, versus 410 females admitted. While the health concerns of female IPs are not to be ignored and deserve further investigation, the focus of this research is on male IPs in CSC facilities.

Basic statistics and demographic information related to IPs in CSC facilities is disseminated by Statistics Canada. According to Statistics Canada (2023a), in 2021/2022, there were 6,886 total custodial admissions – those individuals incarcerated in CSC facilities. In addition, there were 6,277 community admissions, comprising individuals released on day parole, full parole, or statutory release, but still bearing conditions of release under the authority of CSC and the PBC. Statistics Canada (2023b) identifies numbers of incarcerated persons by age group but does not distinguish between those in federal custody and those in provincial custody. However, according to Public Safety Canada (2023), in 2020-2021, 25.6% of IPs in custody in CSC facilities were 50 years of age and older. This agency also reports on the profiles of federally incarcerated persons in Canada. In 2020-2021, 26.8% of all federally incarcerated IPs were serving life and/or indeterminate sentences. Most federally incarcerated persons were convicted of offences causing death (49.8%), followed by convictions of sexual offences

(20.8%). In the same year, 14.9% of new admissions to federal institutions were individuals 50 years of age and older. The majority of the CSC population self-identified as white (52.4%), followed by Indigenous (27.0%). Many were incarcerated in medium-security facilities (67.5%), followed by minimum-security (17.9%), then maximum-security (14.6%). In addition, IP deaths do occur in CSC facilities, and the majority (89.9%) of IP deaths within federal custody in 2020-2021 were attributed to 'other causes,' described as natural causes, accidental deaths, medical assistance in dying (MAiD), or unknown causes. The remainder of deaths were attributed to suicide (8.7%) and homicide (1.4%).

The monetary costs of incarceration are also tracked by both Statistics Canada and Public Safety Canada. In 2019-2020, the annual cost of keeping an individual incarcerated was $126,253; the cost of maintaining an individual in the community was $34,214, or 72.9% less than incarceration. Statistics Canada (2023c) reports on the average daily cost of incarceration but does not differentiate between federal and provincial facilities in this data. A significant increase in cost was reported between 2019/2020 and 2020/2021, from $264/day to $349/day, which would suggest that the cost of federal incarceration significantly increased from 2019-2020, as reported by Public Safety Canada (2023).

Aging Incarcerated Persons

Of particular concern for this study is this proportion of IPs 50 years of age and older. According to the CIC and CHRC (2019), this portion of the federal prison population had increased by 50% over the previous decade. While the age of 50 is not considered 'old' amongst the general Canadian population, multiple authors have indicated that the age of 50 constitutes what is 'old' amongst IPs (CIC & CHRC, 2019; Stevens et al., 2017; Turner et al., 2018). Associated with this definition of 'old' amongst IPs is the concept of 'accelerated aging,' which

proposes that IPs aged 50 and older present as 7 to 15 years older physiologically than their chronological age suggests (Burles et al., 2016; Loeb et al., 2008; Maschi et al., 2012). A combination of stressors experienced while incarcerated, as well as those experienced prior to incarceration – difficult lives involving struggles such as homelessness, mental health challenges, poverty and/or substance use – contribute to this acceleration in physiological aging (Skarupski et al., 2018; Thomas, 2012). Iftene and Downie (2020) placed the life expectancy of Canadian federally IPs at 62 years of age.

Associated with this 'old' federal prison population and the concept of accelerated aging is a higher incidence of chronic illness and infectious diseases as compared to the general population (CIC & CHRC, 2019). The CIC and CHRC (2019) identified chronic illnesses such as obesity, hypertension, high cholesterol, diabetes, and chronic pain, as well as mental health concerns such as depression and anxiety as more prevalent amongst federal IPs compared to the general population. Iftene (2017b), conducted an extensive study of aging (50+) federally incarcerated persons in Canada and similarly noted significant health concerns. They reported that 63% of IPs interviewed "believed their health had deteriorated since they entered prison on their current incarceration" (p. 67). This author added that arthritis, digestion concerns, psoriasis, cardiac issues, and hearing and vision problems were commonly reported amongst this population. Furthermore, mirroring the findings of the CSC & CHRC (2019), this author noted chronic pain to be the most debilitating condition reported amongst aging IPs. Associated with this chronic pain was a reported increase in risk of falls. Henning (2021) reported higher rates of communicable diseases, including Hepatitis C, HIV/AIDS, Tuberculosis, and sexually transmitted infections such as gonorrhoea and syphilis. Furthermore, dementia has also been identified as a concern amongst aging IPs within CSC facilities (Peacock et al., 2018).

In addition to these myriad physical and mental health concerns of aging IPs within CSC facilities, research suggests that these individuals are at high risk of victimization within the prison environment. The CIC and CHRC (2019) reported that these aging IPs are regularly the victims of bullying, intimidation, and assaults. Iftene (2017b) noted that these acts are perpetrated by both peers and prison staff. They included acts of intimidation, violence, and sexual assaults among the phenomena this population endured. Older IPs, according to the CIC & CHRC (2019) are more likely to "voluntarily request to be placed in segregation… most commonly out of fear for their personal safety." (p.?)

Provision of Healthcare Services Within CSC Facilities

Provision of healthcare services to federal IPs is the responsibility of CSC. The Corrections and Conditional Release Act (Government of Canada, 1992) mandates that CSC "is responsible for providing every inmate [sic] with essential health care and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration in the community" (CSC, 2020, para 1). This requires that CSC facilities provide healthcare services equivalent to those available to non-incarcerated persons in the community. IPs require access to healthcare professionals, including nurses, physicians, and psychiatrists, in spaces that permit appropriate confidentiality (CSC, 2015a). They are entitled to make healthcare related requests and have access to medications. If appropriate healthcare services are not available within CSC facilities, including in emergency situations, IPs can access external community healthcare services, such as a community hospital or emergency department.

Despite this mandate, the limited research on aging in federal institutions has indicated that the healthcare needs of this population are not always being met. According to Burles and Peternelj-Taylor (2019), "older incarcerated persons are especially at risk of having unmet health

needs due to educational, resource, and infrastructure limitations" (p. 238). Iftene (2017b) outlined several deficits in the delivery of care to aging IPs. They noted a general lack of experience amongst CSC staff in delivering care appropriate to an aging – or geriatric – population. This included a lack of 24-hour nursing staff at a number of CSC facilities. Associated with this staffing limitation is challenges in appropriate medication administration outside of staffed nursing hours. Pain management, particularly chronic pain management, was identified as a widespread deficit; limited options for pain medications, linked to concerns about diversion of narcotics to non-intended recipients, resulted in the under-treatment of IP pain. Iftene (2020) described one individual with stage four cancer who was left for a week in their room without any pain medication provided. The CIC and CHRC (2019) confirmed these observations in their report. Access to pain medication was again highlighted as a significant deficit amongst aging IPs. They did note that CSC had established two healthcare units, one in the Pacific region and one in the Prairie region, designed to better meet the needs of aging IPs. Martin (2021) described these units in greater detail. The psych-geriatric unit, located in Abbotsford, British Columbia offers 64 beds for aging male IPs, including peer support for ADLs. The assisted living unit in Bowden, Alberta offers 14 beds for aging IPs with a focus on those living with mobility issues. While these limited spaces do exist, Martin (2021) identified a lack of evaluation of service efficacy. Likewise, the CIC and CHRC (2019) identified deficits in these units, including a lack of 24-hour nursing care and a lack of specialized training for staff.

If the necessary care for an aging IP – or an IP of any age – cannot be provided within CSC facilities, these individuals require security-escorted transport to community-based facilities, such as hospitals. If such care is scheduled or non-urgent, IPs are typically taken to their appointments via CSC transport vehicles. The CIC and CHRC (2019) indicated, however,

that many of these vehicles are not appropriate for the transport of aging individuals, particularly those with mobility issues, such as the need for a wheelchair. This is further complicated by the fact that IPs being transported in such a manner are hand cuffed and shackled at the ankles. Falls and other injuries were reported as resulting from these transports. If IP transport is required on an emergency basis, or outside the hours when facility healthcare staff are available, transport to hospital in an ambulance is required (CIC & CHRC, 2019; Iftene, 2017b). This may require non-healthcare staff, such as correctional officers to provide first aid or other treatment until the ambulance arrives. As Iftene (2017) noted, many CSC facilities are in remote locations, where ambulance transports can be lengthy.

The limitations of healthcare provisions within CSC are most significant to those at end-of-life and require palliative care. Both the CIC and CHRC (2019) and Iftene (2017b) identified several deficits in service provision for those at end-of-life. As previously noted, a lack of 24-hour nursing in many facilities results in gaps in professional care. The limited access to pain medications earlier described has a profound effect on the management of pain for individuals at end-of-life. As Iftene (2017b) observed, there are no palliative care services within correctional settings – only regional hospitals may be capable of providing this service. They stated that "dying prisoners are housed in the same facilities as everyone else and thus subjected to the same security rules and medical regulations" (p. 73). Furthermore, these individuals are not entitled to special permissions regarding family visitations and are required to travel to the same visitation spaces used by all other IPs, regardless of their physical ability to do so. Burles & Peternelj-Taylor (2019) described the importance of (re)connection with family members as a component of meaningful end-of-life care within prisons. If appropriate, when holistic care cannot be provided within CSC facilities, the recommendation of the CIC and CHRC (2019) is to arrange

for release of these individuals to community-based facilities (or family members) who can provide the necessary care. According to Iftene (2020), the CSC "has an obligation to seek alternatives to incarceration when someone becomes irreversibly sick. Nonetheless, an increasing number of people are dying in prisons of expected deaths" (p. 759). And, put simply, most IPs do not want to die in prison (Sanders & Stensland, 2018). This matter of transfer of care outside the prison and the obstacles faced in doing so is central to this project.

Practices of Correctional Services Healthcare Professionals

Healthcare services in CSC facilities are primarily provided by nurses. The presence of nurses varies across facilities; most lack 24-hour nursing care, except for regional hospital and psychiatric facilities (CIC & CHRC, 2019). The duties of nurses in CSC facilities range from medication administration, assessment and treatment of chronic conditions and minor ailments, response to incidents and injuries, and treatment of drug overdoses (Iftene, 2017b). Acute injuries or significant medical concerns typically exceed the capacities and infrastructure of CSC healthcare facilities and require escort of IPs to outside facilities (CIC & CHRC, 2019). As Burles and Peternelj-Taylor (2019) described, in most correctional settings nurses offer primary care; specialist care, such as palliative treatments are not prioritized. Subsequently, the primary focus of nursing skill sets and education are in these treatments of primary care concerns. Both education and knowledge of the specific needs of aging IPs, such as the treatment of advanced chronic illnesses, dementia and provision of end-of-life care are lacking (Burles & Peternelj-Taylor, 2019). The prioritization of security also affects the work of nurses, where access to IPs with health concerns may not be immediate and is often mediated through correctional officers. As noted by Kucirka and Ramirez (2019), movement of nurses within correctional facilities is often restricted due to security measures, limiting access to patients, which the authors concluded

particularly affected the ability to offer mental health services. When healthcare concerns arise during times where nurses are not present, response and treatment is relegated to correctional officers and, if necessary, emergency services (CIC & CHRC, 2019).

Prison Infrastructure

Most CSC facilities in Canada are several decades old, if not older – Stony Mountain Institution, located in Manitoba, was opened in 1877 (CSC, 2022) – and were constructed at a time when prisons were occupied by a younger population. Traditionally, the needs of aging IPs were not considered in the design of prisons (Becket et al., 2003). The effects of these designs on the day-to-day lives of aging IPs are profound. The physical environment of a prison significantly affects the activities of daily living (ADLs) of aging IPs, particularly those with mobility issues. The basic layout of the prison environment presents multiple barriers and obstacles to these individuals. The CIC and CHRC (2019), in their extensive survey of CSC facilities, outlined a number of these barriers. They identified a lack of wheelchair accessible cells, noting that only 2.5% of cells across CSC facilities met this criterion, as one of many design deficits. They included inaccessible shower facilities, uneven walkways, steep inclines, and stairs for entry into buildings, a lack of call-bells within most cells, and inaccessible family visitation areas.

The realities of winter in Canada further complicate matters. Many CSC facilities consist of multiple buildings or houses, requiring movement outside to access services such as health services, medications, cafeterias, or canteens. Those aging IPs living with chronic pain and/or significant mobility issues are still required to move between buildings to access basic services, such as administration of pain medications. Iftene (2017b) noted that the healthcare units in many facilities a very small, requiring IPs to wait in line outside – even in winter – for up to an

hour to receive their medications. Furthermore, aides for daily living, such as walkers and canes, may not be permitted within all CSC facilities, out of concern over their use as weapons. This can lead to an increased risk of falls for aging IPs, and increased difficulty in accessing basic services. Requests for other necessary supplies, such as appropriate mattresses or orthopedic shoes, according to Iftene (2017b), are often denied. Within many CSC facilities exist structured intervention units (SIUs). These cells were introduced in 2019 as an alternative to solitary confinement cells, used for the management of IPs who are deemed unable to exist in the general prison population. These cells provide limited infrastructure or opportunity for engagement, and may be occupied by aging IPs (OCI, 2020). And finally, the prison environment presents significant challenges for those aging IPs living with cognitive issues, such as dementia. Peacock et al. (2018) described the prison environment as particularly confusing and challenging for this population. As the CIC and CHRC (2019) asked, "one has to question what is being accomplished in managing an individual with dementia who may no longer know or understand why they are in prison in the first place" (p. 49).

Jurisdictions Outside of Canada

These challenges posed by an aging prison population are not unique to Canada and have been identified across western nations. Hayes (2017) noted widespread increases in aging IP populations across multiple countries, including the United States, Japan, and the United Kingdom. They noted a 1300% increase in the number of IPs aged 50 and over in American prisons. Skarupski et al. (2018) identified older IPs, here defined as aged 55 and older, as the fastest growing demographic of the United States prison system. The widespread prevalence of chronic health conditions, such as hypertension, chronic pain, diabetes, and COPD amongst these populations is also well documented across jurisdictions (Hayes, 2017). Baidawi et al. (2011)

charted the increasing number of aging IPs within Australian prisons, highlighting the challenges this population present to the delivery of healthcare services. Skarupski et al. (2018) indicated challenges to activities of daily living for a high proportion of aging IPs associated with prison architecture and infrastructure not suited to the needs of this population. Psick et al. (2017) referred to this population as 'prison boomers' and linked the challenges of providing healthcare services to the overcrowding of prisons in California. Stevens et al. (2017), in an examination of the growing population of aging IPs in Australia, pointed to a lack of knowledge amongst prison staff in how to meet the needs of these older individuals. Limited access to pain medications was also identified in UK prisons by Turner et al. (2018). These demographic shifts in prison populations and subsequent challenges in the provision of healthcare extend beyond the Canadian context. A small but growing body of research is emerging in highlighting these challenges while looking for solutions in jurisdictions across the planet.

Aging Incarcerated Persons Convicted of Sexual Offences

Aging incarcerated persons convicted of sexual offences (IPCSOs) constitute a growing proportion of the prison population in Canada. The most recent data available on federal IP demographics (Public Safety Canada, 2023) does not provide age-specific data on the nature of convictions, however, according to the CIC an CHRC (2019), in 2018, 24.7% of those aged 50 to 64 and 37.9% of those 65 and older had convictions of sexual offences. Only 11.2% of federally IPs under the age of 50 have convictions of sexual offences. These offences comprise the second largest proportion of convictions leading to admission to CSC facilities, and a large number of these individuals are being admitted as older adults. Many of these convictions are attributed to historical offences, where improved investigatory techniques, such as DNA testing, have led to convictions years, if not decades after the offence had been committed (CIC & CHRC, 2019).

Furthermore, the Conservative government in Canada (2006-2015) introduced multiple pieces of legislation applying mandatory minimum sentences to a wide range of offences, including sexual offences (Allen, 2017). Such approaches to sentencing have not only led to an increased number of older individuals being sentenced and incarcerated but has extended the time in which these individuals must remain incarcerated, often into older age. Given this large – and increasing – proportion of aging IPCSO within CSC facilities, further examination of this specific population is prudent in this study.

This demographic trend of increased incarceration of aging individuals convicted of sexual offences is not unique to Canada. In the United Kingdom, the proportion of aging IPs convicted of sexual offences is higher than that of Canada; according to Turner et al. (2018), 45% of IPs aged 50 and older have convictions of sexual offences, and this rate is growing. As previously stated, aging IPs comprise a vulnerable population within the prison environment. This effect is intensified for those convicted of sexual offences. Prison hierarchies amongst IPs typically place IPCSOs at the bottom of this hierarchy. A ranking logic amongst IPs in prison settings, often based on the nature of conviction(s), with those convicted of sexual offences typically viewed as least desirable to affiliate with and most deserving of exploitation and abuse (Ricciardelli & Moir, 2013). Maguire (2021) described "the overt rejection of, and often violent policing of, perpetrators of taboo crimes" (p. 505), particularly sexual offences. These individuals are often the victims of violence and, according to van den Berg et al. (2018), less likely to receive support from prison staff. The ongoing danger posed to this population leads to increased concerns of social isolation and mental health challenges.

Release of Aging Incarcerate Persons

A wide array of sentences and options for release exist for federally incarcerated persons in Canada. The potential release of aging IPs can be complicated or inhibited by the conditions of their sentence. The Government of Canada (2021) outlined the various types of sentences for convictions and how these sentences are imposed. Upon conviction, the court imposes a sentence of a specific length, with those sentenced to two years or longer being relegated to CSC facilities. Specific offences bear mandatory minimum sentences, as outlined by the Government of Canada (2023a). Life sentences are imposed on those convicted of either first- or second-degree murder. Those convicted of first-degree murder are not eligible for parole until they have served 25 years of their sentence, whereas those convicted of second-degree murder must serve at least 10 years of their sentence before they are eligible. Indeterminate sentences, bearing no end date, are imposed on those designated as dangerous offenders.

Release from prison falls under the authority of the Parole Board of Canada (PBC), based on information and assessments provided by CSC (CSC, 2019a), via the Corrections and Conditional Release Act (Government of Canada, 1992). The forms of release granted include day parole, full parole, statutory release, and release on expiry of sentence. These forms of release, other than expiry of sentence, are classified as a form of conditional release, wherein conditions are placed on the individual IPs existence outside the correctional institution, and release may be revoked if they fail to adhere to these conditions. Day parole permits IPs to enter the community for daily activities while continuing to reside at their correctional institution. According to CSC (2019a), eligibility for day parole occurs:

> After serving the longer of two times: either 6 months before eligibility for full parole or after serving 6 months – if serving sentences of two years or more [or] 3 years before

eligibility for full parole or after serving 3 years – if serving life or indeterminate sentences (Day parole)

Full parole is a form of release that permits an IP to serve a portion of their sentence in the community. According to CSC (2019a), IPs "(except those serving life sentences for murder) may apply for full parole after serving the lesser of either: a third of their sentence, or 7 years" (Full parole). As described above, full parole eligibility is different for those convicted of either first- or second-degree murder. Statutory release is a requirement that IPs serve the final third of their sentence in the community. This form of release is available to those who either did not apply for parole or were denied full parole. A detention order may be issued by the PBC preventing statutory release of IPs "if there are reasonable grounds to believe that the inmate is likely to commit: an offence causing serious harm or death, a sexual offence involving a child, or a serious drug offence" (CSC, 2019a, Statutory release). These forms of release are considered conditional release, wherein parole officers monitor the conduct of the individual while released. The final form of release, a form of unconditional release, is that which occurs on expiry of sentence, also known as warrant expiry. This applies to individuals deemed too dangerous for statutory release and occurs at the end of their court-imposed sentence. At this point, no conditions are placed upon their release to the community as neither the CSC nor PBC have any authority over the individual.

These various forms of release available to IPs are particularly important for the potential release of aging IPs, especially those with significant health concerns that cannot be met within CSC facilities. As noted above, CSC has an obligation to pursue early release of aging IPs in these circumstances, but release must be granted by the PBC, on recommendation from CSC. If

an aging IP is eligible for one of these forms of release, transfer to the community may be granted.

Compassionate Release

Circumstances may arise wherein an aging IP with considerable healthcare needs would benefit from release to the community, but that individual is not eligible for any of the above discussed forms of release, either conditional or unconditional. For instance, an individual serving an indeterminate sentence or a life sentence who has not yet served the length of time necessary to be eligible. In these cases, CSC may apply to the PBC for compassionate release. Those IPs serving life or indeterminate sentences are not eligible for this form of release unless they are deemed terminally ill (CSC, 2018c). This form of release, also known as medical parole or parole by exception (Burles et al., 2016; Iftene, 2017b) is typically provided for medical reasons, particularly when an IP is nearing end-of-life. In such cases, the individual is released from the prison environment to a setting where their medical needs can be better met, such as a long-term or palliative care facility. Though this form of release is available, it is rarely pursued. In 2019, for instance, only seven requests for compassionate release were pursued, with only four granted by the PBC (OCI, 2020). The process of applying for compassionate release is described as "time consuming, resource intense, and requires interdisciplinary collaboration and coordination" (Burles & Peternelj-Taylor, 2019). The CIC and CHRC (2019) officially recommended expanded access to compassionate release and improved planning by CSC to coordinate early release of aging IPs.

Escorted Temporary Absences

In cases where the healthcare needs of an aging IP can no longer be met within CSC facilities, and early release, via parole or compassionate release either has not or cannot be

obtained, IPs may be escorted to community-based facilities. These are defined by CSC (2019a) as an escorted temporary absence (ETA) and require the IP to be supervised by one or more escorts, typically correctional officers. During these medical ETAs, according to the CIC and CHRC (2019), IPs may still be subjected to restraints, such as hand cuffs and ankle shackles, both during transport and while in the healthcare facility, and supervised by one or more correctional officers.

Other Jurisdictions

The challenges of providing healthcare to aging and, at times, dying IPs outside of correctional institutions is not unique to the Canadian context. Outside of Canada, agencies have developed various specialized services for aging IPs. In the United States and Germany, for example, nursing homes within prisons have been constructed, and in Australia and the United Kingdom specialized healthcare facilities within prisons have also been developed (Loeb, 2013; Stevens et al., 2017). Compassionate release provisions exist in some European nations, including Spain, France, Germany, and Switzerland. However, as Handtke et al. (2017) reported, release of seriously ill and aging IPs on compassionate grounds rarely occurs in these nations. In some jurisdictions, prison hospices have been developed (Stone et al., 2012). Such facilities are widespread in the United States, wherein other IPs are often tasked with the provision of end-of-life care. Specialized units or facilities dedicated to the provision of long-term and/or palliative care operated by CSC have been officially recommended by the CIC and CHRC (2019) to better meet the needs of the aging prison population. However, such pursuits would require considerable investment and time for construction; in the meantime, the recommendation remains to move these individuals outside of CSC facilities and into settings where appropriate healthcare may be provided.

Risk and Recidivism

Rationale for Incarceration

In penological theory, von Hirsch and Ashworth (2005) described two predominant rationales for the incarceration of persons convicted of crimes. The first rationale, retributive, calls for the punishment of those who break the law, whereas the second, utilitarian, argues that incarceration acts to protect society from those who commit crimes. Even within the retributive rationale, it is misguided to suggest that a lack of access to appropriate care for aging IPs is simply a component of their punishment. The Nelson Mandela Rules (United Nations, 2015), of which Canada is a signatory, dictate that all incarcerated persons have the right of access to healthcare services equivalent to those available in the community to non-incarcerated persons. Conviction of a crime and its subsequent punishment does not justify the withholding, either intentional or unintentional, of healthcare services. The utilitarian rationale for incarceration is dominated by questions of risk. If the purpose of incarceration is to protect society from those who pose a risk, then, when an IP no longer presents a risk, they should be entitled to *decarceration*.

Aging Incarcerated Persons and Risk

Empirically speaking, the older one gets, the less likely they are to engage in criminal activities. Rates of offending increase during adolescence to a highest rate during late adolescence – typically at age 17 – then decline significantly as one ages (Cornelius et al., 2017; Ray & Jones, 2023). According to Cornelius et al. (2017), “this trend has, over the years, withstood stringent testing and examination across time periods and maintains consistent results regardless of race/ethnicity, education level, or income” (p. 25). This inverse relationship between age and criminal activities is often referred to as ‘aging out’ (Auerhan, 2013), and is

considered as a given in the field of criminology (Cornelius et al., 2017). Exceptions to this rule may exist; Ray and Jones (2023) described "life-course-persistent offenders" (p. 1590) as a sub-group of individuals who continue to engage in criminal activities throughout the lifespan. However, as the authors note, this is a small sub-group that exists contrary to strong overall trends.

With this concept of 'aging out' of crime, those aged 50 and older represent the lowest risk to offend or reoffend. Rocque et al. (2015) offered that long prison sentences may be counterproductive in many cases, noting that aging IPs are among the lowest risk to reoffend. Ray and Jones (2023) linked impulsivity to this trend, with the suggesting that impulsivity, and thus criminal activity, peaks in adolescence. Recidivism – the act of reoffending after release from incarceration – follows this same age trend. Piquero et al. (2015) concluded that likelihood of recidivism, in particular violent recidivism, declines with age. Such empirical data is highly relevant to this project: aging IPs, particularly those with significant health problems, represent a low risk to reoffend if released into the community, yet the CIC and CHRC (2019) suggest hesitance to do so remains.

Sexual Offences and Risk

This trend of 'aging out' of criminal activity also applies to those convicted of sexual offences. However, as Harris & Socia (2016) described, perception of decreased risk with aging tends to elude those convicted of sexual offences, a population where myths and misconceptions of their level of risk abound (Federoff & Moran, 1997). Empirical evidence supports this low level of risk, particularly rates of recidivism, for IPCSOs. Hanson and Morton-Bourgon (2005) reported rates of sexual recidivism for all ages of IPs to be below 14%, significantly lower than recidivism rates for other offences, and that this risk decreases with age (Ambroziak et al., 2021;

Crookes et al., 2022). If and when released into the community, Hanson et al. (2018) reported that risk of sexual recidivism decreased in relation to the amount of time spent offence-free. As a sub-population of the aging prison population in Canada – and globally – IPCSOs represent a growing proportion of this population but pose a low risk to reoffend if released. However, negative perceptions of persons convicted of sexual offences affect a willingness to release these individuals. Boothby and Overduin (2007) reported that negative perceptions towards IPCSOs affected the potential for early release not only of this sub-population, but of all aging IPs. Concerns about risk, outside of this empirical data, can hinder attempts to release these individuals into the community (Ollove, 2016). In Canada, where access to long-term and palliative care beds is limited, many would ask why IPs, particularly those convicted of sexual offences, should have equal access to these beds as those from the general public (Burles & Peternelj-Taylor, 2019). The CIC and CHRC (2019) described the "intersectional discrimination" (p. 18) that aging IPs face, noting that multiple factors may contribute to negative perceptions of this population. Morrison (2018) identified numerous barriers to access to palliative care in Canada in the general population already exist. Discriminatory attitudes can affect access for specific populations. For instance, Huynh et al. (2015) noted inequalities in access to palliative care services for persons experiencing homelessness, a population facing similar stigmatization and discrimination as incarcerated persons, a finding mirrored by Stajduhar et al. (2019).

Stigma and Risk

A common theme consistent throughout the literature on incarcerated persons, particularly those released into the community, is that of stigma. Though the empirical risk posed by IPs, including those convicted of sexual offences to reoffend continually decreases with age,

public perception of these individuals remains negative. Such stigma affects multiple aspects of post-release existence, including access to housing (Keene et al., 2018) and employment (Sheppard and Ricciardelli, 2020). Social isolation often results from this stigmatization of released IPs, particularly those convicted of sexual offences (Klein et al., 2018). Persons with histories of criminality are viewed with suspicion and distrust, despite the low risk they pose to reoffend.

Release into the Community

Aging IPs face several obstacles and challenges in being released into the community, particularly if they require ongoing healthcare services in facilities like long-term care homes. Poulin et al. (2023) examined the reintegration of aging IPs into a Canadian community residential facility, documenting these challenges. They described the challenges faced in securing placements for released IPs, noting that initial attempts at placement are rejected, requiring a lengthy and complicated appeal process. They noted that aging IPCSOs were ineligible for placement. Considerable stigmatization of these aging IPs was noted amongst both the staff and residents of the long-term care facility, based on perceived risks associated with the IP, even if their conviction had occurred several decades prior to their release. The authors noted that released aging IPs would instead be transferred to hospitals, a costly and otherwise unnecessary alternative to long-term care. In a similar study, Brown and Straker (2012) surveyed Ohio-based nursing homes on their willingness to accept aging IPs. They reported that the majority of facilities would refuse to accept these individuals, with aging IPCSOs as the least likely to be accepted. Despite empirical evidence suggesting these individuals pose minimal risk to reoffend if released, these public perceptions of risk overshadow attempts at release.

Paradoxically, this lack of support and acceptance within the community for recently released IPs places them at higher risk of recidivism. Baker et al. (2021) described this re-entry phase as critical in "desistance from criminal offending" (p. 135). This initial transition period from institution to community is described as stressful and destabilizing. Those who transition with a sense of autonomy and social connectedness are more likely to succeed in remaining in the community, offence-free. The lack of support aging IPs face in transitioning to community facilities, like long-term care homes, based on fear and misguided perceptions of risk, may place these individuals at higher risk of recidivism. This reality is amplified for those convicted of sexual offences. These individuals, as Taylor (2019) noted, are subjected to intense scrutiny, surveillance, and restrictions on where they can live and with whom they can interact. The result of these measures, as Klein et al. (2018) reported, have an isolating effect, producing conditions that ultimately increase the risk of recidivism. Even within prison environments, IPCSOs experience weaker social bonds and a general lack of support, which continues upon release. A lack of access to housing, based on this lack of supports and stigma, persists for IPCSOs (Baker et al., 2021). Aging IPs, in particular those convicted of sexual offences, face significant barriers in the successful and meaningful transition to the community. Negative perceptions and stigma, and a refusal of care facilities to accept them, contribute to these challenges.

Despite these concerns, a project in Maryland, described as the 'Unger group' after the name of a particular court case, saw the release of 178 aging IPs, incarcerated on life sentences for convictions of homicide or sexual offences, into the community (Millemann et al., 2017). These individuals were between the ages of 52 and 82, and all had been incarcerated for several decades. After this initial release, additional aging IPs were released in the following years (Millemann et al., 2021). Many of these individuals were not recommended for parole, but were

released, nonetheless, under this project. Of note, in the six years following release, 97% of those released remained in the community, with only 3% being re-incarcerated. Contributing to the success of this project, according to Millemann et al., (2017), was the fact that these newly released aging IPs were all provided access to the supports of a social worker. This social support, typically described as absent in the release of many aging IPs, particularly those convicted of sexual offences, was attributed to the successful re-entry of this population.

The Difficulties of Prison Research

Prison settings and prison populations, both incarcerated persons and prison staff, present unique challenges in conducting research. Access to both spaces and persons may be limited. Waldram (2009) outlined the myriad obstacles faced when attempting to conduct research within prison environments. Ethics approval for studies are required from not only the researcher's institution, but also from the prison's review boards, which often possess different concerns and priorities than those of a university. Approval from prison agencies can be a lengthy and frustrating process. Even with ethics approval from a prison, access to the institution itself may be limited or denied if security personal deem the researcher ineligible to enter. Waldram (2009) described lengthy delays in entering the prison environment on a daily basis, despite having approval to enter and conduct research. Correctional institution staff, from correctional officers to administrators to nurses to the IPs themselves share a distrust of outsiders and are often hesitant to share information or engage in a meaningful manner (Moolman, 2015; Patenaude, 2004; Waldram, 2007, 2009). A sense of paranoia amongst prison staff was described by Waldram (2007, 2009) over concern that, despite presenting themself as an outside researcher, that they were somehow affiliated with correctional or justice agencies. A panoptic surveillance defines existence within prison settings (Holmes, 2005; Waldram, 2009); staff are under the

perpetual gaze of cameras, security staff and supervisors. Engagement with outsiders and the exposition of sensitive or personal information may open those within the prison system to judgement or discipline.

However, when trust with participants is established, researchers working in prison environments report participants very willing to share and engage, provided they feel safe that their confidentiality will be maintained. Klein et al. (2018) noted that many participants shared information and experiences well outside the parameters of the intended research topics. Prison staff who work with ICPSOs may be hesitant to share their experiences with others, on account of the stigma attached to this population. Many may welcome the opportunity to discuss their experiences with a researcher who approaches their work in a non-judgemental and open manner (Addo, 2006; Asher, 2014). Ensuring the confidentiality of participants is of paramount concern; ensuring that all data collected remains secure and the dissemination of data removes any potential of personal identification is necessary in building trust with participants (Waldram, 2007).

Chapter 3: Theoretical Framework

In an examination of the aging federal prison population in Canada and obstacles to early release, a theoretical framework grounded in a poststructuralist perspective permits critical reflection and analysis. Correctional environments are highly restrictive settings, the power relations therein having received considerable attention (Armstrong, 2020; Holmes, 2002, 2005; Perron & Holmes, 2011). In addition, negative attitudes towards IPs, particularly IPCSOs affect their treatment and potential for release (Jacob et al., 2009; Ricciardelli & Moir, 2013; Waldram, 2009). A poststructuralist framework, in concert with a thematic analysis methodology – to be explored in the following chapter – permits critical examination of the forces and factors that affect the practices of CSC workers on a day-to-day basis. Questions such as how these CSC staff view their roles, how they view aging IPs and aging IPCSOs and how they view risk can then be interrogated via this framework to better understand the power relations and other factors at play. The challenges posed by an aging prison population are suitable for examination via this critical perspective.

Poststructuralism

The starting point for this project is a theoretical framework grounded in a poststructuralist epistemology. Several themes and concepts from key theorists will provide the basis for analysis of the data. Primary theoretical approaches focus on the works of Michel Foucault (1926-1984) and Julia Kristeva (1941-). Poststructuralism as a philosophy began in the 1960s, with France as its epicenter, primarily as a rejection of structuralism, but also of established ideas of science and morality (Williams, 2005). Structuralism aimed to identify inherent structures: rules and mechanisms that governed phenomena. In addition to a critique of structuralism, poststructuralism departs from the humanist perspective “that each individual is in

essence distinct from others, and that the individual is the key to ways of making sense of phenomena" (Mills, 2003, p. 26). Both Foucault and Kristeva, according to Mills (2003), were part of the early questioning of structuralism in France. Provision of a concrete definition proves challenging, as it is based on the philosophical perspectives of a wide range of thinkers, including Foucault, Deleuze, Kristeva, Lyotard and Derrida, who do not present a unified vision of the framework. Nonetheless, Williams (2005) defined poststructuralism by its tendency to disrupt conventional understandings of identity, language, and history, and "its power to resist and work against settled truths" (p. 3).

Integral to a rejection of the tenets of structuralism is the notion of a core or stable understanding of the world. Structuralism aims to identify regular patterns – or structures – that constitute the norm. Deviations from these norms may exist but are viewed as aberrations from the supposed 'truth' of this norm (Williams, 2005). In contrast, poststructuralism is more interested in the limits or margins of what is considered the core; in fact, it rejects the notion that this core constitutes the truth at all. According to Williams (2005), it is the examination of the effects of these limits that comprise the basis of poststructuralist thought. That which is conventionally viewed as the truth and that which is taken for granted constitutes the primary focus of poststructuralist analysis. As Williams (2005) stated, "poststructuralism does not simply reject things. It works within them to undo their exclusive claims to truth and purity" (p. 8).

The avenues followed in which these claims to truth and purity are critically examined vary by theorist. The theoretical approach in this project primarily follows the work of French philosopher Michel Foucault, who is perhaps best known for examining how power relations affect, over time and space, what knowledge is valued and produced, how human identities are constructed, and the role of discourses in influencing these processes, all of which will be

explored in greater detail in the following pages. These concepts – power, subjectivity, and discourse – are central to this examination of the aging prison population in Canada. Yet the work of Foucault is insufficient in fully explaining the phenomena and processes at play with this aging prison population and those who work with them. The work of Bulgarian-French philosopher Julia Kristeva, primarily her psychoanalytic concept of abjection – related to the experience of disgust – and its contribution to the production of human subjectivities and our sense of boundaries will be mobilized to this analysis. Though Foucault and Kristeva do not present a unified or congruent analysis on these various concepts, particularly the production of human subjectivities, an amalgamation of their approaches best describe the phenomena explored in this research. The work of Margrit Shildrick (2002), primarily her analysis of monstrosity – greatly informed by the work of Kristeva – is mobilized to examine the psychic effect of IP subjectivities on both correctional service providers and the public. Finally, the concept of risk, briefly addressed by Foucault (2004), is further expanded, and mobilized using Deborah Lupton's (1999) and Robert Castel's seminal works (1991). These concepts – power, discourse, subjectivity, abjection, monstrosity and risk – will interconnect in a productive manner, ultimately inseparable from one another in this analysis.

Related to this poststructuralist epistemological framework is a critical theory ontological perspective, wherein reality is shaped by various social, economic, political, and cultural factors. In contrast to positivist and postpositivist ontologies, reality is not viewed as fixed and apprehensible (Guba & Lincoln, 1994). From this perspective, described by these authors as historical realism, what is considered to be real has been shaped and solidified by these myriad factors into that which (incorrectly) appears as both real and permanent. There exists not a single, transcendent truth that underlies all phenomena, but multiple truths and interpretations

that may shift over time and space, influenced by myriad factors. Guba and Lincoln (1994) posit that a research paradigm consists of three factors: an ontological perspective, an epistemological perspective, and a subsequent methodology. As Agger (1991) argued, both critical theory and poststructuralism offer critiques of positivism, forcing positivist empiricism to question taken-for-granted assumptions. The methodology that follows – in this case a thematic analysis methodology, to be described in the following chapter – must reflect both the ontological and epistemological perspectives. This research aims not to reveal a single, underlying, and universal truth, and will instead present a critical analysis of the multiple factors that contribute to the provision of care to aging incarcerated person, including those convicted of sexual offences, and the decisions being made around care and release when their inmate needs can no longer be met within the correctional setting.

Subjectivity

The question of subjectivity – the idea of the self – is central to a poststructuralist epistemology. According to Mills (2001), poststructuralism questions "the very fundamental bases of liberal humanist ideology, rooted as it is in the notion of the individual self with agency and control over itself" (p. 34). Here the work of both Foucault (1990) and Kristeva (1982) are mobilized to illustrate the production of subjectivity – for Foucault through various power relations, and for Kristeva, adopting a psychoanalytic approach, through the process of abjection. As noted by Mansfield (2000), Foucault rejected the model of the individual or the self as being a pre-existing whole that then encounters the outside world. Instead, the subject comes into existence as an effect of power relations and language. The individual – or, more accurately, the subject – is not free and autonomous, but is instead endlessly produced by complex webs of political, historical, economic, and cultural forces. According to Foucault (1997), the techniques

and forms of power that shape subjectivities have shifted and changed over time. As summarized by Mansfield (2000), "this subject does not develop according to its own wants, talents and desires, but exists for the system that needs it" (p. 53). Kristeva (1982) utilized a poststructuralist psychoanalytic approach to the construction of subjectivities. To Kristeva, subjectivity is not fixed, but is an ongoing process (Mansfield, 2000). Despite one's continuous efforts to draw boundaries around oneself and maintain an invulnerable, fixed sense of self, these boundaries are forever under threat. That which threatens these boundaries is the abject, which will be further explored below. Our sense of self remains unstable: the subject in process. There is no distinct demarcation between the inside and outside of the subject; its boundaries are porous. As McAfee (2004) stated, "subjectivity occurs in an open system" (p. 41). In contrast to liberal humanist notions of the free and autonomous self, the poststructuralist subject is fluid and dynamic, malleable to the greater political and cultural forces in which it is immersed, as well as the abject forces that continuously threaten its fragile boundaries. Of particular interest in this work is the production of aging IP subjectivities, especially those convicted of sexual offences, by both CSC staff and the broader public body, and how they differ/contrast with the subjectivities of non-incarcerated persons. The work of both Foucault (1990) and Kristeva (1982) present the framework for this examination, with Shildrick's (2002) conceptualization of the 'monster' allowing additional interrogation of these IP populations.

Discourse

Within a poststructuralist framework, it is impossible to explore the construction of subjectivities without an examination of discourse. Mills (2001), adopting a Foucauldian perspective, described discourse as "groupings of utterances or sentences, statements which are enacted within a social context, which are determined by that social context, and which

contribute to the way that social context continues its existence" (p. 11). A discourse is not simply that which is said (or written). It is tethered to the context in which it is said, and it shapes and perpetuates the context in which it exists. Discourses cannot be separated from the complex web of power relations in which they are situated (Foucault, 1990). Discourse goes beyond the description of reality to a structuring and shaping of how we perceive reality (Mills, 2003). Relations of power shape what discourses are privileged, and which are marginalized, what is said and what is not said. These shape what is perceived to be true, as Mills (2003) stated, "those in positions of authority who are seen to be 'experts' are those who can speak the truth. Those who make statements who are not in positions of power will be considered not to be speaking the truth" (p. 58). There is no single, universal truth to be uncovered, but a contextual truth, shaped by discourses and power relations. Poststructuralism, as Williams (2005) suggested, questions any exclusive claim of truth. And like subjectivities, discourses are not fixed or static. They are fluid and dynamic and change over time and place. Those with access to privileged discourses contribute to the construction of subjectivities within existing power relations.

Within correctional and forensic settings, discourses play a significant role in the production of IP subjectivities, and subsequent nursing practices associated with these individuals. According to Perron and Holmes (2011), "discourses shape the way nurse-patient relationships emerge and produce effects. In Foucault's view, discourses, like power, are productive because they make possible the creation of social categories and social practices" (p. 193). These authors studied nursing documentation in a mental health unit in a Canadian penitentiary and found that nurses produced the subjectivities of inmates through these notes. Nurses developed different categories based on the behaviours and conduct of IPs on the unit. These categories were rooted within the highly restrictive rules and expectations of the

institution; IPs who failed to adhere to institutional rules were constructed as deviant, and subsequently subjected to disciplinary action. Not only did these discourses shape the subjectivities of IPs, but they also shaped nursing practice. Berring et al. (2015) reached similar conclusions in an analysis of nursing records of patient aggression. Those who engaged in aggression were constructed as deviant or dangerous and were subject to disciplinary actions. The production of patient subjectivities as deviant or dangerous was linked to nursing practices focused on risk management, more so than the provision of therapeutic nursing interventions. Within the highly restrictive correctional setting, where power relations shape nursing practices (Holmes, 2005; Holmes & Federman, 2006), the subject is developed within a context and discourses of control and risk. The use of discourses has social effects.

Foucault and Power

Philosopher Michel Foucault wrote extensively on the concepts of power and power relations from a poststructuralist perspective. To Foucault, power was not something to be possessed exclusively by institutions or those in positions of power and did not exist specifically for the purpose of oppressing (Mills, 2003). Instead, power flows – it is capillary – and can move and operate in all directions. In this sense, power is productive: it can bring about events, shape behaviours and influence discourses. As Mills (2003) suggested, "power is something which is performed, something more like a strategy than a possession. Power should be seen as a verb rather than a noun, something that does something, rather than something which is or which can be held onto" (p. 35). In this poststructuralist lens, there is no single truth to power or universal essence; instead, it shifts and adapts depending on context. It is a set of relations that permeate social realms. To Foucault, multiple forms of power have emerged over time, and continue to coexist, as products of various social, political, economic, and cultural factors. A number of

these forms of power are considered in this research, forms which both coexist and, it will be demonstrated, produce inter-form tensions. The forms of power considered here include governmentality (Foucault, 1991, 2008), sovereign (Foucault, 2003), disciplinary (Foucault, 1997, 2006) and pastoral (Foucault, 2009) power, as well as biopower and biopolitics (Foucault, 1990, 2008). Furthermore, the role that these various forms of power play in the production of subjectivities will be further explored.

Unsurprisingly, as Holmes (2002, 2005) illustrated, various forms of power relations, as conceptualized by Foucault, coexist within correctional institutions. These various power relations are not only mobilized as a means of social control, but also in the production of IP subjectivities and the subsequent practices adopted in the management of these subjectivities. However, as noted above, power is not simply possessed and exercised by those in positions of authority, such as correctional officers or nurses within prison settings. Power is fluid and capillary and moves in all directions. As Foucault (1990) famously stated, "where there is power, there is resistance" (p. 95). Incarcerated persons engage in acts of resistance against the various forms of power in operation within these settings (Holmes, 2005).

Sovereign Power

Foucault (1997, 2004) described sovereign power as the power of the king – one that is absolute and required strict obedience to laws. This form of power emerged as a necessity to the ruling of a kingdom; the day-to-day lives of its subjects were of little concern to the sovereign, provided they maintained obedience to the law. The sovereign's power is tied to their ability to kill. As Foucault (2003) stated:

> sovereign power's effect on life is exercised only when the sovereign can kill. The very essence of the right of life and death is actually the right to kill: it is at this moment when

> the sovereign can kill that he exercises his right over life. It is essentially the right of the sword (p. 240).

As Taylor (2017) observed, "what it does not seize it leaves alone" (p. 43). Those who do fail to adhere to the will of the sovereign are subjected to spectacular punishments executed upon their bodies. Foucault's (1997) famous description of the public torture of Damien the regicide illustrated this fate, wherein a lengthy and particularly gruesome series of punishments resulted in his eventual death and dismemberment. The purpose of this right to kill – in a very public manner – was to discourage violation of the sovereign's will amongst other subjects, and a reminder of the sovereign's absolute right to take life. As Taylor (2017) remarked, the Middle Ages and Renaissance in Europe was characterized by widespread death; high infant mortality rates, famines and plagues eliminated large proportions of populations. Tactics for avoiding death were effectively nonexistent, as Taylor (2017) concluded, "death could not be managed, and was viewed as God's will." The actions of the sovereign merely contributed to this widespread death, in which one transitioned from a sovereign power under the king to one under God.

While power began to shift away from sovereign to other forms, such as disciplinary power or governmentality, it did not disappear completely; it merely acted in concert with these new forms of power (Foucault, 2004). Sovereign power as a tactic, or as a verb, continues to operate, particularly within correctional settings. Perhaps the most transparent and unapologetic manifestation of sovereign power within correctional institutions lies in the death penalty (Trumbull, 2015), the literal ability to kill those who violate the laws. But the exercise of sovereign power in these settings can be more subtle. As Holmes (2002) observed, "sovereign power plays a pivotal role in settings where human beings are kept captive and where the rules

have significant discretion in the application of sanctions" (p. 88). He pointed to nurses bringing correctional officers "of great stature" (p. 88) with them when confronting an IP to ensure cooperation. The submission of the IP to the correctional order, executed by those capable of punishment, represents the manifestation of sovereign power in correctional settings.

Disciplinary Power

Disciplinary power constituted a shift from the might of the king to a more diffused and insidious form of power, aimed at the micro-management of individuals, as Foucault (2004) stated, "managing it in depth, in all its fine points and details" (p. 107). In contrast to the strictly hierarchical composition of sovereign power, disciplinary power operates in a continuous and horizontal manner, depending upon surveillance, partitioning and normalization. Foucault (2006) placed disciplinary power's origins in religious communities in medieval societies, where monastic tendencies prescribed disciplinary methods for day-to-day existence. He pointed to the expansion of disciplinary power as emerging in the armies of the 17th century. Prior to this point, armies consisted of temporarily organized rogues and vagabonds, assembling for specific actions before disbanding. The organized and disciplinary army saw the production of full-time soldiers, engaged entirely in training and preparation, even in times of peace. The soldier's existence here was one of continuous control and surveillance, of actions continually monitored and assessed, where the smallest of deviation from the norm required correction. Foucault (2003) described the expansion of this form of power to the boarding school and to the factories of the industrial revolution, where strict and continuous surveillance of students and workers occurred.

Perhaps the most famous, and most relevant example of disciplinary power for this study is that of the panopticon, Jeremy Bentham's (1995) 18th century conceptualization of the ideal prison. This panoptic prison was organized in a circular manner; in the centre, a single watch

tower, at the periphery, the cells. In this arrangement all cells, and, thus, all activities of their occupants, were visible from this central tower. This observation post was designed in such a manner that the prisoner could not tell if and when they were being watched. In time, the prisoner would recognize that they were effectively under constant surveillance – any misdeed would be identified and corrected. This prison could function even without any guards in the tower; the prisoners would simply begin to police themselves. As Foucault (1997) suggested, "to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power" (p. 201). Such power relied upon the strict partitioning of individuals, constant surveillance, and extensive documentation of the captives' activities. This produces detailed knowledge of individuals and, with it, the ability to predict (mis)behaviours. A focus on potential behaviour, as Foucault (2003) noted, requires that "one must be able to spot an action even before it has been performed, and disciplinary power must intervene somehow before the actual manifestation of the behaviour" (pp. 51-52). Those who fail to adhere to the regulations of the disciplinary order are subject to punishment, and new systems of discipline are created to recapture them back into this order. A primary target of discipline is normalization. A micro-physics of power that "analyzes and breaks down… individuals, places, time, movements, actions, and operations… such that they can be seen, on the one hand, and modified on the other" (Foucault, 2004, p. 56). In doing so, it separates the normal from the abnormal. Those who are defined as abnormal require correction. The modern prison system does exactly this: persons who break the law are those who fail to adhere to the disciplinary order of society – the abnormal – and require the prison as a form of capture to correct these (mis)behaviours.

Whereas sovereign power acts upon the body only to punish, under disciplinary power, according to Taylor (2017), "the soul is occupied, refashioned, and transformed, and so,

ultimately, there is less need for physical violence" (p. 44). Indeed, whereas sovereign power relied upon public displays of violence and punishment, disciplinary power hides away this correction and manipulation of the soul. There is no ceremony to discipline, only exercise. Foucault (2003) offered the madness of King George III as an example. The King, a sovereign power, was described to fall into madness, requiring his seclusion away in a padded room under the supervision of faceless guards and an anonymous physician. Over time, a steady routine of hygiene and discipline was described to have cured the King of his madness. The sovereign power of the King was stripped away, he was confined away from public view and subjected to a strict regime of exercise upon both his body and his soul to correct his deviance.

Disciplinary power is exercised on a broad scale within correctional institutions. Holmes (2005) explored in detail disciplinary power within a Canadian correctional institution, documenting specifically the role that nurses play in its operation. He noted that in addition to the day-to-day tasks typically associated with nursing practice, nurses are also required to contribute to the maintenance of the disciplinary order. He observed that nurses surveil IPs to ensure they remain within the expected spatial distribution of individuals in the prison: they are not to enter another IP's cell, they are to remain in permitted areas at permitted times, they must maintain the tidiness of their cell, they must maintain adherence to prison routines. Should any IP fail to adhere to these disciplinary routines, nurses possess the authority to sanction IPs, or to request assistance from correctional officers to ensure adherence – a shift from disciplinary to sovereign power. In addition to this surveillance of activities, prison staff – including nurses – conduct ongoing assessments and documentation of IP activities and behaviours. Such activities are aimed at better understanding of the IPs character, or soul. Such information is mobilized in

risk assessments of individuals, aiming to predict the probability of recidivism should the IP be released. Such interventions are unique to disciplinary power, aimed, as Taylor (2017) offered:

> To predict and control the individual's chance of recidivating, the criminal needs to be subjected to psychological examinations, surveillance, and rehabilitative practices unknown under sovereign power. For this reason, the punishment is less likely to put an end to the criminal's life and more likely to control it through tactics such as prison, psychiatric treatment, parole, and probation (p. 46).

Disciplinary power permeates all aspects of the prison environment, and no one is invisible to its gaze. Beyond the constant surveillance of IPs, prison staff themselves are under constant watch, their activities and practices scrutinized by their peers and their supervisors. Holmes (2005) described nurses as both subjects of power – those who mobilize techniques such as discipline – and as objects of power. As objects of power, nurses themselves are subjected to the same methods of surveillance and normalization they themselves employ. They may be reported to their superiors for not adhering to institutional protocols. Nursing practices outside the realm of that considered "normal" or acceptable are criticized, requiring the self-policing of behaviours to fall back in line, similar to expectations placed on IPs. As Foucault (1997) suggested, "in this central tower, the director may spy on all the employees that he has under his orders: nurses, doctors, foremen, teachers, wardens: he will be able to judge them continuously, alter their behaviour" (p. 204).

Pastoral Power

Pastoral power is a third form of power described by Foucault (2003) aimed at influencing and shaping the conduct of individuals. He defined it as the:

> Art of conducting, directing, leading, guiding, taking in hand, and manipulating men, an art of monitoring them and urging them on step by step, an art with the function of taking charge of men collectively and individually throughout their life and at every moment of their existence (p. 165).

Similar to disciplinary power, pastoral power is a highly individualizing power, aimed at intimate knowledge of the subject. However, it is described as a beneficent power, the "power of care" (Foucault, 2003, p. 127). The enactor of pastoral power is the metaphorical shepherd, who guides and cares for their flock. It is exercised not through might or force, but through salvation of the individual soul. The pastor achieves this end via three means: salvation, the law, and the truth. The pastor leads the flock to salvation via a submission to the order of God: the law. This requires the acceptance of a particular truth: the truth of God. Obedience to the pastor is required of subjects to achieve salvation. Much like disciplinary power, the conduct of subjects is the target of this form of power. The vehicle for this ultimate salvation is, as Foucault (2021) described, through confession. The subject is to confess – to the pastor – their sins and other hidden transgressions. This act of liberation acknowledges past (mis)conducts and places the subject on the path to salvation and proper conduct.

While not as visible or obvious in its implementation in correctional settings as disciplinary or sovereign power, pastoral power operates alongside these forms of power. Holmes (2002, 2005), in examining the role of nurses within Canadian correctional settings, described therapy as the manifestation of pastoral power. This is the caritative act more typically associated with nursing practice. Nurses encourage IPs to engage in therapy, to reflect upon their past (mis)behaviours, to identify their future goals and to divulge deeply personal information. Here the nurse acts as the pastor, or shepherd, pursuing the salvation of the individual. The IP is

the sheep who escaped the flock. They must confess their sins and, through therapy, aim to correct the behaviours that led to their incarceration, working towards eventual salvation: release from prison and return to the flock of civilian society. The IP who fails to engage in this pastoral process of therapy is less likely to be released (Johansson & Holmes, 2022a). Working in concert with the accumulation of knowledge of the individual IP achieved via disciplinary power, an IP's confessions during therapy contribute to risk assessments of their potential to recidivate. Tierney (2004) explored the role of pastoral power in the medical case study, exercised by physicians with their patients. The author likened the discussion between physician and patient to a confession, wherein the patient divulges their activities and behaviours that may have contributed to their hospital admission. The details of this confession would then be compared with the physical 'evidence:' test results, scans, etc. to verify the veracity of their claims. Patient narratives are viewed with suspicion, though they must be assessed via the operation of pastoral power. While pastoral power operates in a more beneficent manner, it remains a form of coercion.

Governmentality

The concept of governmentality was coined by Foucault (2004) as a shift in power relations away from a focus on the conduct of individuals to a broader focus on populations. No longer was the territory the primary focus of the state, or the sovereign: growing populations and longer life expectancies required the management of growing numbers of people, alongside "the birth of political economy" (p. 106). Integral to the emergence of governmentality was statistics, or the science of the state. Statistics reveal regularities or tendencies of a population to be analyzed and integrated into the practice of government. While governmentality focused on the management of populations, the conduct of the individual was still relevant. Foucault did not

propose a stepwise replacement of sovereignty with discipline and subsequently governmentality; instead, he proposed that all three forms of power coexist. In defining governmentality, he offered:

> By 'governmentality' I understand the ensemble formed by institutions, procedures, analyses and reflections, calculations, and tactics that allow the exercise of this very specific, albeit very complex, power that has the population as its target, political economy as its major form of knowledge, and apparatuses of security as its essential technique instrument (p. 108).

With this shift to social control of populations came the necessity for self-government. No longer did the state concern itself with the micro-direction of conduct of all individuals. This is neither feasible nor desirable. Instead, individuals are left to self-govern their conduct according to the laws and expectations of society. However, those who fail to properly self-govern, such as those who break the law or present as mentally ill, require more specific attention. Here, institutions such as prisons, psychiatric institutions and hospitals take on this task of the focus on the individual, employing the three forms of power outlined above: sovereign, disciplinary and pastoral. The delinquent, he suggests, has broken with the social contract and is considered to have "fallen outside the collective subject" (Foucault, 2004, p. 44), leading to a people/population dichotomy. The mobilization of individualizing forms of power within institutions, according to Foucault (2004), "connected up with an absolutely global project, which we can broadly call public hygiene, which is directed towards society as a whole" (p. 117) and aims to bring these delinquents (people) back into the (self-governing) population.

This concept of security, as applied to the population, differs from the aims of discipline. While "discipline allows nothing to escape" (Foucault, 2004, p. 45) and focuses on even the

smallest of infractions, security takes a broader and less specific approach. He continued, stating "security… let's things happen" (p. 45). It stands back, relying upon statistics to inform how and where to intervene. Not all transgressions are subject to correction; some degree of deviation is permitted, as intervention against all transgressions is unfeasible in the management of a broader population. Necessary for the functioning of governmentality is the presence of "qualified 'state agents' who are trained to identify those falling outside established norms and who can implement interventions needed to circumvent the effects of this nonconformity" (Perron et al., 2010, p. 106). When those subjects who are expected to properly self-govern fail to do so, these 'state agents' intervene and correct the missteps.

The correctional setting has been described in relation to Foucault's concept of governmentality (Armstrong, 2020; Holmes, 2002, 2005; Holmes & Federman, 2006). Within these settings there exist expectations that proper self-government occurs, not only amongst inmates but also staff, including nurses. When inmates fail to properly self-govern, nurses act as state agents to maintain control, and have at their disposal techniques of sovereign, disciplinary, and pastoral power. Nurses, too, are expected to properly self-govern, and are subjected to correction when they go astray. Expectations around the treatment of inmates, rooted in a highly masculine setting, forbid the demonstration of compassion or empathy. Other nurses or corrections officers may act as state agents and correct these behaviours that fall outside the expectations of proper self-government within the correctional setting.

Biopower and Biopolitics

In the historical shift away from sovereign power, where the king exercised the power to take life or to let live, to both disciplinary and governmental forms of power, this calculus of power over life also shifted. This transformed into, as Foucault (2003) described it, "the power to

'make' live and 'let' die" (p. 241). In concert with the emergence of governmentality and a focus on populations, more so than individuals, Foucault (2003) described biopolitics as a "seizure of power that is not individualizing, but, if you like, massifying, that is directed not at man-as-body but at man-as-species" (p. 243). This form of power, like governmentality, relied upon statistics, rates of mortality, morbidity, birth rates, etc. to function as a form of public hygiene, viewing the population as a *biological* problem. However, as was the case with governmentality, individuals within the population may require specific attention regarding these biological processes. Here, Foucault (2003) mobilized the term 'biopower'. As Taylor (2017) highlighted, Foucault's use of the term biopower was, at times, defined separately from discipline, while at other times the two terms were intertwined. In attempting to resolve these discrepancies, Taylor (2017) argued that "biopower is a power over bios, or life, and lives may be managed on both individual and group levels" (p. 46). They then differentiated between biopower and biopolitics at this individual/population level. Taylor (2017) continued:

> Discipline… may be seen as biopower that targets the individual body, therefore, while another level of biopower (biopolitics) targets the species [population] body… These two levels of power are necessarily intertwined since bodies make up populations and populations are made up of individual bodies.

Ostensibly, both biopower and biopolitics are aimed at the improvement of life and its prolongation. This is the power to make live. Such a shift in power affected how death was viewed. Prior to biopower and biopolitics, death was often "those spectacular ceremonies in which individuals, the family, the group, and practically the whole of society took part" (Foucault, 2003, p. 247). Death represented a transition from one sovereign power – the king – to another – God. In contrast, however, under biopower and biopolitics, death became shameful,

something to be hidden away: it became privatized. Here, as Foucault (2003) continued, "power has no control over death, but it can control mortality… death now becomes, in contrast, the moment when the individual escapes all power" (p. 248).

Power and Subjectivity

As described above, the question of subjectivity – what it means to be a 'self' was a common theme in Foucault's work. To Foucault (1990), the subject is formed via power relations. Unlike the liberal humanist view of identity that suggests the individual pre-exists the outer world, Foucault proposed that power relations pre-exist the subject; it is only through power relations that the subject is produced. As Mansfield (2000) surmised:

> Power comes first, he argues, and the 'individual' – and all the things we identify as making up our individuality (our separate body, its idiosyncratic gestures, its specific way of using language, its secret desires) – are really effects of power, designed for us rather than by us (p. 55).

Disciplinary power is instrumental in the production of subjectivities. The distinction between normal and abnormal. Those who are perceived as abnormal are subjected to disciplinary measures: surveillance, routine, careful control of activities, documentation of behaviours. From these are derived knowledge of the subject. Power/knowledge and discourses continue to perpetuate and reproduce subjectivities.

This production of subjectivities, particularly the role of disciplinary power, is highly relevant within correctional institutions. Incarcerated persons are those who have been deemed as abnormal or deviant within the population, relegated to this highly individualizing institution. As Perron and Holmes (2011) argued, both power and discourses "are productive because they make possible the creation of social categories and social practices" (p. 193). Within the prison

setting, these authors observed both power and discourses as operating to produce IP subjectivities, particularly those who fail to adhere to institutional expectations. The IP becomes the object of knowledge that is constructed, rather than discovered (Taylor, 2019). Not only does one's delinquent behaviours constitute them as abnormal, so too does their sexuality, particularly relevant to those convicted of sexual offences. As Taylor (2019) offered:

> Just as the offender became a delinquent, so the sexual agent became an individual with a determining sexuality, a being whose very existence was defined by the sexual acts they desired, and which existence, like that of the delinquent, was constituted as an object of scientific knowledge (p. 5).

The individual convicted of sexual offences becomes a double offender, on account of their criminal activities and their supposed sexuality. Such subjectivity formations are particularly concrete, according to Taylor (2019), such that they are viewed as permanent. Subsequently, IPCSOs are constructed as doubly deviant within correctional institutions; the discourses produced via and through these subjectivities result in a specifically harsh treatment of these individuals within prison settings, as this study will explore.

Kristeva and Abjection

The work of Kristeva (1982), specifically her concept of abjection is central to the concept of subjectivity. While Foucault pointed to the role of power in the production of subjectivities, Kristeva takes a psychoanalytic approach to this phenomenon. Both Foucault and Kristeva adopt a poststructuralist perspective on subject formation, rejecting liberal humanist notions of a stable and fixed identity in favour of something more fluid, resulting from processes beyond the individual. Kristeva, however, looks to psychic forces, as opposed to Foucault's broader approach.

Abjection and Subjectivity Formation

Kristeva (1982) looked to psychoanalysis for an assessment of subjectivity formation, a field heavily influenced, at the time, by the psychoanalytic work of Jacques Lacan (McAfee, 2004). Lacan, according to McAfee (2004), departed from Freud's Oedipal description of subjectivity formation – the stage at which the infant or child comes to recognize itself as separate from its mother – the notion of being an 'I' as a distinct entity. Lacan pointed to the mirror stage as the origins of this process, occurring somewhere between 6 and 18 months, where the child sees its reflection in a mirror and comes to recognize itself as an 'I' separate from the mother. Kristeva (1982) described this pre-subjectivity stage, where the child cannot differentiate itself from the mother, as the *chora*, an undifferentiated space lacking borders between child and mother. Unlike Lacan, however, Kristeva offered that subjectivity formation began before Lacan's mirror stage, through the process of abjection.

Abjection is described by Kristeva (1982) as an act of rejection or repulsion, specifically that which is external to the subject. McAfee (2004) described this phenomenon as "the state of *abjecting* or rejecting what is other to oneself – and thereby creating borders of an always tenuous 'I'" (p. 45). The initial stage of this process is the violent rejection of what seem to be the self: the mother's body. In this pre-subjective chora, there is no differentiation between the child and mother, but through the process of abjection the child comes to see itself as separate from its mother and rejects that from which it was once part of. Abjection is described as a visceral and psychic form of disgust, a feeling of repulsion produced through encounters with objects of disgust: the abject. As noted, the mother's body is the first abject 'thing', the point at which the child draws a line between itself and her (McAfee, 2004). But this process continues, with other objects coming to represent the abject: feces, vomit, and urine constitute other abject

‘things’, which may come from the child’s body itself. The subject can never be entirely free from the abject, requiring an ongoing rejection of parts of the self to become and maintain the self.

Through this act of abjection, the subject aims to secure the boundaries of the self, to secure the liberal humanist notion of the self as wholly intact and secure. However, this is impossible. The abject does not disappear from the unconscious but remains an ongoing threat to what Kristeva (1982) defined as the ‘clean and proper self’ (McAfee, 2004). The subject is forever working to maintain the borders, or boundaries of this clean and proper self, but the abject remains a life-long threat to these boundaries. It continues to haunt the subject, remaining on the periphery, representing the threat of falling back into the mother, or chora, and a subsequent loss of a sense of distinct self. The process of abjection becomes a protective measure, a psychic form of revulsion that works to maintain the subject’s boundaries. As Kristeva (1982) described, “I abject myself within the same motion through which ‘I’ claim to establish myself” (p. 3). This act of rejection simultaneously produces the self. And while that which initially constitutes the abject for the child is that which is immediately around, or within, such as the mother’s body, vomit, feces, other ‘things’ come to constitute the abject. Kristeva (1982) identified the corpse as “the most sickening of wastes… a border that has encroached upon everything” (p. 3). Still further ‘things’ and even persons can come to represent the abject. As Kristeva (1982) continued:

> It is thus not lack of cleanliness or health that causes abjection, but what disturbs identity, system, order. What does not respect borders, positions, rules… The traitor, the liar, the criminal… the shameless rapist, the killer who claims to be a saviour…. Any crime, because it draws attention to the fragility of the law, is abject, but premeditated crime,

> cunning murder, hypocritical revenge are even more so because the heighten the display of such fragility (p. 4).

Not only might tangible objects of disgust or repulsion represent the abject, but so might transgressive persons, such as the killer or the rapist. These individuals threaten the very boundaries we work so hard to build and maintain around our own subjectivities and reveal their vulnerabilities. This process of subjectivity formation, what Kristeva (1982) described as the subject in process, "occurs in an open system" (McAfee, 2004, p. 41). Here Kristeva both deviates and aligns with Foucault's notions of subjectivity formation, with Kristeva taking this psychoanalytic approach, but both indicating the role of forces external to the self. Judith Butler (1990) noted both the discrepancies and similarities between the work of Foucault and Kristeva. To Butler, Kristeva's psychoanalysis risks placing the maternal as an entity pre-existing discourses and power relations, inconsistent with poststructuralist perspectives. However, when examined from a Foucauldian perspective, this concept of the maternal is viewed "as a product of an historically specific organization of sexuality" (p. 324). For the purposes of this research project, the work of both Kristeva and Foucault describe the productive forces at play in the construction of subjectivities.

Kristeva's concept of abjection and its role in the production of subjectivities has profound implications for nursing practice, and, within correctional facilities, for all professions involved (Johansson & Holmes, 2022b). Nurses frequently encounter the bodily fluids and excretions of their patients, from feces and urine to blood and pus. In particular, illnesses associated with end-of-life, such as cancer, can produce in patient's tumours and wounds and their associated odours that may elicit a sense of abjection in those they encounter (Kaiser et al., 2018; Lawton, 1998; Van Der Riet, 2006). With this experience of abjection in response to the

realities of patient bodies comes an attempt to erect and maintain the boundaries of the clean and proper self. The abject represents, psychoanalytically, this persistent threat of falling back into the chora and a loss of sense of self. And nurses very explicitly enter into these encounters on a regular basis. The protection of boundaries, particularly the skin, is widespread, what Kristeva (1982) described as the rituals of self-protection. Nurses and other professions wear gloves, masks, gowns, even boots to protect themselves from the fluids of other bodies (Ostaszkiewicz et al., 2016). Nurses describe minimizing their encounters with such patients to minimize feelings of disgust, a form of erecting both physical and emotional boundaries (Butcher, 2020; Muggleton et al., 2014).

Beyond these physical 'things' that elicit a sense of abjection in nurses and other professions, the transgressive person – the murderer, the rapist – also represent, according to Kristeva (1982), the abject. Such individuals represent a persistent psychic threat to the clean and proper subjectivities of non-criminal persons. They expose, as Kristeva (1982) noted, the fragility of the law, and threaten to somehow cross boundaries, infecting others. Jacob and Holmes (2011) described the fear and anxiety that nurses felt in forensic and correctional settings when working with patients with criminal histories. Such patients, or IPs, may have been convicted of such egregious crimes to be considered 'monsters' (Jacob et al., 2009). Efforts are made to maintain the clean and proper sense of self when working with these populations, with boundaries being a particularly prominent measure (Johansson & Holmes, 2022b). A focus on boundary maintenance is widespread in forensic and correctional nursing (Aiyegbusi & Kelly, 2012; Peternelj-Taylor & Yonge, 2003). These boundaries are considered a critical element of professional practice, but they also represent an attempt to maintain the clean and proper self from the threats of the abject patient/IP population. Nurses have described feeling contaminated

by their abject patients, getting “into their minds” (Harris et al., 2015, p. 133) and envisioning themselves capable of committing similar acts (Hellzen et al., 2004). A distancing, where possible, is described. For instance, Asher (2014) described the ‘dirty work’ of nurses working with persons convicted of sexual offences, and the efforts made by nurses to distance themselves from this population, such as minimizing discussions of their work outside the occupational environment. Efforts are made, with the abject person, to erect and maintain firm boundaries, be they physical boundaries, such as distancing or even incarceration, or emotional boundaries, where engagement is limited.

Shildrick and Monsters

The concepts of monsters and monstrosity prove relevant to the focus populations in this study. Margrit Shildrick (2002), in her genealogy of monstrosity, examined the production and conceptualization of the monster over time. Monsters, to Shildrick, represent a deeply disturbing and disruptive force, an *other* that exposes the vulnerability of those who consider themselves as ‘normal.’ Building upon the work of Kristeva (1982), notably abjection and the attempts made to construct and maintain boundaries around the clean and proper self, Shildrick constructs the monster as that which threatens to disturb not only these boundaries, but also social order. Effectively, the monster is the abject person. Historically, monsters were those possessing distinct corporeal differences: conjoined twins, those living with physical injuries or bodily abnormalities at birth. These monsters are less problematic, as their corporeal difference places them firmly within the realm of distinct other of ‘not-me.’ However, far more troubling, to Shildrick, is when those monsters begin to resemble us, the normative subject, that a deep sense of dis-ease is felt. Like Kristeva, she points to our continued insistence of the ideal self as that autonomous and self-contained being who resists the encroachments of monstrous others.

However, like Kristeva, she acknowledges the porosity of the subject's boundaries that cannot be permanently maintained. While the monstrous other, particularly one who does not immediately reveal themselves as such requires the ongoing protection of the clean and proper self, they also serve a productive purpose. The normative, clean and proper self is that which the monster is not. Normativity is produced in opposition to monstrosity. The incarcerated person as a 'monster' was described by Jacob et al. (2009). Those convicted of serious crimes, such as homicide, filicide, and sexual offences, often bear this label. While the incarcerated person convicted of egregious crimes may not *look* like a monster, knowledge of their crimes reveals them as such. Within correctional environments, as explored above, persons convicted of sexual offences represent the most abject and stigmatized monsters of the prison population. Ricciardelli and Spencer (2014) described the significant efforts that IPCSOs would take to not be exposed of their convictions – to not be revealed as monsters. The criminal, particularly the monstrous criminal, represents a threat to normative vulnerability; on the surface they may appear normative, but knowledge of their histories reveals a deep deviance that requires separation outside the boundaries of the clean and proper. Prisons serve this exact function: to separate monsters from the rest of us. As explored above, a large proportion of the aging federal prison population in Canada are those convicted of sexual offences and/or have been designated as dangerous offenders. Their containment in correctional environments protects the clean and proper boundaries of non-incarcerated citizens and maintains social order. To release these individuals into the public presents a threat to both the clean and proper boundaries of subjectivity and to social order.

Risk

The concept of risk rounds out the theoretical framework of this project. Risk itself is to be viewed through a poststructuralist lens, rejecting the notion of a pure or true sense of risk, and instead placing it within historical, political, and social contexts. Lupton (1999) analyzed the concept of risk through a poststructuralist, Foucauldian lens of governmentality, wherein she explored "the ways in which the discourses, strategies, practices and institutions around a phenomenon such as risk serve to bring it into being, to construct it as a phenomenon" (p. 86). This contemporary notion of risk is tied to governmentality, relying upon statistics, the human sciences, and empirical data to predict the behaviours of, and ultimately manage, large populations, without the micro-management of individuals (Foucault, 2004). The ideal governmental subject is one who self-manages risk throughout the lifespan. A failure to avoid risk is viewed as a failure of self-management.

The governmental shift from a focus on individuals to the management of populations has resulted in a subsequent shift from a focus on dangerousness to one of risk factors (Castel, 1991). To Castel (1991), dangerousness represents "the affirmation of a quality immanent to the subject" (p. 283) to be individually targeted. However, the management and confinement of all individuals viewed as potentially dangerous is unrealistic within a governmental framework. Observation of individual concrete behaviours has given way to statistical analyses of risk probabilities. Those who meet a series of risk factors are placed within a 'risk population'. This has led to a proliferation of "preventative interventionism" (Castel, 1991, p. 283) in lieu of rehabilitative efforts (Lupton, 1999). Within a governmental framework, those identified as high risk are expected to self-govern their actions to prevent risk. If unable to do so, they are positioned within "a network of surveillance, monitoring, and intervention" (Lupton, 1999, p.

116). In effect, risk has shifted from a disciplinary examination of the individual to a governmental consideration of risk factors, such that entire populations are managed for risk, as opposed to the micro-management of potentially dangerous individuals. Such an order, Castel (1991) argued, "is no longer obsessed with discipline; it is obsessed with efficiency" (p. 295).

With this shift to a population-focused, governmental consideration of risk, one which moves away from individual notions of dangerousness, risk is viewed as quantifiable and calculable (O'Byrne, 2008). Foucault (2004) illustrated this point in describing the difference in management of smallpox to that of leprosy. Historically, the management of smallpox, via vaccination, was viewed in statistical terms; the risk of a child contracting the illness could be quantified, as could the risk of death. Vaccination of large portions of the population was demonstrated to lower the risk of both contracting and dying from the illness. While individual illnesses and deaths occurred, and were to be expected, the overall management of the illness on a population level was achieved. In contrast, leprosy eschewed this governmental approach for one of discipline. All individuals diagnosed with leprosy were separated from the rest of the population, closely monitored, and treated. Such an approach is not one focused on risk, but on dangerousness. Contemporary risk assessment tools, used to predict the risk of recidivism of IPs, should they be released into the community, adopt this governmental, statistical approach to risk. These tools aggregate empirical analyses of data, which are then applied to specific populations of IPs.

The paradox presented here with this governmental notion of risk is the empirically validated recognition that aging IPs, including aging IPCSOs, represent, statistically, a very low risk to reoffend if released into the community. Such data, recognizing the inverse relationship between age and criminal behaviours and the particularly low rates of sexual recidivism would

suggest that aging IPs, including those convicted of sexual offences, should receive early release from prisons at a high rate. Of course, this is not the case (Ollove, 2016). Lupton (1999) tied perceptions of risk with Kristeva's (1982) concept of abjection. Lupton stated that "strategies of exclusion directed at 'risky' individuals or subgroups are often explicitly concerned with maintaining bodies within certain geographical limits" (p. 145). There is no more certain maintenance of a body with geographical limits than indeterminate incarceration. Despite evidence to the contrary, aging IPs, particularly IPCSOs, are perceived as high risk; abjection and the desire to secure boundaries justifies their ongoing detention. These monstrous individuals are not perceived in accordance with their statistical level of risk. Instead, abjection contributes to these perceptions. The monstrous other, by means of their deviant subjectivity, threatens to penetrate or contaminate the clean and proper subjectivities of the non-monstrous. Protective barriers, such as prison walls, must be maintained to ensure they do not disrupt the order of the outside world. As Shildrick (2002) noted:

> We understand that a contaminated object is one to be avoided or kept at a safe distance, lest we too become affected, our bodies opened up to the forces of disintegration. Our well-being, our very lives, are dependent then on the maintenance of a self-protective detachment, an interval not only between ourselves and evidently dangerous others… but also between ourselves and the mere potential of risk (p. 69).

A poststructuralist framework provides the theoretical basis from which this research project is developed and informs both the methodology and analysis of data collected. The concepts of subjectivity, discourse, power, abjection, monstrosity and risk provide a framework for the investigation of aging IPs in the Canadian federal prison population, the perspectives of CSC staff who work with this population and the obstacles that are faced in both providing

healthcare services and accessing early or compassionate release. This theoretical framework supports the methodological and analytic framework of the study, to be explored in the following chapter.

Chapter 4: Methodological Considerations

Design

Thematic Analysis

The research design to be used in this study is thematic analysis, specifically the methodology proposed by Reissman (2008). Thematic analysis is a form of narrative inquiry. The concept of a narrative is, according to Reissman (2008) varied, ever-changing, and dependent upon the theoretical framework in which it is considered. Put simply, a narrative is a story, one composed by an individual interview participant, or collected from written materials, or even based upon observations. Within this methodological framework, Reissman (2008) described 3 'nested uses' of the term narrative, "the practice of storytelling (the narrative impulse…); narrative data (the empirical materials, or objects for scrutiny); and narrative analysis (the systematic study of narrative data)" (p. 18). Narratives are collected, in this study via interviews with participants, the narrative data is identified and then subsequently analysed.

Narrative methods provide opportunity to analyze the intersection of personal encounters with social institutions, such as hospitals or prisons (Ewick & Silbey, 2003; Reissman, 2008). As Reissman (2008) noted, the construction of stories or narratives are not simple, straightforward processes, but exist within historical contexts, "and they draw on taken-for-granted discourses and values circulating in a particular culture" (p. 13). The stories and experiences of staff working with aging IPs within CSC facilities present a series of narratives that exist within the culture of practice in federal correctional environments.

Thematic analysis is a sub-form of narrative inquiry wherein the 'what' of what research participants say is the primary focus (Reissman, 2008). Such an approach has seen widespread implementation within the nursing literature, including forensic and correctional environments

(Gray & Brown, 2017; Mason, 2002; Stewart et al., 2015). Yet while the focus of analysis may be on the individual narratives provided by participants, they offer potential effects beyond the individual towards collective action (Reissman, 2008). Qualitative interviews are a common form of narrative examined via thematic analysis. Several interviews with participants are analyzed – a specific minimum or maximum number is not prescribed – and, initially, considered one at a time. Subsequently, as outlined by Reissman (2008):

> After the process has been completed for all interviews, the researcher zooms in, identifying the underlying assumptions in each account and naming (coding) them. Particular cases are then selected to illustrate general patterns – range and variation – and the underlying assumptions of different cases are compared (p. 86).

The intention is not to tally a distribution of participant perspectives, but instead "to map the contours of the interpretive process" (p. 86). A theoretical framework – in this case, a poststructuralist perspective – is then mobilized to interpret the narratives provided. The broader context in which individual accounts have been presented is then considered.

Thematic analysis permits sociological consideration of the complexities of participants' daily lives within their institutions. As Reissman (2008) noted, with this methodology "complex and fluid relations of power are made visible" (p. 90). The work of Ewick and Silbey (2003) is presented as a salient example, wherein the authors use thematic analysis to examine individual citizens' resistance to sources of authority. These authors mobilized a Foucauldian conceptualization of power – and subsequent resistance to power – to explore how power relations shape and affect the lives of those navigating complex systems of power.

This research considers the experiences of CSC staff in their interactions with aging IPs in correctional settings. However, the mobilization of a thematic analysis methodology within a

poststructuralist theoretical framework requires critical examination of this concept of experience, itself a concept typically viewed from a phenomenological perspective. Some poststructuralist theorists have argued that an examination of experience is incompatible from this theoretical lens (Butler, 1993, Scott, 1992). Scott (1992), for instance, argued that experience is typically viewed as an ahistorical concept, independent of time and space. This would suggest that phenomenological experience is pre-discursive: that it exists prior to encounters with power relations and discourses. However, as Stoller (2009) identified, a methodological examination of experience from a poststructuralist perspective is possible. What is necessary is an acknowledgement that these experiences themselves are produced within the context of power relations and discourses – that they do not pre-exist these forces. In this research, it is recognized that participant experiences exist within the context of power relations and discourses – that what participants share as their experiences do not and cannot exist independent of this context.

Thematic analysis is a well-developed research design centered around the examination of individual narratives. These narratives are then considered from a broader context via a defined theoretical perspective. A narrative in this application of the methodology does not require thorough examination of an individual extended account but can consider multiple segments of individual texts (Ewick & Silbey, 2003; Reissman, 2008). The individual account provided by a participant is of less concern than the overall 'moral' of the story. As Reissman (2008) concluded, "an investigator can link every day, seemingly insignificant acts that people engage in… with social change processes" (p. 94). The local, micro contexts of individual narratives are of less interest than the broader, macro context. Such an approach is particularly important when conducting research across multiple correctional facilities. Given the importance of maintaining participant confidentiality, as will be explored in greater detail below, the

specifics of an individual participant within an individual institution cannot be thoroughly explored. Instead, the collection of narratives together will provide opportunity to better interrogate the broader context of CSC staff experiences with aging IPs across multiple institutions.

Setting and Sampling

Conducting research within correctional facilities presents a number of unique logistical and ethical challenges (Apa et al., 2012; Waldram, 2009). Correctional staff, including nurses and corrections officers, administration, and incarcerated persons often share a distrust of outside observers (Patenaude, 2004). Correctional institutions and their review boards may erect obstacles to researchers attempting to gain access to facilities, staff, and inmates, and may place embargoes on research findings barring institutional approval (Perron et al., 2015; Waldram, 2007). This study utilized a public recruitment strategy, locating volunteers from CSC without working directly with the agency to avoid the aforementioned research challenges. This research was not conducted within any CSC institutions. Geographically, recruitment permitted participants from diverse settings across Canada.

Recruitment

To develop an in-depth understanding of working with aging offenders and compassionate (or other forms of early) release within CSC, recruitment from a number of correctional staff disciplines (beyond nurses) was included. Research ethics approval allowed for up to five participants from each of the following disciplines: nurses, physicians, correctional officers, and psychologists/therapists. Inclusion criteria required that participants had worked full or part time in a CSC setting for six months or longer, or who had worked in such a capacity in these settings over the past five years at time of recruitment. Further criteria included they had

worked with incarcerated persons convicted of sexual offenses and have worked with aging IPs (those over the age of 50). Given that compassionate release is rarely utilized in CSC (OCI, 2020), specific experience with this process was not required for participation.

Neither narrative inquiry nor thematic analysis prescribe a specific sample size, but instead aim to understand the perspectives of multiple participants. This methodology collects the perspectives of participants to further develop an understanding of the broader, or macro context in which their experiences exist (Reissman, 2008). With an aim to conduct an in-depth exploration of this research project, a diversity of perspectives from multiple disciplines is necessary. A sample size of up to 20 participants across the four identified professions was indicated as sufficient to collect a diversity of perspectives. Follow up interviews to clarify elements of initial interviews or to further explore specific topics identified during data analysis were also approved by research ethics, if necessary.

Multiple forms of public recruitment were ultimately utilized in this study. Initial research design relied primarily on facilitation of recruitment through professional agencies representing the four professions included in this study. Given the primary researcher's geographical location in Alberta, this phase of recruitment centered primarily on local provincial agencies. For the recruitment of nurses, this phase included contacting the College of Registered Nurses of Alberta (CRNA) and the College of Registered Psychiatric Nurses of Alberta (CRPNA). In Alberta, and across western Canada, both Registered Nurses (RN) and Registered Psychiatric Nurses (RPN) work in correctional facilities with a similar scope of practice. Registered Nurses working in Alberta can self-declare their area of practice and can indicate if they permit receiving information from third parties regarding research participation; when working with CRNA to contact potential participants, a limited number of RNs were identified,

with contact information provided. These individuals were emailed about participation in the project, with an attached research project poster (APPENDIX A). The CRPNA was contacted via email but indicated they were unwilling to facilitate dissemination of research project information to its members, with no specific explanation provided.

For the recruitment of psychologists and therapists, the Psychologists' Association of Alberta (PAA) was contacted regarding this research project. A small advertisement about this project was placed (free of charge) on the PAA website's classifieds page. For the recruitment of correctional officers, facilitation was attempted via the Union of Canadian Correctional Officers (UCCO). In the early planning stages of this project, the UCCO was contacted, via email, about their ability to facilitate recruitment, and indicated a willingness to do so. Upon receipt of ethics approval and initiation of the project, however, the UCCO did not respond to requests and, ultimately, did not facilitate any participant recruitment. Similarly, for the recruitment of physicians, the College of Physicians and Surgeons of Alberta (CPSA) had initially indicated a willingness to facilitate recruitment via their member newsletter. However, upon receipt of ethics approval and provision of their office with information on this project, they indicated that this project did not meet the guidelines for publication. Again, despite initial indications that the CPSA could facilitate participant recruitment, this did not occur. While initial efforts at recruitment began with Alberta-based agencies and organizations, this approach failed to produce any significant interest in this study.

The second, and more successful method of participant recruitment was via stakeholders and gatekeepers working with CSC. Over years of work and research within forensic nursing settings, the primary researcher in this project has developed an extensive network of colleagues and contacts across Canada. As per research ethics approval, several of these individuals were

contacted, via email, about the study and were asked to disseminate project information throughout their networks. This method of recruitment proved more productive; several interested individuals contacted the primary researcher indicating they had received information via these networks.

The final form of recruitment utilized in this project was snowball recruitment, which utilizes one participant to recruit additional participants. This method, according to Speziale et al. (2011), is particularly useful when recruiting participants proves difficult. In this method, individuals who participated in interviews were asked to consider colleagues or co-workers (past or present) who might be interested in participation. Through this method of recruitment, some individuals contacted the primary researcher directly, via email or telephone. In other cases, contact information was provided to the primary researcher, with interested individual's permission, and these individuals were contacted via email or telephone, depending on their preference. This method of recruitment, along with the use of stakeholders and gatekeepers, facilitated most of the participant recruitment, resulting in a wide range of participants from across Canada.

Individuals who did express interest in participating were provided with the informed consent document (APPENDIX B), which outlined the details and goals of the project as well as parameters of the research project and given opportunity to ask any questions or express any concerns prior to participation. The importance and commitment to participant confidentiality was emphasized to all individuals who expressed interest, including the steps taken to ensure confidentiality. As per research ethics approval, participants who were actively working with CSC were asked to not use their CSC email addresses for any contact with the researcher, or to conduct interviews during their CSC working hours. Participants were given the option to

conduct interviews via telephone, on secure web platform (Zoom), or in person if they were located within Alberta. No reward or compensation was offered to participants.

Obstacles to Recruitment

As previously explored, conducting research within correctional institutions and with staff of these institutions presents myriad challenges and obstacles. As outlined, multiple forms of recruitment were utilized to find participants, as agencies who initially indicated a willingness to facilitate recruitment were of limited to no assistance in this matter. Additionally, the use of a public recruitment approach, as opposed to seeking official ethics approval and cooperation from CSC, created further obstacles. A number of individuals contacted the primary researcher expressing interest in participation, however, upon learning that this project was being conducted outside of official CSC approval, the majority of these individuals either declined participation or simply ceased communication. Similarly, some individuals who expressed interest in participation stated they would ask their supervisor/manager at CSC if they were permitted to participate. In all cases, these individuals did not participate. Furthermore, some individuals who expressed an interest in participation, upon learning that the study was being conducted without official CSC approval, indicated that their conditions of employment with CSC forbade them from participation. Some of these individuals indicated that their employment with CSC could be terminated if it was discovered that they had participated. Many of the individuals who did participate indicated concern about confidentiality, and the potential repercussions if it was discovered that they had participated in this research project, outside of CSC approval.

Data Collection

Participants

In total, 13 interviews were conducted with participants who met the inclusion criteria, representing all four of the proposed professions (nurses, physicians, correctional officers, and psychologists/therapists). These individuals worked (either at the time of participation or in the five years previous) in a variety of CSC settings across Canada. These included maximum, medium and minimum security facilities, halfway houses, and regional hospitals and psychiatric facilities. A breakdown of these numbers according to profession or site(s) of practice is not provided. Given that multiple participants indicated concern about potential repercussions for participation, all efforts have been made to ensure confidentiality, including exclusion of their profession or site(s) of practice in the presentation of data. Similarly, demographic information about participants, such as age, gender, or years of experience working in CSC are not presented here. Participants expressed concern that even the inclusion of this basic information could make it possible for them to be identified.

Interviews

All interviews were conducted in English. Interviews with participants included all three options for format, as chosen by each participant: telephone, online (via Zoom), and very few in-person. Interviews were semi-structured, following several guiding questions (APPENDIX C). However, interviews were also open-ended and flexible, allowing for deeper exploration of specific topics, the use of examples from practice, and following lines of inquiry not initially outlined in the interview guide. Interviews typically began with an exploration of a participant's role in CSC, site of practice and the IP populations they worked with. From here interviews often diverged from the set of guiding questions, though the essence of these questions was addressed with all participants at some point of their interviews. Notes were taken during interviews to

highlight areas for further exploration, and to guide future interviews. As interviews progressed and new issues emerged, some topics received greater discussion, whereas others received less, specifically as the primary researcher grew more familiar with the roles of staff within CSC facilities and many of the policies and procedures were discussed. Depending on the experiences of the individual interviewee, topics of discussion at times shifted. For instance, some participants had considerable experience working with IPCSOs but less experience with compassionate release. The primary researcher also allowed for extended pauses and the strategic use of silence during interviews, which often led to participants further elaborating on specific topics.

Informed consent was received by all participants prior to starting interviews. All interviews were audio recorded and immediately transferred to the primary researcher's password protected laptop from the recording device. When the secure online platform Zoom was used for interviews, these interviews were recorded both by the platform and on a recording device. The video and audio components of these online interviews were saved to the primary researcher's password protected laptop, and not to the available online storage offered by Zoom. In-person interviews were conducted in private spaces of the participants' choosing to ensure confidentiality. Telephone and online interviews were conducted in the primary researcher's private home office, and all interviewees indicated they were participating from private spaces. Interviews varied in length between 25 and 105 minutes, with an average interview length of 41 minutes. Length of interviews primarily corresponded with the level of experience an individual had with the various elements of this study. All participants agreed to the option of follow-up interviews; however, these were deemed unnecessary as data analysis progressed.

All interviews were transcribed verbatim. A professional and trusted transcription service was used for 9 of 13 interviews. The remaining interviews were transcribed by the primary researcher at the request of participants, who wished to ensure minimal sharing of their data. Audio and transcript files were shared between the professional transcriber and primary researcher using a secure and temporary file-sharing program. This transcriber has more than 25 years of experience working with Research Chair Professor Holmes and possesses extensive understanding of the importance of confidentiality with sensitive data. Transcript files were saved on the primary researcher's password protected laptop. All transcripts were verified via multiple re-listens of each audio file. A single copy of each verified transcript was printed for use by the primary researcher.

While the length of formal interviews were between 25 and 105 minutes, discussions with the majority of participants were much longer than these times indicate. Some of this time was dedicated to reviewing the informed consent form and answering any questions the participants had. However, much of the non-recorded time with participants included discussions of participants' concerns regarding confidentiality and the personal and professional implications of being 'found out' of their participation. At the conclusion of the formal interviews, many participants described information and/or incidents that they did not feel comfortable sharing in the recorded interview. This information is not included in the formal results of this study, however it was helpful in providing greater context to participants' experiences.

As a result of these discussions, particularly around concerns for participant confidentiality, it became clear that protection of their identities was paramount. The non-disclosure of basic demographics, sites of CSC work experience, and non-identification of participants' professions in this document is aimed at the protection of participant identities. The

consequences of being identified as a participant from disseminated data were described as potentially severe by some participants, including termination of employment. Furthermore, in the presentation of interview data, all efforts have been made to anonymize or generalize information. Names or other descriptors have been removed, and many quotes have been modified and/or had specific elements omitted in a manner that presents the essence of the quotation while working to ensure confidentiality. While the richness or poignance of specific quotes may have been compromised in this process, the confidentiality of participants is of greater importance. As noted above, a thematic analysis focuses not on the local context of a participants' experiences, but on a broader, macro context; such an approach permits the omission of workplace/institutional specifics to ensure confidentiality.

Data Analysis

Data analysis in thematic analysis consists of in-depth review of the collected narratives and subsequent identification of themes (Reissman, 2008). Data analysis occurred concurrently with data collection, and informed subsequent interviews. Transcription occurred shortly after interviews were conducted, and verification and analysis of these transcripts occurred simultaneously with subsequent interviews. Thematic analysis involves the review of data sets – in this case, interview transcripts – to identify themes that repeatedly occur (Reissman, 2008). Multiple readings of transcripts occurred, with notes taken or written on the transcript papers themselves. This process resulted in the identification of common themes and related sub-themes. Transcripts were then re-examined, and relevant sections of interviews coded based on these themes and sub-themes. Specific quotations from interviews were assembled to illustrate both the general patterns of participant contributions, but also allow for an examination of underlying assumptions. Ultimately, results were organized into four key themes, with

subsequent sub-themes identified for each. Finlay (2021) outlined six stages of data analysis: first, to become familiar with the data, second to develop rudimentary codes, third to search for themes, fourth to review these themes, fifth to both define and name these themes, and finally to write-up these themes. This process was followed in this study.

The narratives offered by participants allowed for critical examination of the contexts in which they occurred and the power relations in which they are situated. As Ewick and Silbey (2003) offered:

> Narratives are fluid, continuous, dynamic, and always constructed interactively – with an audience and within a context – out of the stuff of other narratives. They are produced retrospectively (with some previous narratives in mind) and prospectively (with some audiences in mind) (p. 1343).

As the sole interviewer of participants, my role must be considered here. Participants recognized that I was someone with some level of familiarity with the settings and populations they were describing, and, at times, they were asked to elaborate on information provided so as to provide greater context for those who are less familiar with the setting. At the same time, participants recognized that the information provided could be made public in dissemination and, despite assurances that specifics would be generalized, many were hesitant to elaborate on specific situations (or narratives) out of concern that their identities could be determined. This, in itself, facilitates understanding of the complex power relations in which CSC employees exist, to be considered in much greater detail below. In this sense, not only did the specific details of what participants described provide insight into their experiences in working with aging IPs related to the research questions of this study, but the broader, ‘macro’ power relations, subjectivity formations and discourses could also be interrogated.

Thematic analysis thus permits an examination of the power relations present within the CSC setting, and the role discourses played in the production of subjectivities, and subsequent practices associated with these subjectivities. According to Perron and Holmes (2011), "discourses shape the way nurse-patient relationships emerge and produce effects. In Foucault's view, discourses, like power, are productive because they make possible the creation of social categories and social practices" (p. 193). The way nurses and other professions described IPs, and each other, is productive. It produces categories, assumptions, practices, and expectations around those subjects. Discourses and power relations form a dialectic relationship to shape the subjectivities and practices within a specific context and setting. Of particular interest in this research was how nurses and other professions produced the subjectivities of aging IPs, including those convicted of sexual offenses, and how those subjectivities affect practices. For example, were the discussions of nurses and other professions different for aging IPs convicted of sexual offences compared to those convicted of other offences? If so, did this influence the practices around this category of IP? Were nurses and other CSC staff less likely to advocate for compassionate release of an aging IPCSO? A thematic analysis of transcribed interview texts allowed for an examination of these texts to better understand the power relations, discourses, and subjectivity productions that exist within CSC facilities.

Trustworthiness and Rigour

The question of trustworthiness in qualitative research is contentious, with some arguing that it is incompatible with qualitative methodologies (Rolfe, 2006; Tobin & Begley, 2004). In lieu of assessing the trustworthiness of a thematic analysis research study, scholars have instead suggested qualitative studies be assessed according to their rigour (Finlay, 2021; McCloskey, 2008). As Finlay (2021) proposed, "rigour asks if the analysis has been competently managed

and systematically worked through. Do the findings match the evidence in a convincing way? Have the knowledge claims been tested and argued for?" (p. 110). In this study, the data was reviewed and analyzed multiple times, themes were identified, and individual quotations attributed to each. Extensive presentation of data is provided to illustrate all proposed themes. As will be further explored in the discussion chapter, the results of this study do match the existing literature on the subject. In the following presentation of results and analysis, these criteria are followed. These guidelines provide a framework to ensure interpretive rigour when analysing data and forming conclusions. In particular, though the topic of compassionate release has not been well explored in the literature, correctional settings, their social practices, power relations, discourses and subjectivities, and inter-professional dynamics have been well explored in the Canadian context (Holmes, 2005; Jacob, 2012; Perron & Holmes, 2011). These studies provided guidance in ensuring interpretive rigour was maintained in this research.

Ethical Considerations

Ethical considerations are critical when conducting research in correctional settings; data collection often focuses on sensitive information, and the maintenance of confidentiality of participants, be they staff or IPs, is of critical importance. (Apa et al., 2012; Patenaude, 2004). Ethical approval from the University of Ottawa was be obtained prior to conducting research, which outlined the measures taken to ensure participant confidentiality (APPENDIX D). As a result of the described recruitment challenges, the one-year ethics approval provided was renewed (APPENDIX E) to facilitate additional participant recruitment.

The topic of this research was recognized as potentially sensitive or traumatic to participants, who were asked to describe potentially challenging experiences in the correctional setting. Participants were briefed prior to commencement of interviews, informed consent was be

obtained (Appendix B), and information regarding workplace counselling services was provided. As noted above, many individuals expressed reservations about participation and sharing of information, noting concerns about the consequences of their participation being 'found out.' Prior to commencement of formal interviews, the multiple steps taken to maintain confidentiality were reviewed with participants, including the steps taken to ensure recordings and transcriptions remained private, the use of a professional and trusted transcription service, and that only the primary research team would have access to unmodified data. Furthermore, participants were briefed on the steps taken in the dissemination of data, such as masking of participant identities and modification of direct quotations. This modification of direct quotes included the omission of any participant, co-worker or IP names, omission of the names and locations of CSC sites being discussed, masking of participant professions, and modification of quotes to minimize the potential the any individuals could be identified. This information was conveyed to participants prior to the start of formal interviews, as part of the informed consent process, but was reiterated when formal interviews concluded. In some cases, participants asked that their interviews not be transcribed via the professional transcription service; in these cases, the primary researcher transcribed these interviews. When contacting participants (and potential participants), they were encouraged to use personal email and/or telephone numbers. If persons did use a CSC email address, they were asked to switch to a personal email address for any further communications. Participants were asked, if conducting interviews via telephone or online, to not do so from CSC facilities or during CSC work time. No CSC facilities were visited in the collection of data. As recruitment of willing participants proved challenging, as described above, a renewal of ethics approval from the University of Ottawa to ensure a suitable number of participants was obtained.

Given that a large proportion of the federal prison population in Canada is comprised of Indigenous IPs (Public Safety Canada, 2023), it is necessary to acknowledge that exploration of participant experiences with this population occurred in this research. While this research did not specifically explore this particular population of IPs, they were discussed by participants. Aveling (2012) cautioned that non-Indigenous researchers must recognize that conducting research with these population risk the perpetuation of colonial approaches. The concluded that non-Indigenous researchers should instead ally with Indigenous researchers to conduct any work with these populations. Datta (2018) emphasized the importance of collaborative approaches with Indigenous communities when conducting research. Given that such measures were beyond the scope of this research project, it is necessary to explore any issues of Indigeneity in the federal prison population in a respectful manner, while acknowledging my status as a non-Indigenous researcher.

Chapter 5: Results

This chapter presents the results of data collected from participant interviews. These results are organized into four themes, including an in-depth examination of aging incarcerated persons in CSC facilities, the prison environment itself, release from prison of aging IPs, and an exploration of risk. These themes are subsequently categorized into sub-themes.

Participants presented a diversity of perspectives from a wide range of practice settings, including maximum, medium and minimum-security facilities, as well as halfway houses. Levels of familiarity or experience with the various foci of this study varied. For instance, some participants had direct experience with all elements of this study: working with aging IPs, working with IPCSOs, and compassionate and other forms of release. Other participants had never contributed to or been part of a compassionate release request. All participants, however, had experience with aging IPs, and all had at least minimal experience with aging IPCSOs.

Degree of specificity of information provided by participants varied. Some participants were very candid and open in discussing their sites of work and the IPs with whom they worked. Some even named specific IPs, particularly those who were considered high profile. Other participants were guarded and careful in how they spoke about their work and experiences. In an effort to ensure the confidentiality of all participants, data presented here has been disguised or altered, or portions of quotations omitted, where necessary, such that participants or the IPs with whom they work, or the site at which they work(ed) cannot be identified via their contributions, as suggested by the American Psychological Association's most recent publication manual (American Psychological Association, 2020). Any alterations or omissions have been made with an intention to best maintain the spirit of the participant's contribution.

Table 1

Themes and Sub-Themes

Aging Incarcerated Persons	**The Prison Environment**	**Release from Prison**	**Risk**
What constitutes old	Levels of security	Types of release	Aging IPs
Older IPs – who they are	Health services provided within CSC facilities	Compassionate release	Aging IPCSOs
Aging IPCSOs	Infrastructure concerns	Other forms of release	Risk: public perception
Risks and vulnerabilities	Staffing concerns	Site of release	
Physical and mental health concerns of aging IPs	Knowledge concerns	Finding community placements	
	Care in CSC healthcare facilities	Institutionalization	
	Escorted temporary absences	Preparation for release	
	Negative attitudes towards aging IPs	The Parole Board of Canada	
		Post-release monitoring	

Theme 1: Aging Incarcerated Persons

All participants had direct experience working with aging incarcerated persons (IPs), including some degree of experience in working with aging incarcerated persons convicted of sexual offences (IPCSOs). Participants described the characteristics of this prison population, the physical and mental health concerns specific to this population, as well as their specific vulnerabilities within institutional settings. The majority of participant contributions related to male IPs, though some had experience working with female IPs. The sub-themes of this over-arching theme are explored below, including what constitutes ‘old,’ older incarcerated persons – who they are, aging incarcerated persons convicted of sexual offences, risks and vulnerabilities, and the physical and mental health concerns of aging incarcerated persons.

What Constitutes 'Old'

Participants noted that the overall prison population in CSC facilities is aging. Participant 1 stated that "it feels to me like the population is getting older." Participant 9 also noted "that there's definitely an aging population within CSC" and went on to suggest "that's going to get bigger and bigger." It was also suggested by Participant 13 that "our population is aging quickly."

When asked what age constituted 'old' for IPs, participants generally agreed that anyone over the age of 50 is considered to be 'old.' Participant 13 stated "in terms of what is considered geriatric within CSC, it's anybody over the age of 50, although we do have some guys on geriatric units that are under the age of 50." This participant stated that "CSC has had guys that are over 90." Based on experience, it was suggested that "when we talk older I guess we probably look at is as probably like 55 plus" (Participant 3). Those considered 'old' in CSC facilities, particularly those housed on geriatric units, are described as being 'retired' and not required to engage in programming offered by the institution:

> They're basically quote-unquote retired, right? They're not necessarily required to work, they're not required to necessarily, I mean we would love for them to engage in stuff but they really just kind of, for lack of a better word, sit there and rot. (Participant 13)

Not only are those over the age of 50 (and, at times, even younger) considered 'old' within CSC facilities, those over the age of 50 may not be obligated to engage in any form of work or programming.

Multiple participants spoke of the effects of incarceration on the aging of IPs. Participant 2 suggested that:

> Lots of them age faster than other people that you see outside of jail, because of like drug use, like difficult life situations that they've had in their lives, so I would say that after 50 they usually have more health problems.

Participant 8 supported this position, stating "we definitely have people 50 and over and I do feel like being in prison does age a person a lot." Even those under the age of 50 show signs of aging, as Participant 4 observed "sometimes it's hard to tell, because I do find that, you know, the hard life, they age faster and you're surprised, you're like 'oh you're only 40, but you look 50 plus.'" A consensus among participants on what constituted 'old' in CSC facilities was 50 and older, and many suggested that challenging lives both within and prior to incarceration were to blame for this perceived acceleration in aging and onset of health problems.

Older Incarcerated Persons – Who They Are

Many participants identified commonalities amongst the older – over the age of 50 – population in CSC facilities, primarily based on their convictions and legal statuses. Significant crimes, such as homicide or sexual offences, and being designated as a dangerous offender (often simply a 'D.O.' to participants), or being on a life sentence (often described as 'lifers' by participants) were often associated with those being incarcerated at an older age.

Those IPs serving life sentences were described as those who often reach an end-of-life or palliative stage while incarcerated. Participant 12 suggested that this status is very common "particularly amongst the lifers." Participant 6 stated "some of these guys are older and they spent most of their lives in jail and you know they have to face the fact that they're going to die in jail."

Life and indeterminate sentences were often associated with more serious crimes, such as homicide or sexual offences. With such offences, IPs were more likely to remain in prison into

old age. Participant 1 identified one individual as "an old timer who had done virtually his entire life incarcerated." Participant 12 observed:

> I'd be hard-pressed of a single case where the incident or index offence for someone – I'll say 60 or older – where they, it was homicide or sexual offences. Very, very rarely you see anything else. I actually would be really hard pressed to think of a case that I've seen that was something else. Very, very rarely.

Many of those entering CSC facilities later in their lives, as opposed to as young adults, were described as having historical convictions for sexual offences. Participant 12 described those with convictions of sexual offences:

> It was very, very predictable: for instance, if someone was 60 something plus and first time offence, a hundred percent accordance rate, actually. They were there for a historic offence, that's what they were there for.

Participant 12 went on to state that "most of the really aging offenders, they were grossly disproportionate to sex offenders. Grossly disproportionate." Here this participant noted that those entering federal prisons for the first time at an older age almost exclusively were convicted of sexual offences that had occurred years, if not decades prior. Participant 3 mirrored this observation, stating "the older ones that we do get, I'd say would typically be sex offenders." The IPs described by participants who entered and/or remained incarcerated into old age were identified as having convictions for homicides and/or sexual offences.

Dangerous offenders comprised a group of IPs who remain in prison into old age that were widely discussed by participants. As Participant 13 observed "if they're a DO, which is a dangerous offender, or they're serving a life sentence, technically, I mean: they're under CSC control until the day they die." Many older dangerous offenders remained in maximum security

settings due to concerns about risk. As participant 10 suggested "usually the reason that they were still in the maximum was that because they were still involved in assaults and stuff like that. You know, stuff that would not allow them to cascade in their security level." Many of these individuals, as Participant 11 suggested "couldn't be housed anywhere else." Participant 13 offered insight who becomes designated as a dangerous offender, stating "dangerous offenders are largely sex offenders." Becoming designated a dangerous offender often occurs after the age of a young adult. Participant 13 continued:

> We're getting more and more where the average age of someone getting DO'd is in their 40s, right? Late 30s, early 40s, so they're already reaching what we consider a geriatric age and that's only when they're coming into the system.

Because of their indeterminate sentence, Participant 13 concluded "we have to, ah, we keep them, and they eventually die in prison." With aging, even those designated as Dos were described to present less risk. Participant 5 described this change:

> Some of these guys are people who have been incarcerated for an immense amount of years… maybe they were really dangerous offenders at one point but now they can't really do much anymore – they require a lot of healthcare.

Those serving indeterminate sentences, such as those with life sentences or designated as dangerous offenders comprise a large proportion of the older prison population, and these individuals were identified as most likely to remain incarcerated into old age and to the point where they may die in prison.

An additional group of IPs identified by participants as making up the population of older individuals were Indigenous men. Participant 1 described the older IPs in a facility as "primarily Indigenous." Participant 13 also described the aging IPs in a setting as "mostly Indigenous."

Participant 13 went on to describe the context in which many Indigenous IPs who age and/or die in prison:

> We need to make this right, because every elderly Indigenous person who attended residential school that dies in prison is like, you know, like that's the perception is, is that it's not right and a lot of these guys that were DO'd back in the 80s when the legislation was very different would not meet criteria to be DO'd today. And, so, their crimes are minimal in comparison to many of the crimes that are occurring in the last couple of decades, or well last decade and therefore there's the perception of, like, oh there's a lot worse that aren't DO'd. We had this guy in his 60s, he'd been DO'd for 30 plus years on offences that would have never, if he was trialed today got him DO'd, so why do we continue to keep him incarcerated, right?

Participant 1 added to this context, stating "there is the Gladue factors, that's part of that cycle of abuse, sexual abuse that started with colonisation… There's a certain perspective that's important… that they've been abused themselves." Participant 7 added:

> The over-representation … in maximum security with… Indigenous folks, so you know everything is layered, right? So, you have an older Indigenous man, so two strikes against him, who's committed a sexual offence, right? Because of the racism, you know… someone in the maximum security is less likely to be released.

Many of the aging IPs in the facilities in which participants worked were Indigenous, and participants recognized contributing factors not only to their incarceration, but factors that may have led to indeterminate sentences that would no longer be permitted today. Regardless of these factors, because of the IPs status, they were described as more likely to remain in prison into old age, and to potentially die in prison.

Aging Incarcerated Persons Convicted of Sexual Offences

Given that those convicted of sexual offences are a high proportion of persons incarcerated over the age of 50, participants were asked to describe this population in more detail. Primarily, participants described the special or specific considerations of this population, separate from those convicted of other offences, as well as the specific risks they face, which will be explored in further detail in the following sub-theme.

Participants described the hierarchies that exist amongst IPs within the prison environment. As Participant 1 observed "it's like there's kind of the hierarchy, right? If you're a sex offender you're at the bottom." If an IPCSO's crime is discovered or revealed within the prison environment, their treatment is negatively affected. Participant 4 offered "they are not well liked by the general population… if they know your crime, if your crime is like, Googleable, you know, they don't last long on other units." They continued "they get beat up and there's nowhere for them to go, so they go to SIU essentially, or segregation… for their own safety." Because of this risk of violence against IPCSOs, they often get placed in specialized units, and may even be placed in segregation not because they are at risk of harming others, or even themselves, but simply for their own protection.

Some CSC facilities have specific units designated for those convicted of sexual offences aimed at protection from other IPs. As participant 11 suggested, they "couldn't be housed anywhere else – the sex offender unit can offer them proper security from other inmates." This participant suggested that those housed on these specialized units "tended to be an older population. I would say male and probably late 40s to 60s, is the age range I noticed." Participant 6 described similar demographics on a unit dedicated to IPCSOs, stating "they're mostly older men on that unit… I'm not too sure if it's because they are being arrested as older men or

they've been in jail for quite a while that they're aging." The appropriateness of these units at times, however, was questioned. Participant 13 noted:

> It works for someone who offends against females, but not against someone who offends against males. Like, you wouldn't want to put him in a male facility. If anything, you'd want to put him in a female only facility, and it looks weird, but like, he wouldn't, you know what I mean, that would reduce his access to victims because he's not interested in offending against women. But you're never gonna convince the community of that, right?

Because of the risks to this population, specialized units exist within some CSC facilities, though these may not be available at all facilities, or appropriate for all ICPSOs.

Because aging IPCSOs were often older and/or incarcerated at an older age, participants described their admission and transition to the prison environment as challenging. As Participant 12 surmised "they tend not to be highly criminalized folks, they tended most of their lives were going just fine except for this area of sexuality." Because of this lack of criminality, adapting to the prison environment often proved challenging. Participant 7 observed:

> They're usually quite terrified. I mean, they've led pro-social lives, all of their lives, you know… at intake… it's extremely difficult for them. Prisons get very, very noisy and they get very frustrated with younger offenders who are, you know, still trying to position themselves in the hierarchy and playing games… I personally think they don't do very well.

The stressors of the prison environment can have consequences on their wellbeing. This participant went on to ask, "if a person is incarcerated for the first time in their 70s, for an offence 40 years prior, I mean that incarceration is completely unnecessary and isn't risk based." Participant 5 observed "I noticed that the ones that have done sexual crimes in the past, they have

deteriorated faster than the ones that have done like, you know who have killed people… they deteriorated faster than all the other senior population." They continued:

> Life is hard for them in prison, not because of other inmates or because they were being assaulted, but because it was always that they were trying to defend themselves as you know, they know what they did. They realize that it's wrong, and they, I felt that they felt the need to defend themselves to other inmates, that they are considered dangerous, you know what I mean… So it's like they're trying to protect themselves, so living a life of protecting yourself, living afraid of life, it has a big toll on people's mental health. And as you get old, you know what I mean, you realize that you can't defend yourself as much, so you deteriorate faster.

Because of their position within the prison environment hierarchies, older IPCSOs spend considerable time and energy in defending themselves, which was described as taking a heavy toll on their wellbeing and mental health.

Difficult circumstances in the prison environment extended beyond the prison population itself. Participant 4 suggested "you would also have to consider they're treated differently by staff as well." In some facilities, as this participant suggested "there are no programs for them." However, even when programming does exist, as Participant 9 suggested:

> Often, they have refused to engage in programming or any kind of rehabilitation, so they don't progress along in their correction plan, they don't reduce their security, they do eventually get to a point where they reduce their security just for the fact of being old, and they're not physically able to do what they used to… There's a number of males who just refuse to accept responsibility or refuse to talk about what they did and so, then they just stay here for a very long time.

Such a situation presents a paradox, wherein ICPSOs may be treated poorly be some staff and not have access to programming, but where more supportive staff and programming do exist, it is refused. Such a refusal may lead to older ICPSOs remaining at a specific site or even remaining incarcerated for longer periods of time, not being eligible for parole or even statutory release, despite opportunities to progress.

An isolation from broader social connections was described by participants about this population. Many lack family or social supports outside of the prison environment, leading Participant 9 to observe that "it's more surprising when they do have supports." These individuals may be further isolated within the prison environment to units designated for those convicted of sexual offences. And despite some efforts amongst staff to engage, Participant 10 observed:

> Usually, the guys there were pretty quiet in the sense that they tried to solve their problems by themselves… they had like the guy who kind of acted as a unit rep for them all, so he would do all the problem solving and mediations on the unit and stuff like that.

Participants observed that IPCSOs were less likely to reach out for healthcare supports, especially older individuals who adhered to so-called "old-school" rules within prison. Participant 10 observed "in old-school corrections more so they don't really reach out to people in mental health. It's more so they figure out their stuff culturally, like on their own." An isolation of ICPSOs was described, and in some cases a specific individual may have been assigned as a liaison between IPs and prison staff.

Knowledge of the specific crimes for which aging IPs were convicted was addressed by those providing healthcare services. Some participants suggested that, if possible, they would not look up or inquire into the specific charges for which an aging IP had been convicted. As

Participant 2 stated, “I don’t want to know.” This was particularly prevalent for IPCSOs, which will be explored in the following sub-theme. However, other participants suggested that knowledge of an aging IPs criminal history was necessary for working with them. Participant 4 suggested that “you always have to consider the person’s background and their criminal history and if they have a history of manipulating the system.” This participant described the case of an aging IP showing symptoms of dementia and asked “it’s hard to tell if they’re faking or not with the dementia.” This concern that aging IPs may be exaggerating of ‘faking’ symptoms of dementia to meet their needs was expressed. In such cases, aging IPs showing symptoms of dementia may be transferred to regional hospitals or psychiatric facilities, where levels of security were described as typically less restrictive than those found in conventional CSC facilities.

Risks and Vulnerabilities

As just explored, aging IPs, especially those convicted of sexual offences, face unique risks and vulnerabilities within the prison environment. These will be explored in greater detail in this sub-theme.

Participants identified the challenges faced by older IPs in general, not just those convicted of sexual offences. Regarding older IPs, Participant 4 observed:

> Because a lot of them are on more medications, especially like more desirable medications to the other inmates, so they can get beat up for their medications. And obviously they’re not as able to defend themselves if they’re older or maybe have mobility or vision issues or whatever the case may be, but they are more likely to be prescribed, like Gabapentin, for example, or pain medications that are like currency in prison.

This issue of prescribed medications being stolen, sometimes forcibly, from older IPs was identified as a concern. Participant 2 stated “inside they really want to have less diversion of medications.” Here, diversion describes prescribed medications being used by someone other than the intended recipient. This is of particular concern with opiates, including those used in opioid agonist therapies. Participant 2 noted that many IPs, mostly younger in age:

> [They] don’t have an opioid use disorder outside, but they start suboxone inside and then, at some point, could be prescribed suboxone inside. The only opiate that they have ever used, or regularly used is suboxone, which is diverted from someone else’s prescription inside. We’ve seen that mostly in younger populations.

Not only is this diversion of medications, including opioids and opioid agonists keeping these medications from being used by the intended recipient, it can create substance use concerns for those who are receiving these diverted medications. And older IPs are typically the targets for this diversion. Participant 1 noted that:

> Geriatric inmates are vulnerable. That, as you would call it, they get charged ransom, right? If someone is, if they can’t make their food and someone volunteers to make their food – no, they’re not volunteering to make the food, right? They’re skimming something off the top or whatever… I know an inmate who got tasked with pushing a wheelchair around, among his other work duties and he, you know, he was a pretty trustworthy guy and it all made sense… some people help out others for a little bit of rent or tax.

Participant 13 confirmed these challenges for older IPs:

> They also become more vulnerable when they get older. They get picked on a lot more, they’ll get muscled for their medications, they’re usually on… like pain medications and different stuff. So, they tend to get bullied more, assaulted more, muscled more,

> pressured for their medications. We've had some older gentlemen get pressured for money – a lot of them have residential school and admin seg [segregation] claims and stuff where they receive supplements and so they have a fair bit of money and we'll see a lot of the younger people…prey on them and get them to essentially send their money to these, you know, to people who they don't even know out in the community.

Older IPs were described as being vulnerable to having things taken from them, primarily medications and funds, but even if they required help to conduct basic tasks, such as cooking or mobilizing, they are still having to provide some form of compensation to whomever is assisting them, even if it is voluntary.

Within the prison environment and the hierarchies that exist amongst IPs, some individuals were described as having more influence or authority. Participant 10 described these individuals as "heavies" and continued:

> A heavy, it's someone who is considered, like, kind of powerful and they have, like, they're heavy, they just have a heavy power to them, if that makes sense. And so they're someone that they don't mess with and they're usually the people that run their unit. Usually, they're like gang leaders or have affiliations or they're someone that is just pretty tough who then kind of like runs the unit.

The participant added that older IPs, especially those convicted of sexual offences, typically require placement on specialized units, stating "when they did… go to other units unless they were a bit of a heavy, they would usually be the ones fighting." Unless an aging IP carries a status as a 'heavy' or can defend themselves, they are likely to be placed on specialized units for their own safety.

Other than these described 'heavies,' participants described most aging IPs as presenting few security or management concerns. As Participant 6 noted, "older life guys just want to hang out and don't want to be bothered with people." Participant 10 added that "they do start to quiet down a bit so they are able to cascade in their security." Participant 8 observed that many aging IPs simply want to quietly serve their sentences:

> The older guys I'd say are a bit more relaxed than the younger guys. I feel like they're more understanding of the rules in prison, and there are kind of old-school rules is what they say… older guys are kind of like, we're just here to finish our time, or to just survive… a lot of them are pretty quiet for the most part.

With these aging Ips, particularly those serving lengthy sentences, often comes fewer security concerns, as Participant 12 described:

> If you really want to be in an institution that has almost no incidents, you want to be in an institution that's full of lifers. That sounds totally paradoxical to people from outside. But the reason being is: a lifer – this is their home. They don't want it burning down every day. They don't want riots. They don't want none of that.

Aging IPs were primarily described by participants as less likely to cause issues within the prison environment, and less likely to pose security concerns.

With this shift away from a security focus for aging IPs came an increased focus on their healthcare needs. When an aging IP is admitted to a new facility, Participant 11 noted a focus on "an assessment of their health" more so than an assessment of their security requirements. This shift away from a security mindset was identified even amongst corrections officers. As Participant 5 noted, "they become more like caregivers than actual correctional officers." This participant continued that some corrections officers "actually take pride in saying that, basically,

they're there to assist them." Adding to this shift in focus amongst corrections officers with aging IPs, Participant 6 stated:

> There are inmates that are respectful and kind and they do their time quietly and they let them do their time and no big deal. They get to know some of those guys, build rapport with them and have those conversations with them. And then there's others that see them as the enemy, just as bad as the cops that threw them in jail in the first place.

With these aging IPs and descriptions of officers building less antagonistic relationships, it was described that compassion for them was possible. Participant 6 added that "they get to know them a little bit, some of them and they see it's sad because they didn't have a chance from the get-go… that relationship changes a little bit as they grow older." Participant 7 expanded on this change as Ips age:

> Let's say somebody who committed murder, you know, he'd still have 15 years at least before they're able to apply for parole or perhaps 25, and by the time they get there, they're so far removed from the young person who has committed a crime. I mean, they're just not the same person they were when they were twenty-one.

IPs who receive lengthy sentences, including life or indeterminant sentences, at a younger age will age considerably while incarcerated; participants noted that, as they age, they typically become quieter, more respectful, and uninterested in disrupting the prison environment.

Aging IPs who require aides for daily living, such as mobility aides, face challenges within the prison environment. Participant 13 noted that items like canes are "considered weapons" in prison. Participant 4 stated "some of them have things like walkers, or a cane, or something, which is also, it presents a challenge because quite frankly those things can be used as weapons." Participant 11 described the challenge of placement for individuals requiring a

wheelchair, stating “it is very dependent on the type of unit they were placed on and if that wheelchair was going to be approved, which most of the time it was not.” Aging IPs may have access to mobility aides restricted to minimize the potential for these aides to be used as weapons.

Participants spoke at length of the various risks and vulnerabilities of aging IPCSOs. As explored in the previous sub-theme, these individuals are not well regarded by other IPs or even some prison staff. Participant 6 was frank about the dangers to this population:

> If you have a sex offender on a unit, as soon as staff realize what they’re in for and other inmates have kind of figured it out, it’s really tough for that person. In jail, truly, it can be really unsafe… sex offenders are treated horribly. They will be killed in general population or at least be knocked if they are found out… some guys say if you move any of these people onto this wing, I will kill them. It may not be today, it may not be tomorrow, but eventually when I get the chance, they will be.

Participant 11 observed “sometimes they had targets on their backs.” This required, in some facilities, specific units for those convicted of sexual offences. As Participant 10 suggested “they are placed on a unit together, as themselves, because of the safety issues.” If specialized units for IPCSOs are not available within a facility it can cause concerns for their management. Participant 9 noted if it is “difficult to manage them in a regular institution they have to reside at a regional psychiatric facility.” As noted, IPCSOs face significant danger within correctional facilities, at risk of violence or even death if their convictions are uncovered. This required movement of many individuals, according to participants, to specialized units or to other facilities entirely.

Placement on these specialized units came with its own concerns, however. Participant 7 described the concerns of placing older individuals, especially those incarcerated later in life, onto units that were not entirely appropriate, stating "you don't put the low-risk individuals with the higher risk ones because they come up with things they never would have thought of on their own… with folks who were more criminalized than them." They expressed concerns at the potential for increased criminalization of individuals otherwise considered low risk if placed on a unit with IPs considered higher risk.

Aging IPCSOs were described as wanting to stay quiet on units and not draw attention to themselves. Participant 8 observed:

> The ones who are sex offenders I would definitely say they are more quiet because they don't want to rock the boat or cause any trouble because a lot of those people get attacked – anyone with a sex crime. A lot of them just keep to themselves.

This participant observed that this tendency to keep a low profile meant that older IPCSOs were hesitant to reach out for mental health supports or healthcare needs:

> Some of the older guys, they might not bring it up right away. We've noticed they tend to be more quiet because they don't want to rock the boat. They tend to be, like, I'm just here to do my time, so I feel like they move on.

The rationale for not bringing up concerns, Participant 8 continued:

> A lot of them don't want to be a bother, especially if they're in a maximum-security prison. Meeting with mental health can be a risk in their eyes, because if you're leaving your cell to go talk to an individual maybe on a more regular basis, there have been discussions from other offenders – I can say this for either geriatric or for young guys, but a lot of people feel like they could be, like, to use their words, like a rat. Or ratting out

> something that's going on on the unit if they're having a hard time. So some guys refuse to meet with mental health to just not be associated, because they're worried people will think something of them, or that they're involved in something else. So it's more of a safety thing.

If an aging IPCSOs is experiencing healthcare concerns, especially related to their mental health, they were described as hesitant to utilize supports out of fear that they would be divulging information about fellow IPs to prison staff and be labelled a 'rat.' Participants described aging IPCSOs are existing in fear of being found out for their convictions and being attacked by other IPs, and that this fear had a negative impact on mental health, however prison culture prevented them from reaching out for appropriate supports.

Physical and Mental Health Concerns of Aging Incarcerated Persons

Participants were asked to describe some of the physical and mental health concerns they had observed in aging IPs, including those convicted of sexual offences. A wide range of issues were identified and are explored in greater detail in this sub-theme. In this section, many of the participants described specific individuals dealing with various physical and mental health challenges. To ensure the confidentiality of both participants and the IPs being discussed, much of the information in this sub-theme is presented as summaries of participant contributions; direct, verbatim quotations have been modified in many cases.

Participants described a wide range of chronic health conditions common amongst aging IPs. Among those conditions identified included dementia and Alzheimer's (Participant 1, Participant 4, Participant 6, Participant 8, Participant 10, Participant 13), chronic pain (Participant 2, Participant 4), vision concerns (Participant 8), Parkinson's disease (Participant 1), diabetes (Participant 2, Participant 4), amyotrophic lateral sclerosis (ALS) (Participant 9), and

chronic obstructive pulmonary disease (Participant 2). Participant 9 added "there can be cancer, there could be liver failure… I've worked with liver and kidney failure… heart problems." Participant 5 noted that IPs over the age of 50 "require a lot of health care." Overall, Participant 4 surmised:

> A lot of our older ones do have more health complaints in general, but that's, I mean, I think that's expected, right? They do have more, you know, chest pain and heart issues and diabetes and just pain in general.

All of these conditions were described as requiring care for aging IPs.

Associated with many of the health concerns of aging IPs, as described by participants, were mobility issues. Participants 2 and 5 described working with aging IPs who required the use of wheelchairs. Regarding aging IPs, Participant 13 offered:

> A lot of them have ambulation problems, they're not moving as well, they're not moving as fast, they start to decrease in their physical health and that makes it more difficult in terms of reintegrating into a regular population.

Participant 13 added that falls risks were high and that injuries such as broken hips had occurred, and subsequent effects included the risk of "bed sores." Participant 11 observed that higher level security units could not always accommodate these needs, stating:

> If they needed a walker, if they needed a cane, if they were in a wheelchair, generally a maximum-security unit can't support something like that. Some facilities have cells in health care that are wheelchair accessible and they would be kept there until they find a proper facility for them to go.

Participant 9 noted that some facilities had units specifically for geriatric IPs with mobility issues.

A wide range of additional physical health problems were associated with the aging prison population. Participant 2 identified "musculoskeletal, like you know joint paint and back pain. Lots of that. Shoulder and hip, too." Both Participant 2 and Participant 4 noted it was common for many aging IPs to be prescribed opioid agonist treatments, such as suboxone or methadone. Participant 2 added that "we've seen some older guys who…they're worried about still being able to perform sexually." More acute concerns were also identified. Participant 3 added "there's overdoses… we've had heart attacks – those are always the unexpected ones." Participant 5 added "you never know, like a stroke or a heart attack can happen." Participant 4 identified the potential for injuries resulting from violent altercations, such as fights or stabbings. Such issues rounded out the wide range of physical health concerns identified amongst aging IPs by participants.

In addition to these physical health concerns amongst aging IPs, participants identified a wide range of mental health concerns, specifically amongst those convicted of sexual offences. Participant 10 identified to need for mental health supports:

> We do a lot of, like, crisis intervention, so if people are feeling suicidal or just like a mental health crisis of sorts, we will do…like risk assessments for suicide… and figure out interventions going forward. Something like following up with them again, or placing them in a higher level of observation, so like a camera cell, stuff like that.

Participant 6 added:

> A lot of mental health starts kicking in because some of these guys are older and they've spent most of their lives in jail and you know they have to face the fact that either they're going to die in jail or they're going to be – I think actually most of our guys that are older

> are not being released at all and they will eventually die in custody, so you do see some of those mental health pieces.

Participant 13 mirrored this issue, stating "nobody wants to die in prison." Participant 5 also identified this tendency in aging IPs:

> As they get old, they realize that their life, like you know, they regret life choices. That's something that I have noticed a lot. Like, they start realizing as they get older, they're spending a great amount of time inside the jail, and sometimes they feel like there's nothing out there waiting for them.

This realization of time spent in prison and the likelihood of dying in prison or being released without any supports was identified as leading to mental health concerns amongst aging IPs.

Aging IPCSOs were identified as having particularly notable mental health issues by participants. As explored above, IPCSOs are high risk for being victims of violence and poor treatment in prison because of their convictions. An ongoing life of fear and perceived need to continually defend oneself was identified as leading to mental health concerns, as Participant 5 noted "they deteriorate faster." However, this perceived poor treatment could come from prison staff, as well. Participant 8 observed:

> Some older individuals are very vocal and they say "I feel like I'm being mistreated", so then they'll at least open up to the mental health piece so we can either work on like, what's the facts of the story? What had happened? Do we need to talk to correctional managers? Do we need to figure out if there's a conversation with staff members that needs to happen? But then also trying to support them in that they can manage their own feelings and emotions and help them cope with where they are as well. So, I do think that it affects their mental health.

Participant 13 identified other factors that contribute to mental health concerns, especially amongst aging IPCSOs, noting:

> A lot of them are Indigenous… obviously with reconciliation and residential schools and colonialism and you know, trauma and intergenerational trauma and we have lots of guys who were part of the sixties scoop and residential schools and suffered massive abuses. And then, of course, the whole segregation era when they just threw everybody in the hole, put them up and segregated them and then they realize the impacts of that on mental health.

These historical traumas, particularly those suffered by Indigenous IPs as well as the iatrogenic mental health impact of long-term use of segregation were identified as having a significant effect on the mental health of aging IPs, particularly those convicted of sexual offences. Those individuals with significant mental health concerns could not always receive appropriate care within conventional prison settings and may be transferred to one of the regional psychiatric facilities run by CSC. These facilities will be explored in greater detail in the following theme.

Theme 2: The Prison Environment

Participants interviewed described experiences working in the full suite of facilities operated by CSC, including maximum, medium and minimum-security centres, psychiatric facilities and regional hospitals, and halfway houses. The prison environment itself, including infrastructure, staffing and services offered within (and without) the facilities was described as playing a significant role – and present, at times, significant challenges – in the care of aging IPs. This theme will explore the various types of CSC facilities in which aging IPs are incarcerated, how services are provided by CSC staff, the phenomenon of IPs being transferred to civilian facilities – primarily hospitals – to receive treatments and interventions, as well as some of the

negative attitudes that exist towards aging IPs in CSC facilities, especially aging IPCSOs. Several sub-themes are presented here, including levels of security, health services provided within CSC facilities, infrastructure concerns, staffing concerns, knowledge concerns, care in CSC healthcare facilities, escorted temporary absences, and negative attitudes towards aging IPs.

Levels of Security

Participants described a wide range of CSC facilities, located across Canada, in which they had experience working. Some participants had experience working in multiple institutions, while others had only worked in a single site. Some institutions had multiple levels of security in a single site, while others were dedicated to one level of security.

Maximum security facilities, be they mixed with other levels of security or their own dedicated site, were described as particularly limiting in what could be offered to IPs, especially aging IPs. Given their high level of security and incarceration of IPs considered high risk, a focus on safety and management of IPs was described by participants. Participant 8 stated:

> Typically, individuals in a max prison, if you had a sex crime or a murder… you go to the max, and then, based on behaviour you would be able to cascade down to like a medium or a minimum. There are also other people there for gangs, other reasons a lot of people are not really released from there, a lot of them tend to be in prison for life, as in 25 years.

Much of an IP's time in maximum security facilities in spent in their cell. Participant 8 stated that "a lot of them only get four hours of allotted time out of their cell… some of them might have jobs. Some of the older guys might have jobs if they want, but it's not an expectation." In these facilities were specialized units or wings for certain categories of IPs. Participant 6 noted of a maximum-security facility:

> There's a general population unit, another is protective custody – guys that aren't really safe on other units. We have a mental health unit… there's a unit for the Indigenous population, with programs to see the elders… there's a unit with, you know, older life guys who just want to hang out and don't want to be bothered with people… there's a sex offender unit for, you now, sexually based crimes, and there's a structured intervention unit, or SIU.

Within the maximum-security facilities, participants noted that many of the aging IPs were spread across multiple units. Participant 8 offered:

> They're kind of dispersed depending on their affiliation or needs. The mental health unit can have older guys… and there's people with sex crimes – there's a bunch of older people there. So, they're kind of dispersed evenly through the institution. It's not like there's one specific spot for geriatrics or seniors.

Aging IPs were described as often being a lower priority within maximum security settings, with Participant 11 observing "unfortunately within the system, the elderly kind of get pushed to the back-burner, if that makes sense…because of the acuity of things that happen sometimes." For the healthcare staff, incidents such as fights or acts of self-harm often take priority. Schedules for care and appointments are made, however, as Participant 2 observed, "if there's a stabbing or something, or someone cut themselves… then obviously everything gets a little bit thrown off."

Within maximum security facilities, or larger, multi-level facilities, participants also identified other specialized units. The structured integration units (SIUs), as Participant 1 offered "used to be called segregation. We got in trouble for segregation…some call it segregation with toys…more meaningful interactions and that kind of stuff." Those placed in SIUs were described by Participant 10 as:

> Usually if they were involved in a pretty serious crime… like if you were involved in a murder in the prison, stuff like that. So, they would be placed on the segregation unit… or sometimes it was for people's own protection because they just were not able to integrate into any other unit, so that was the safest place for them. Sometimes it was because of who the person was and if there were safety concerns around them, like if they were a big gang leader.

This participant went on to note that it was rare for aging IPs to be placed on these units, adding "they were mostly still young." The other specialized units identified within maximum-security settings were intake, or admission units. Participant 6 offered that "new inmates stay there for two weeks before they go anywhere else… it's a good way for security intelligence officers and mangers to talk to them and see where they would best fit." Participant 11 described to intake process for aging IPs:

> When it comes to the aging population, like the elderly… when they come in they do… an assessment of their health… and when it came to finding appropriate units, they would be placed on certain units depending on what their history was. But it would also be dependent on what their abilities are, so when it comes to are they able to do ADLs [activities of daily living] correctly. If that were the case and let's say the person was, you know, not able to do their daily ADLs, they would sometimes have to suggest that the maximum-security facility isn't proper for them, and they would get sent to a different federal facility where ADLs were assisted.

Upon admission to CSC for a federal sentence, IPs would be assessed for an appropriate placement. If an aging IP with specific health needs was admitted, staff would aim to place that

individual in a facility where their needs could be met. It was rare, however, for aging IPs to be placed in SIUs, according to participants.

Medium and minimum-security facilities were described by participants as more open, with less of a focus on security as the maximum-security sites. Participant 1 stated “minimum security is between houses or building.” These sites were described as having more programming and activities, where IPs are not locked in their cells for most of the day. The most open and least restrictive of sites under CSC authority are halfway houses. Many of these, as Participant 7 described, resemble “apartment buildings” in residential neighbourhoods. Participants described the goal for most IPs was to ‘cascade’ to lower levels of security where conditions were less restrictive. However, some IPs, particularly older IPs with significant health or mental health issues, required, as Participant 12 stated “moving to some kind of health care unit within an institution or to an institution that has some kind of geriatric facility.” This participant was referring to the regional hospitals – units equipped with staff for constant care of medical needs – found in certain CSC facilities across the country or to a regional psychiatric facility. Both of these facilities will be explored in greater detail in the following sub-themes.

Health Services Provided Within CSC Facilities

Participants described, many at length, the healthcare services offered within various CSC facilities, as well as those services which required the involvement of community-based interventions, such as hospitals. Levels of service, such as staffing levels and access to different healthcare disciplines, varied across sites, with some offering a wide range of services and others relying more heavily on community-based services. This was particularly relevant for the healthcare needs of aging IPs, including those convicted of sexual offences. Participants noted that all CSC facilities in which they had worked provided some level of access to health services,

including physicians, psychiatrists and nurses. The degree of access to these professions, however, varied.

Nurses were described to be present at all sites, however the frequency varied. Describing a halfway house setting, Participant 3 noted “there is a nurse who comes in three days a week.” However, there existed needs for aging IPs that exceeded the capacities of the nurse of the site staff. Participant 3 continued:

> If there are functioning issues, they have home care come in and help with just their daily showering. Staff won’t help them with stuff like that. If it’s something like laundry or cooking, but when it comes to the actual physical touching stuff they don’t want staff doing that.

Site staff were not tasked with activity of daily living (ADL) assistance, requiring external home care services to be brought in to meet the needs of aging IPs.

At larger institutions, participants described more present and consistent nursing staff. However, not all sites provided 24-hour nursing services, and much of the nurse’s time may be dedicated to the preparation and administration of medications. As Participant 2 described:

> The healthcare department is open from seven to seven every single day. Nurses dispense medications, do admissions, discharges, transfers, respond to emergencies as they happen, if they happen during work hours.

This participant described the process of dispensing medications in greater detail:

> The majority of medications are given at seven-thirty. There are three med rounds: seven-thirty, eleven, and then sixteen hundred. But they try to do most in the morning because a lot of it is methadone, suboxone and it has to be observed after they take it, they have to

> be observed for a period of time, so they try to divide the medications between all of the nurses for seven-thirty, so it's just heavy.

They noted that during these rounds, IPs may discuss health concerns or make requests:

> If they have any requests or complaints, that's often when they'll say so. They'll say, like, I've got a tattoo and it's infected now, or I need some Tylenol, or whatever… that's like, that's their point of access for a lot of them. There is paper – they request and they can fill out and give to healthcare, but they have I think two weeks to respond to them, so if it's something they want dealt with sooner, they will usually tell a nurse during med rounds.

Nurses present a point of contact for healthcare concerns during these medication rounds. IPs may not have any contact with nurses other than these rounds, as Participant 4 continued:

> When morning meds are done, there's narcotic count, then making sure that meds for eleven and sixteen hundred are there and in order… they basically need the rest of the day to start preparing for the next day, since there's so much at seven-thirty… if there's a stabbing or something, or someone cut themselves or whatever then obviously everything get a little thrown off.

The nurse's daily schedule was described as busy and primarily dedicated to routine tasks, such as medication administration. As such, IPs may have limited opportunity to interact with nurses, with tasks considered routine in other healthcare settings as less feasible. Participant 4 noted:

> If you have a guy with diabetes, nurses don't have access for them all the time. Like, they can't, you know, it's not feasible for them to go out and wait until they eat their meal and then check their blood sugar and then give them insulin… it's not like a hospital where

> you can go and make sure they are, like, their blood sugars are being managed properly. Here it's harder to do that or if not impossible some days.

Participant 8 described a reactive approach to healthcare:

> There are limited resources within the prison. There's psychiatry, social work, psychologists, and nurses, however the actual time each of those individuals may dedicate to that individual is very, very limited. So almost like on an as-needed basis versus, like for continuity of care. So, unless there's an issue, I feel like these individuals are not seen. Unless something comes up either from officers or something else or they start to deteriorate, that's when healthcare hears. Otherwise, they're pretty much on their own.

Because of limited resources, daily scheduled tasks and the need to respond to emergent situations, participants noted that, in facilities without 24-hour nursing care, the amount of attention given to IPs was limited.

Physicians and psychiatrists were noted to make regular visits to CSC facilities, though the frequency varied, as did the amount of time spent on site. Participants stated that physicians – typically general practitioners - visited between 1 and 3 times per week, depending on site, with psychiatrists visiting 1 to 2 times per week. As Participant 8 stated "on site we only have nursing, whereas the physician is only in once or twice a week for like 4 hours." The focus of these physician visits can vary. Participant 4 observed:

> The physician comes in twice a week and one clinic is devoted to…opioid agonist therapy, so the suboxone and methadone program, but if there are any pressing things, that will get added to that clinic. And then the other clinic they do all the other stuff, they'll go by unit, so they'll do unit a, b, c, d this week and the next, you know, e, f, g, h.

Participant 2 added that site visits by a physician are very busy, stating:

> It's long days, the doctor sees a lot of patients during those days… there's a big wait list for some issues. So, the nurses will triage… for urgent stuff there's no a big waitlist, but for some stuff there's a longer waiting list.

These waitlists were described by other participants as lengthy. Participant 11 added "sometimes they would only get – they'd have a list of 10 people and only two or three would get seen." In addition to visits from general practitioners, participants noted the regular visits of other professions and services. Participant 2 observed "within the facility, psychiatry is inside, dentistry, some eye care as well." However, as Participant 11 concluded:

> XRay once a week, dentist in every two or three weeks and the optometrist every three or four weeks. But that's about all that they could offer in-house and a lot of the times access to those was very limited.

These other services were available within CSC facilities, however access was described as limited.

Participants described long waits for IPs to see physicians within the CSC facilities, except for emergency or high acuity issues. However, as multiple participants described, not all healthcare issues could be handled within the facility, even when the physician was present. Referrals to specialists were described by participants, and the waiting time for these could be significant, complicated by the fact that these specialists did not visit CSC facilities, requiring IPs to be escorted by corrections officers for community-based visits (a topic to be covered in a following sub-theme). Participant 8 suggested "they have quite a bit of those because the GP is wanting to consult, like the specialist versus dealing with it in house, because they want to get more information. So, you'll have like cardiology, geriatrics, things like that." Participant 2

added “they access specialists, in the same way as outside… it works pretty well, it’s about the same as outside.” However, because of transport issues, finding appointments with specialists near the facility is prioritized, as Participant 2 included “even if it could be a bit longer.” Participant 6 added:

> There are medical escorts all of the time. Usually, we try and handle most things in-house, so we don’t have to do that but obviously there’s things we can’t always do, so inmates go for medical appointments. We try and do it at the hospitals but sometimes they go to community healthcare facilities as well.

These wait times and need for IPs to be sent outside the facility were identified as particularly challenging for aging IPs. Participant 11 stated:

> For those in the aging population, sometimes they require orthotics, so they would send them out on orthotics appointments… they have a team take them out in the community, so sometimes appointments aren’t given right away… there are definitely some barriers to care when it came to elderly clients.

Participant 8 added “there isn’t a geriatric specialist on site, so they get a consultation, but that could take months for someone to come in.” Furthermore, Participant 6 observed:

> A request has to be answered within 7 to 10 days. Well if there’s a concern that, you know, that’s like those big obvious ones, like chest pains of things like that, the longer it takes to access healthcare, well, you know, the longer the situation may be worse… that can go very poorly, so I definitely think that the healthcare needs to be changed and how we do things, to have these guys access their care.

Participant 7 added “I remember them saying the standards of care needs to be more than in the community, right? This is our benchmark. And I don’t see that being true.” Participant 6 added

"those medical pieces that pop up… they don't have access to care as much as they probably could." Due to concerns with diversion, access to pain medications may be limited; Participant 2 stated "with the pain medication, there's less access to it, like it's more regulated, for sure." Access to physicians was described as limited within most CSC facilities, with at times long wait lists for IP concerns and the prospect of waiting for an appointment for specialist care. Emergent issues typically took priority over less urgent or chronic issues, according to participants.

Health issues too severe for on-site physicians to address, or those that occur when a physician is not present, or that happen at night when nurses are not present were described as requiring emergency response, typically via ambulance. When describing sending IPs off site for medical issues via ambulance, Participant 4 stated:

> We almost always do because we don't always witness the event, so you just never know, right? You may have a guy with tiny stab wounds… but you better send him out because we don't know what the weapon is, right? Sometimes they end up requiring surgery because the weapon was quite long, so we always lay on the side of caution and send them to the hospital even if, not by ambulance then under escort with officers if they're stable and there's no chance of head injury… nothing that they can decompensate rapidly on transport… like if someone maybe sprained an ankle, we don't know if it's broken, then they'll go in a van with officers as opposed to an ambulance.

Participant 4 continued:

> The nurses decide on whether to call an ambulance or not. Usually they have to, just to be safe, because they don't have the resources to keep someone, like, that needs observation for a concussion, for example. Like, they can't keep them overnight. So, it's usually, like,

> they do basic trauma response, first aid, start an IV, oxygen. There are emergency medical directives to follow for each sort of incident. Overdose can be a thing, too.

Participant 11 noted "if it had to do with an emergency, paramedics are called in and paramedics will take them in an ambulance." If an incident occurs at night when nursing staff are not available, responsibility for immediate healthcare needs are relegated to correctional officers. Participant 2 stated "if something happens during the night the officers would call 911." If the healthcare needs of an IP sent to the hospital are too severe for a CSC facility to manage, especially if the facility lacks 24-hour nursing care, they remain in hospital. As participant 4 noted:

> Some people have ended up in the ICU, like from a fight, and they have to stay in ICU, and then they step down to a different unit. If they need anything that requires twenty-four-seven care, they have to stay in the hospital until they're well enough to come back here. And if they don't ever get well enough to come back, then they go to a regional hospital facility.

Correctional facilities, especially those lacking 24-hour nursing care, were described as lacking the capacity to meet complex healthcare needs of IPs. This was noted to include end-of-life or palliative care of IPs. Participant 11 noted this care "most of the time, it would be in the hospital… with guards at the bedside. They stay in the hospital and pass away in the hospital." If the needs of IPs are more significant on a long-term or permanent basis, especially with aging IPs, they may be transferred to a facility with a regional hospital unit, which may be housed in a regional psychiatric facility.

These regional hospitals and regional psychiatric facilities were described by participants as having more extensive healthcare services, including 24-hour nursing care and expanded

access to physicians and other health professionals. Participant (13) described the regional hospital as "a separate unit and certified separately within CSC, to deal with offenders with medical issues." This is particularly relevant for aging IPs, as Participant 8 observed:

> There's a GP who kind of does everything and if they have someone who is maybe not taking care of themselves and they're super worried about them, one of the avenues is putting in an application to the regional psychiatric facility… they actually have a unit dedicated to the aging geriatrics who have different mental health issues. So, they might have dementia or Alzheimer's, so that's where you put those guys.

The role of these regional facilities will be explored in greater detail in a following sub-theme. It was noted that the range of care in these facilities is greater, with Participant 9 noting:

> They have 24-hour nursing care and on-call psychiatrists and GPs. They have GPs who come in three days a week and psychiatrists are there at least five days a week, plus on-call. They have dialysis, a clinic where they can get all sorts of work done, a dentist office, physiotherapy, occupational therapy.

Those IPs with more severe or ongoing healthcare needs, especially aging IPs, were described by participants as typically being transferred to a regional hospital and/or psychiatric facility.

Within these regional hospitals and/or psychiatric facilities, participants noted a large population of aging IPs, including those who were nearing end-of-life. Participant 13 noted the quality of care provided, stating "within these facilities, you get better care than you'd get in the community, because you know you have literally doctors in every day of the week pretty much or on call, and nurses twenty-four-seven and everything." However, the participant also noted that CSC, as an organization, did not want IPs to die within prison facilities, and should be transferred out of a facility prior to this happening. Participant 13 described the pressure to get

IPs out of custody as "CSC, in their push to get them out of prison, because god forbid anybody die in prison, because that's kind of their position, is nobody shall die in prison. You know, we must get everybody out." This participant added that "really their mandate is we need to get them off the books" prior to an IP dying. One participant, who will not be identified here, even by pseudonym, out of concerns for confidentiality, described an instance of medical assistance in dying (MAiD) occurring within a correctional setting, noting that CSC, as an organization, was opposed to such an occurrence, due to "the perception that CSC is just killing off people." IPs with significant health concerns, especially those who are aging and approaching end-of-life, may be transferred from their primary institutions to a regional hospital and/or psychiatric center, which were described by participants as being better equipped to deal with these needs. Some of these facilities were described to have dedicated units for geriatric IPs. However, as these individuals near end-of-life, participants described a push from CSC to get them out of the hospital such that their death does not occur within the correctional facility in an official capacity.

Infrastructure Concerns

Participants described several concerns, barriers, or limitations to working within CSC facilities that affected the care of IPs, especially aging IPs and those convicted of sexual offences. These concerns were divided into those related to prison infrastructure, staffing levels, and staff knowledge. The first of which is explored in this sub-theme, the latter to be explored in the following sub-themes.

The primary issue explored by participants related to prison infrastructure concerned the mobility needs of IPs, especially those who were aging and had more significant healthcare needs. These concerns spanned across multiple sites, including maximum and minimum-security

facilities, and halfway houses. These concerns were less pronounced in the regional hospitals and psychiatric facilities. A major challenge identified was with IPs who required the use of a wheelchair. Participant 11 described the admission of new aging IPs who required the use of a wheelchair, stating finding an appropriate unit for them could be challenging:

> In one of the newer buildings that had maybe some, like, a wheelchair friendly area, that sort of thing, depending on if they needed a wheelchair, which is very dependent on the type of unit they were placed on and if that wheelchair was going to be approved, which most of the time it was not… sometimes they would suggest that the [current] facility wasn't proper for them and they would get sent to a different federal facility.

Even if there were wheelchair-appropriate spaces on units, the use of a wheelchair may not be approved for an IP. This participant added that if an IP needing a wheelchair was to be sent to a different facility that there were "cells in healthcare that were all wheelchair accessible where they would stay until they found a proper facility for them to go into." As explored above, mobility aides such as wheelchairs or walkers may be considered to be weapons and not permitted. If this were the case, an IP may require transfer to a different facility. Multi-level units featuring stairs were also described as challenging, not only for those requiring mobility aides, but for those living with visual impairment. Participant 8 described the challenge of those with visual impairments waiting for transfer to a more appropriate facility, stating "in the meantime they move them because if they're upstairs, move them to a downstairs unit so they wouldn't be at risk of falling."

Those IPs waiting for transfer to a different facility, particularly aging IPs, may have accommodations made in their current placement, or, as some participants noted, wait in a prison healthcare setting until transfer. Participant 11 described this scenario:

> What they would have to do is pull them into healthcare and they would stay in healthcare, so they'd be isolated there, and they would stay there and during working hours, they would get assessed…. If somebody's in healthcare, it's staffed twenty-four seven by an officer, but nursing staff are only there for part of the day.

When asked to describe a typical stay for an IP in such a scenario, Participant 11 continued "I would say a couple of days. It's just finding transport that can travel to wherever they're going." If an IP was awaiting transfer to a regional hospital or regional psychiatric facility, or another facility more appropriate for their needs, they may be temporarily housed in a healthcare unit, with supervision and care responsibilities placed on correctional officers when nursing staff are not present. This reliance on correctional officers for healthcare related tasks will be explored in greater detail in a following sub-theme.

Mobility of IPs in less secure facilities, such as medium and minimum-security facilities, as well as halfway houses, were also described as a concern. As Participant 1 noted "minimum security is often between houses or buildings." In such settings, IPs still require a regular 'count' from officers, which may necessitate physically checking in for identification. For some IPs, Participant 1 continued, exceptions or modifications may be made:

> If they've got a lot of disabilities, you know, like Parkinson's or something, staff may let you call in for count from a common space. So, they'll pick up a phone there and call in for count to say, 'I'm at the house,' because usually you have to report it to the main officer's desk at some places for count.

The necessity of going outside for tasks presented challenges for aging IPs, particularly in the winter months. Participant 1 continued:

> If they can't make it around, especially in winter, it's really difficult for these guys in winter, because their mobility is so bad, you know. Luckily there are some newer facilities now, so they do have wheelchair accommodations, wheelchair showers, but they still need an inmate assigned to them to push them around. Which seems a bit archaic, but I mean its's – yeah it is what it is in winter.

Participant 7 also identified winter mobility as a concern:

> You have an individual in a minimum-security institution and the concern expressed is, if the fellow uses a walker, if he is 60 or 70 and using a walker, the concern is that they could slip on the ice.

This concern for winter mobility and the need to be outside to access services also applied to medication administration. Participant 7 identified this as a concern specific to correctional institutions:

> In the community you do not line up outside with forty other people in the cold waiting for a med line parade, to take the antipsychotic you may or may not need, but it makes the place more manageable.

These concerns for mobility and accessing basic services also applied to the infrastructure of halfway houses. Participant 3 described one particular halfway house that had made some modifications for aging IPs, including accessible washrooms. They stated:

> The only thing they can't accommodate is wheelchairs, because they're not wheelchair accessible. They're not licenced for it, so that would completely change their licencing. Other than that, they try and accommodate, like anything that they would need.
>
> Q: So, there's no elevators or anything?
>
> No.

Q: And then staff is all on the main floor and the apartments are up on the upper floors? And below.

Q: And below, ok. So, if they had significant mobility issues this would probably not be the best place for them?

Not the greatest, yep.

Q: So, are there other halfway houses that are better suited for those folks?

There's one place… they do have – it's a couple of rooms where they are wheelchair accessible, so that would be the only one that I know of.

Aging IPs who are released from institutions to halfway houses still encounter accessibility concerns, especially if they have significant mobility issues. Appropriate spaces for these individuals are limited. Within these halfway houses, basic medical needs, according to Participant 3: "the medical stuff, they can handle, like any of their medication and those kinds of things. It's more of the when they can't bathe themselves or the, like I said, like the dementia related kind of stuff." For more complex medical needs, IPs would be sent to see a physician in the community. When asked about such a scenario, Participant 3 noted:

They just go on their own.

Q: If they've got some mobility issues, does that kind of thing…

Then they'll either send them in a taxi or sometimes they'll get set up with a community medical transport, so they'll have that ready for them. A lot of the times it's just a taxi, though. They'll have them picked up and kind of back and forth, kind of thing.

The halfway house environment was described as challenging for those with cognitive or mental health concerns. Participant 3 continued:

> You can have older gentlemen where it is more, it is more of their mental health concerns that they just, they just can't understand kind of the, almost just leaving the building and they couldn't understand that they can't just take off for a couple of days at a time, and then they wouldn't know where they were and then technically they would be, you know, unlawfully at large.

In a less restrictive setting, those with cognitive or mental health concerns may leave the facility, reportedly unaware that to do so was not permitted and may result in re-incarceration or placement in higher levels of security.

Participants described a few additional prison infrastructure issues that negatively affected aging IPs. Prison mattresses were identified as a concern. Describing aging IPs with limited mobility, Participant 11 described the necessity for Braden scale assessments:

> Because sometimes they would have limited mobility and mattresses were not the best support, especially if their intake was decreasing, so their body mass is decreasing, bones are starting to protrude, that can often times become an issue… sores and what not. And in a prison population, infection is at a higher rate, right? So, they have to keep an eye on that type of thing with the aging population.

The standard issue mattresses in many facilities were described as a source of health issues. As Participant 2 described:

> The basic one is like, basically like a camp mattress, like army style. And the other ones are more like a regular one. They call it an orthopedic mattress, but it's just like a regular mattress… depending on the facility they may have to prescribe or authorize a better mattress.

To be prescribed this higher quality mattress required a physician's order. As Participant 2 continued:

> In theory they have to show in the file that there's some back issues or neck or something, and there's a reason for a better mattress… it's still a process – they need to ask and then they need to see the doctor and they have to authorize.

In some facilities, IPs are required to put in a request for a higher quality mattress. This request system, as explored above, was described as having limitations. As Participant 8 offered:

> One of the biggest challenges we face, we have with older folks is sometimes communication. Because, since we have the same system as the younger offenders, they will submit like an inmate request, but some of these guys can't write clearly, some of them can't speak clearly, some of them might be a little more forgetful, so their requests might not be super clear.

With these aging IPs, if they do require more extensive healthcare needs and are placed in an infirmary or healthcare unit, or who may be approaching end-of-life or palliative stages, visitations are very challenging. As Participant 2 noted "at the facility it's harder to have visitors." Even access to these facilities for those scheduled to see a physician or other healthcare provided can be challenging, depending on the physical layout of the facility. Participant 4 observed:

> Some of the inmates are incompatible with each other, so when one inmate is out in the yard, you can't send – or passing through the yard – you can't send one from another unit because they'd kill each other. So, it's just, like, all these little things like movement within the institution is a big issue.

These movement issues could negatively impact the schedules of healthcare providers. As Participant 4 continued:

> The interesting thing with clinics too, and that affects the wait time is the movement, because sometimes they just won't let the inmate go out to the yard to come to healthcare, to go to the appointment… there's a lot of waiting just for them to come to healthcare, and it's very expensive to get a psychiatrist in there for four hours and then half the time is spent with like no one in the clinic because they're just waiting for them to come.

Individual prison cells were also attributed to health and mental health concerns for IPs, particularly aging IPs. SIU units, or, as many participants continued to refer to them, segregation units, were described by Participant 1:

> That's terrible because they have these straight hallways, doors with the glass window, the slider doors. And there's no, there's no interaction, so you are truly isolated, just from the physical structure of the building itself.

This lack of stimulation was attributed to cognitive decline, or the exacerbation of cognitive decline by Participant 13:

> What you do see is a lot of the dementia, right? A lot of the cognitive stuff and it's not helped and promoted by the fact that they've lived very isolated, non-stimulating life for years. I mean, they didn't come in necessarily with great backgrounds and then it was not exactly promoted, you know? We promote school, we promote programs, we promote all this stuff, but like let's be honest, I mean, you live in like a nine by nine room, with very little stimulation, twenty-four seven for decades. Like, your brain just kind of goes, right? And it goes seemingly faster, like we see more and more guys at a younger age looking at

probably onset cognitive or dementia process than you would see in the general population.

Participants described how the physical space and infrastructure of correctional environments, in many ways, did not facilitate the health and wellness of aging IPs. In many circumstances, the existing health or mental health issues of these individuals were made worse, according to participants, by their physical environment.

Staffing Concerns

Lack of access to appropriate staff, or appropriate staffing levels was described as a concern amongst multiple participants, especially as it related to aging IPs. This applied to all professions, including physicians, nurses, and correctional officers.

As explored above, physicians are only periodically available within correctional settings, conducting clinics from one to several days a week. This can result, as Participant 2 described, in "a big wait list for some issues." This included access to a psychiatrist. Participant 4 described access to a psychiatrist as up to "a six month wait." However, this participant described a typical wait for psychiatry as "more like two, three months wait. They come in twice a week for four hours." Because of the necessity to triage appointments with physicians, including psychiatrists, Participant 11 observed that "the elderly kind of get pushed to the backburner… because of the acuity of things."

The staffing level of nurses was also identified as a barrier to the provision of care to IPs, including aging IPs. A lack of 24-hour nursing in many facilities was described as a challenge to ensure a continuity of care throughout the day, or the provision of care for 'after-hours' incidents. Describing one facility, Participant 2 stated:

> In the past there was more staff, meaning that at night they had nurses 24 hours, but now sometimes there's no nurses at night, so it's difficult to provide around the clock care… they had 24-hour nurses in the past, I think that's the goal, it's just that they lack staff.

In many facilities, nurses are working, as Participant 4 stated "just seven to seven." Or, in some facilities like halfway houses, a few times per week. This was described as challenging for the appropriate administration of nighttime medications. As Participant 11 described:

> In regard to nighttime medical, because not everybody takes all of their meds at seven, they are given envelopes or their packs of medication… which, for that time to take, in the hopes that they will take them accordingly.

Witnessed or supervised administration of medication is not always possible, leading to concerns about the appropriate use of medication and, as has been explored above, the risk of medication diversion, particularly affecting aging IPs. Even when nurses are on shift, they are not capable of managing all healthcare issues that emerge. Participant 8 described such a scenario:

> They send people out because they have instances, like stabbings, that people like that need to get sent out. Because on site they only have nursing, whereas a physician is only in once or twice a week for like four hours. So, if it's something a nurse cannot handle, they will have to send them out to a hospital.

Participants describe circumstances wherein IPs would be sent out of the prison to a local hospital when appropriate care could not be provided. Even within the regional hospital units such circumstances exist. Participant 13 described a scenario where an aging IP's healthcare needs exceeded what could be provided, stating "the regional hospital unit… they even said we won't be able to care for him."

When IPs are sent out of the prison for scheduled or emergency visits to local hospital settings, they require an escort with correctional officers. Such situations presented staffing issues for correctional officers within the facilities, especially if the IP was sent out in an emergency. Even if IPs were sent for scheduled appointments, Participant 11 stated:

> In regard to regular, everyday appointments… everybody is sent out with two officers.
>
> Q: does that cause issues in terms of staffing? Like, does that cause back logs?
>
> It does, yeah. Absolutely. It's hard sometimes to find staff to take out to appointments, just because, they're already short staffed already, within the prison.

As Participant 6 stated, "they [officers] do medical escorts all of the time." If an IP required an extended stay within a community-based hospital, it required 24-hour correctional officer presence. Participant 11 described such a scenario:

> They would have to figure out staffing needs pretty much at all times for that. And officers would head straight to the hospital and to work.
>
> Q: It creates some, I'm guessing some logistical issues then for staffing?
>
> Absolutely, yes. Very hard, especially if it's something long-term like that, like three, four weeks. Or longer than that in some cases, yeah, absolutely.

Participant 6 described the challenges such requirements placed on correctional officers and the running of programs within the prison:

> They have had quite low, super low staffing levels… if there was a fight or any, it's usually those kinds of emergency situations, not necessarily if there's an appointment in the morning or something, that's no big deal because staffing or the people doing the roster know about it so they're either going to hire overtime to fill spots or what not, or they'll just shut down a gym, or things like that, so they can staff these things. But if

> there's an emergency and there's a fight or someone needs to go out, yeah, it causes a lot of staffing issues, people that get held over, so if they're working just a regular 8-hour evening shift they might… have to do another 8 to 12 hours at a hospital. And that potentially means well they didn't pack their food for that, or like kids to take care of or families to get home to and things like that.

Safety concerns were related to these issues of correctional officer staffing. As Participant 6 continued:

> They would cancel programming if there was low staffing levels to accommodate that, and mostly that's a safety thing. A corrections officer can run a unit by themselves, but it's not, it's not a safe thing to do… so gym is usually the first to go because that's 3 or 4 officers that can be put on units instead… they can still have programming on the units when gym is closed but they don't have the opportunity for being in the gym or being in the yard.

Having correctional officers going out with IPs for medical reasons, which can include planned or emergency situations, or extended supervision of IPs in the hospital presented staffing issues within the prison. Such staffing issues were described as a safety concern that could impact the provision of regular prison programming.

Knowledge Concerns

Participants noted that many staff working within CSC correctional facilities lacked the necessary knowledge or training to provide appropriate care for aging IPs. This lack of knowledge spanned all professions. When asked to describe challenges that arise when working with aging IPs, Participant 4 stated "in general they're not really equipped to deal with some of their more complex issues." Participant 10 observed:

> It just feels like people do not know what they're doing, especially just like with the elderly, like there's no knowledge of geriatrics. So, I feel like it's something that corrections doesn't really focus on…
>
> Q: Across, even multiple disciplines?
>
> Yeah, I would say so.

Participant 10 continued to suggest that this lack of knowledge of geriatrics could cause tension between healthcare and mental health providers within the institution:

> There's a large lack of knowledge in how to treat the elderly in corrections… like when there are problems happening, people in healthcare didn't really know how to handle issues, and so it was just kind of like, it turned, like it became a toss-up between like, oh well we'll just pass them over to mental health and then, like, mental health was like no this isn't a mental health issue, this is clearly a physical health problem… there was a lack of knowledge in how to treat the physical health concerns.

This participant noted that this shuffle of care between two sets of providers came at the expense of aging IPs. They continued:

> Psychiatry sees him and then they're like, no… this isn't a psychiatric issue, it's more their physical health and stuff like that, so they pass it back to the medical doctor and then it's just like, it does a disservice to the inmate because if they need care, like, they're not really gonna get it because people don't really know what it is they need.

Participant 8 mirrored this sentiment regarding care provision for aging IPs:

> I feel like geriatrics is something that this particular site is not well educated on, and I think people tend to freak out and they're like, oh this person has problems going to the bathroom, like, they're crazy or they've completely lost it, and it's like, well maybe they

> just need to trouble shoot a little bit, or figure out what's actually going on – is there physical issues? Is there a mental issue? Things like that. A lot of people tend to jump the gun, just immediately dismiss that because they're older obviously they're losing it. They're just not giving them the chance to actually speak. But then they get assessed and that brings clarity to the situation.

This lack of understanding of the issues and needs of aging IPs extended to corrections officers, as well, who typically have the most contact with IPs. Participant 6 noted that "a lot of their concerns aren't really taken seriously and that's because officers paint their issues with the same brushes they paint younger guys, you know?" A lack of knowledge extended to the provision of end-of-life and/or palliative care. As Participant 2 observed of one site, "with the staff they have, I don't think they've done end-of-life care. Even if they have some cells within the health clinic where you observe someone for that time, but not for that kind of situation." This lack of knowledge of the healthcare needs of aging IPs, according to participants, often necessitated their transfer to a facility more prepared to meet these needs, such as regional hospitals or psychiatric centres within CSC, or community-based facilities.

Care in CSC Healthcare Facilities

Participants described the importance of regional hospitals and psychiatric facilities in the provision of care to aging IPs, especially those with healthcare needs exceeding the capacity of their primary institutions. According to participants, some of these regional hospital units were housed within psychiatric facilities, while others were within more conventional correctional facilities. The transfer of IPs to these facilities was described as either temporary, to address more acute issues, or more frequently as a permanent move where the declining health status of an aging IP required ongoing care.

The scope of care within both the regional hospitals and psychiatric facilities was described by participants as typically much broader than that offered in conventional CSC facilities. According to Participant 9, these facilities "have 24 hour nursing care." Participant 5 described the staffing as multidisciplinary and that "the team is so big." The quality of care is such that, according to Participant 13, "going back to a regular penitentiary is difficult because they don't have that level of support that they've been provided." This participant noted that "they get really good care, to be honest within these facilities, you get better care than you'd get in the community." A shift away from a security-focused perspective was described by Participant 5, who stated that "they're more patients than actually inmates." Such a shift was described in more detail by Participant 5:

> A lot of officers who go there that have worked in other jails, for them, in the beginning, it's a struggle, because in other jails it's more black and white. But there it's a big grey area, where healthcare and security go hand in hand, so they're not used to those types of settings and the amount of freedom they give the patients. So they give them a little more freedom… the way it was explained to me is like, let's say you have an issue and you put your hand around it and you have to keep it tight, you know, control it, eventually it's going to slip between your fingers, it's gonna become messy. So, what they do, and that would be mental health, like if we just lock them up they will become worse. Isolation, all those things have been proven that they create more issues. So, what they do is they kind of open up the hand a little bit, within still rigid boundaries, but let them be a little more independent.

This multidisciplinary approach, with a greater focus on the physical and mental health needs of IPs, was described as better meeting the needs of IPs with less reliance on high security approaches.

According to participants, though regional psychiatric facilities are ostensibly intended to provide supports and treatment for mental health concerns, they often collect aging IPs, including those convicted of sexual offences, simply because of their physical care needs. Participant 9 described a regional psychiatric facility as:

> A treatment centre for federally sentenced inmates, so… max, medium, minimum security levels, so they will, some come as emergency admissions, some come certified, some, most come voluntarily for – it can only be for treatment or for some form of programming.

The intended mental health focus of these facilities, according to Participant 9:

> So as far as like mental health… they see the range. I think they see pretty much every diagnosis there, often times if patients are too difficult at their parent institution, so every patient who goes there has a parent institution… So, when they go there, then there's usually expectation that they return at some point, that they're not there for a long time, but it may just depend on what their needs are.

Though the intention for IPs to be returned to their 'parent' institution exists, this may not always occur, especially with aging IPs. Some of these facilities were noted to have units dedicated to aging IPs. As Participant 9 continued:

> There is a unit specifically for, it's a geriatric unit, and I don't think, there's not really an age necessarily that you have to be to get on that unit, it may be… for mobility purposes. We do have an aging population for sure at CSC. Often, they're more chronically ill, like

> psychosis, schizophrenia, something like that. Or it could be someone who's committed a sex offence and their risk to reoffend may be fairly low, but the community is not willing to take them, and they have enough concerns that would be difficult to manage them in a regular institution… They're seeing more and more people who have been in for a very long time and the parole board seems really averse to letting them have parole and temporary escort options.

As noted, these geriatric units may be used to house individuals who may not have primarily psychiatric concerns, but who cannot be safely held within conventional institutions, including aging IPCSOs. Participant 9 warned that such individuals "get to a point where they're stuck there, and they can't get rid of them because no other institution can manage their physical needs."

Multiple participants described the need to send aging IPs to these regional hospitals and/or psychiatric facilities when their needs could no longer be met in their parent institution. Participant 11 noted that aging IPs who could not perform activities of daily living would be sent to a regional psychiatric facility "where ADLs were assisted." Those aging IPs who were considered close to end-of-life were also described as typically being transferred to a psychiatric facility. As Participant 6 observed:

> There are some guys that for sure it's only a matter of time. There's definitely some of these guys that, you know, it might not be this year or next year, but within the next five years, yeah. They'll probably go… to a psychiatric facility. They don't necessarily stay in higher security.

Participant 4 noted that aging IPs who are sent to a community hospital may get transferred to a psychiatric facility, stating "if they don't ever get well enough to go back there, they go to a

regional psychiatric facility." Provision of palliative or end-of-life care within conventional institutions was described as rare. As participant 8 described:

> They don't really see anyone reach that stage… that end-of-life, palliative care situation. A lot of those folks would get sent to a regional psych facility… that kind of, like, deteriorating, I'm not sure if there would be like a hospital stay, because usually anything like hospital would probably send them to a treatment facility. Each region, like in the country, has their own treatment facility.

For more complex healthcare issues, according to participants, institutions relied on transfer of IPs, especially aging IPs, to these regional facilities, that provided more appropriate levels of care.

The transfer of IPs to these facilities, however, was described as complex, as they are intended to provide care to those with psychiatric needs, often requiring the use of mental health legislation. Those who would potentially benefit from the additional care provided at these facilities, but do not meet the requirements for psychiatric certification according to mental health legislation, are required to give their consent to a transfer. Participant 8 described this process:

> They face a lot of obstacles as it depends on the committee at the facility…. There's a form for application, so they'll get consent from the individual to do a voluntary application there, and once they give that written consent, they can complete the application.

Participant 8 described a scenario where this may be the case:

> They have deteriorated mentally, but psychiatry has deemed this person to have capacity to make their own decisions, therefore they cannot certify or force them to go. But then the GP may be concerned about how to manage their physical health.

This consent may not always be given by the IP. Participant 10 noted there may be situations where the IP "wasn't agreeable to going." In such cases, according to Participant 4, "if they're not certifiable, like, they can't send them against their will." Such situations were described by a number of participants, and presented unique challenges, where the parent institution could no longer provide appropriate care to an aging IP, however they had no authority to transfer the IP to a regional psychiatric facility without consent. The challenges of meeting the healthcare needs of aging IPs were present at both ends of this treatment continuum: the parent facility may not have the capacity to meet their needs, but cannot force them to go, but when they do get transferred to a psychiatric facility, their needs may be too great for them to be returned to the parent facility.

Escorted Temporary Absences

The necessity to send IPs to community-based hospitals or facilities when appropriate care cannot be provided within the CSC facility, due to a lack of staffing, lack of knowledge, or lack of capacity, requires what participants described as an escorted temporary absence (ETA). In these situations, IPs would be transported in facility vehicles for scheduled appointments, or in ambulances for emergency situations. In both circumstances, IPs are required to be escorted by correctional officers. This sub-theme will focus on these ETAs for medical purposes. Participants described other types of ETAs, for matters such as attending funerals; these will be explored in a following theme.

As explored above, participants described emergency situations in which IPs would be sent to a community-based hospital. Such emergencies were often described as the outcomes of prison violence, though others included medical issues, especially amongst aging IPs were described. For instance, Participant 6 described a situation in which an aging IP was sent via ambulance to the hospital for "emergency bypass." Participant 4 described this process of sending IPs out in an ambulance in greater detail:

> At least one officer has to be in the ambulance. And then the other follows with the CSC vehicle or whatever… they wouldn't just let someone be, like – they always have to be within sight and sound… they don't get any privacy in that regard.

Participant 11 described this arrangement as "guards at the bedside." Depending on the level of security, IPs would be escorted and supervised, at all times, by at least one correctional officer. Participant 6 noted that "policy for maximum institution inmates, it's always two officers for one inmate." Participant 13 described the security measures taken with IPs taken into the hospital, and the optics of such:

> There are two officers, right? The only way you can get away, and they're armed, right? Liked armed officers for federal corrections. The only way you can get no leg harnesses and no cuffs and only one officer is if you're at minimum security. Otherwise you have two armed officers and cuffs and leg harnesses, or you have a medical exception of some description… they're sitting there with, you know, leg harnesses and chains on and other people in the waiting room are looking at them like, oh shit.

The presence of armed CSC correctional officers with an IP restrained with handcuffs and leg chains was described as troubling for people within the hospital.

As also explored previously, the need to send IPs to the hospital for medical care was described to occur for less urgent concerns if an issue emerged when healthcare staff were not present, typically at night in facilities lacking 24-hour nursing care. As Participant 2 noted "if something happens at night the officers would call 911." In responding to a question about responding to medical concerns outside of nursing hours, Participant 11 stated "it's an ambulance call and they head out." Even for issues that could be properly addressed by nursing staff and physicians during staffed hours, such issues would require hospital transport, escorted by correctional officers during non-staffed hours.

Participants described some of the logistical and jurisdictional challenges faced by CSC staff when IPs were sent out on medical-related ETAs. As earlier explored, IPs may require extended stays within a community hospital setting for treatment the parent institution cannot offer. Participants described stays of multiple weeks, in some cases. Despite these long stays, correctional officers are still required at all times for supervision. Participant 6 described the staffing challenges of changing correctional officer shifts within the hospital:

> Usually they try to put 12-hour people out there… because 8-hour shifts are a little bit harder to fill… so usually the people that you see in those kinds of situations are 12 hour people, so they'll come in from 6:30 am and then 6:30 pm and the officers will relieve them and stay overnight, and then just kind of switch from there.

As explored earlier, attaining appropriate staffing level of correctional officers could be challenging; when officers were occupied on ETAs, in-prison programming could be cancelled. The exchange of medical information was also described as a challenge when IPs receive treatment in community hospitals. Participant 13 described these situations:

> Getting communication… down is really difficult between hospitals and things, because nobody's quite sure who's entitled to the information and how much information they should have, you know, because everyone's trying to protect patient confidentiality and so it becomes, like, our nurses will call the hospital and be like, what's the status of our patient and they're kind of like, it's none of your business. And it's like, but it is our business because he's ours… It's like they become a non-entity, if you know what I mean. They kind of become not their own person, they feel like they're, like, you know, owned or being tossed around.

The IP in the hospital, as a patient, was described as becoming a liminal entity, a type of jurisdictional possession, caught between public and correctional domains. In some cases, as participants described, IPs sent to the hospital may not recover and end up dying in the hospital. Participant 11 described such a situation where "they stay in the hospital and pass away in the hospital… with guards at the bedside."

Correctional Officers and Care

Of note, as described by multiplies participants, was the role of correctional officers in the provision of care to aging IPs, such as medical or mental health care, even if this does not fall within their intended scope of duty. According to Participant 8, "officers who are on the unit, they're the ones working with the offenders most of the time, so they're more likely to observe any of their behaviour." These observations, beyond their intended purpose for the maintenance of security, include observing for signs of medical or mental health distress, especially with aging IPs. Regarding the role of correctional officers when it comes to aging IPs, Participant 6 noted:

> They're doing their walks every hour to make sure everyone's, you know, breathing and alive and all those kinds of things. Obviously, they're doing their job and they make sure that they're breathing, but they just spend a little bit extra, kind of looking at those guys and be like, are you good? Like, just because they're lying on their bed, you know, breathing, doesn't mean they're not struggling to breathe or that they're not having those kinds of issues. So, they just take a little bit longer and make sure, like, hey you good and those kinds of things.

This participant noted that nurses do make rounds to check on IPs, but that these only happen periodically through the day, and not at night. They continued:

> Nurses… do the med rounds… they'll disperse meds, they'll talk to inmates and things like that, but if there's an issue during the day and it's not during those count times, the officer will, you know, talking to an inmate – hey, I'm having these really bad chest pains. Like, ok, when did they start? You know, those first kind of questions. And they just go and call healthcare… and it kind of goes from there.

Participant 4 noted that "the officers are trained in CPR." However, this may be the extent of an individual correctional officer's healthcare capabilities. This presents challenges, especially after-hours, when the judgement to call in emergency services is placed on these officers. As Participant 2 observed:

> If you're a regular citizen outside of jail, you can call [911] yourself, but in the facility you can't call yourself an ambulance, so there's still the judgement of an officer, and that officer has no training, really, in healthcare… So, it's a bit uncomfortable, because it's hard to ask someone to judge if it's necessary to go to the hospital when they don't have any form of training.

Participant 6 noted the importance of taking seriously the stated concerns of IPs, especially aging IPs, despite any adversarial relationships that may exist:

> A lot of those guys… they call them bugs, right? They're always, like, you know, flying around your face, kind of thing. Really annoying… Officers need to start taking those kinds of concerns seriously when they start hitting those ages because of those health concerns. You know, someone in their twenties, thirties, aren't gonna have those same health concerns. It's really important to start listening. Things can go really poorly if officers don't listen to those concerns.

Significant responsibility is placed on corrections officers to make initial decisions and judgements on health concerns of IPs, even though they may lack significant knowledge or training in healthcare. This is complicated by the often-negative relationship between IPs and correctional officers, which will be explored in a later theme, in that officers may not take seriously or ignore the stated concerns of IPs.

Negative Attitudes Towards Aging Incarcerated Persons

Though most participants in this study espoused positive views towards aging IPs, even those convicted of sexual offences, and both saw the value in and were willing to make efforts to secure early release for them, they also noted widespread negative attitudes towards these populations. These negative attitudes were described as particularly evident towards aging IPCSOs.

Knowledge of an aging IP's convictions was indicated as a potential source of concern or trepidation amongst participants. Participant 5 described how challenging it could be to see beyond an IP's specific convictions:

> You work a lot in trying to feel… to feel something, you know what I mean? To be like, to feel some type of compassion. I mean, they're in jail because of whatever crimes they've committed. We work really hard sometimes, trying to separate things. Trying to keep the line, like keep us human. We try to… keep ourselves in check, otherwise we are no better than the people in here.

Participants noted how the culture of the prison environment and the antagonism between IPs and staff, particularly correctional officers, could make efforts to take more compassionate approaches difficult. Correctional officers were described to typically spend the most time with IPs. Participant 6 stated "the guards, they are the enemy." Participant 4 mirrored this sentiment, suggesting "it's a very us versus them environment with the officers and them." If an aging IP had convictions of sexual offences, participants described this antagonism and negative attitudes to be more significant. Describing working on a unit for IPCSOs, Participant 4 reflected:

> I don't love going to that unit. You have to consider they're treated differently by staff… like, if they are talking to us, sometimes we do just kind of – it's that bias, I guess. Like, not that it would ever affect like, ok I'm not gonna help you more than someone else based on what your crime was.

Participant 10 also noted negative attitudes towards IPCSOs, stating "there was stigma towards that unit in general, but there was like, to be honest, none of the officers wanted to work on that unit." Participant 6 suggested that if an IPCSO is transferred to a new unit, "as soon as staff realize what they're in for and the other inmates have kind of figured it out, it's really rough for that person." Participant 8 added "a lot of people with sex crimes history, unfortunately… officers have a bias against those individuals and maybe insult them or try and make things harder for them in prison, which is unethical and unprofessional." Such negative attitudes were

described as potentially preventing CSC staff from pursuing early release of an aging IPCSO. As Participant 10 suggested, “I don’t think they would put the effort into, like, making that happen. I think if anything it would be like something that was on the back burner.”

Theme 3: Release from Prison

Participants described various forms of release available to IPs, including parole, statutory release, warrant expiry, compassionate release and Section 84 release. While some forms of release are guaranteed to IPs on determinant sentences, others required both request and justification for release prior to an otherwise determined date. For IPs designated as dangerous offenders, no form of release is guaranteed. These latter forms of release were described as challenging to obtain, and particularly relevant for aging IPs, especially those nearing end-of-life.

This theme will explore these various forms of release from CSC facilities and the challenges CSC staff face in securing release, especially for aging IPs, including those convicted of sexual offences. The most significant challenge described by all participants involved in these processes is securing appropriate placement for IPs upon release, particularly for those who require ongoing medical and/or mental health care; community-based facilities have no obligation to accept these individuals. Even when release is available or immanent, participants described the challenges of overcoming IP institutionalization, a product of often decades-long incarceration. Preparation for release and undoing the effects of institutionalization were also described as both lacking and/or challenging. The Parole Board of Canada (PBC) is responsible for granting release, and participants described the struggles faced in affecting their decision making. And finally, when release is obtained, participants described the efforts made to monitor and follow up with IPs and their placement facilities to ensure they are not re-incarcerated. The

sub-themes explored here include types of release, compassionate release, other forms of release, site of release, finding community placements, institutionalization, preparation for release, the Parole Board of Canada, and post-release monitoring.

Types of Release

Multiple forms of release are available to IPs serving federal sentences within CSC facilities. While the purpose of this study was an examination of access to compassionate release, participants also described these other forms of release available to IPs, noting that many were more likely or realistic to obtain than compassionate release. Compassionate release itself was described as rarely obtained, complicated, and often granted too late to be meaningful. Of compassionate release, Participant 7 succinctly stated "I'm fairly familiar with it never happening." This sub-theme will explore the various forms of release described by participants, though the majority of its focus remains on compassionate release.

Incarcerated persons who have been granted parole may be required to reside in community-based halfway houses as part of the conditions of this form of release. Participant 3 described a typical halfway house setting:

> Adult males coming out of all federal institutions will go there to finish off their sentence.
>
> Q: So they would be given parole?
>
> Exactly.
>
> Q: By the Parole Board of Canada?
>
> Yep.

Not all halfway houses are identical in focus. This participant noted that some halfway houses accommodate those considered higher risk, with a longer length of stay:

> It's gonna be longer than another halfway house, because the guys they deal with are gonna be higher risk than another halfway house. They specialize in the higher risk, higher needs kind of guys. They'll get the guys that have been rejected at all the other halfway houses – they've been deemed problematic, or more violent, a lot of behaviour concerns in the institution, whether that's with, you know, other inmates or towards the staff. So, they'll take those guys and the other halfway houses won't. The charges of the offences they've been convicted of are gonna be a lot more violent. So, they have longer sentences, so when they do get their parole, they still have quite a bit of time left to finish off… typically probably a year… there's gonna be a kind of cycle of suspension and stuff before they hit that period, so there's not gonna be, you now, a continuous run before they hit that warrant expiry date.

Some IPs are eligible for day parole, where they can leave their institution during the day, but must return to their facility. Not all IPs are eligible for this status, as Participant 3 continued:

> These guys aren't gonna get released on their day parole. They'll get the guys who are kind of later on able to get released, so it'll be a stat release and then they're gonna have a residency condition with that… The guys who do really well in the institution, when they apply for parole they kind of get released a lot earlier in their sentence… those are the ones who end up at the other halfway houses.

Statutory, or, as often referred to by participants, 'stat' release, can be granted to IPs who have served two-thirds of their sentence within a correctional facility, and resembles parole. Even after being granted statutory release or parole, either day or full parole, IPs are still subject to restrictions on their activities and residency and monitored in their activities. Violation of these conditions may result in extension of their conditions or return to a prison setting. Aging IPs

granted statutory release or parole may be placed in a halfway house which, as explored in the previous theme, may not be able to meet their mobility, ADL, or healthcare needs. Those who have more significant healthcare needs may be granted statutory release but have their residency requirements designated as a care facility. Participant 13 described such a circumstance where "he went to a medical facility on his stat release. They accepted him and then he died… like probably a month after that."

Incarcerated persons who are residing in prison or community-based settings may reach the end of their sentence, known as warrant expiry. At this point, neither CSC nor the PBC have any authority over the IP – no conditions are placed upon their release. This may include release from a maximum-security facility. Describing release from maximum-security, Participant 8 noted:

> A lot of people are not really released from these sites. A lot of them tend to be in prison for life, as in 25 years. But they do have some individuals who just happen to be maxed-out and will be released from the max.

These IPs serving life sentences contribute to the overall aging population in CSC facilities. Even if these individuals have significant health concerns, Participant 9 stated "if they have a life sentence, it's harder to get them out" to a community facility. Nonetheless, when these IPs reach their warrant expiry date and they require more care that can only be provided in a dedicated facility, placement is not guaranteed. Participant 13 noted "if they have… a warrant expiry, like they have a determinant sentence, so they have a release date, they have to go and if they have nowhere to send them, it's a problem." Participant 13 described what may happen in such cases:

> Once they reach their warrant expiry, which is the final date that CSC has any control over them, and they return to the community, they literally have to go back to the

> community. And at that time sometimes where they end up, even just with regular offenders, young offenders, older violent offenders, anything, they end up literally dropping people off either at an emergency room or a shelter. With an older guy… that becomes a health services problem, where they say if you don't accept him somewhere, we're only just gonna drop him off in your emergency department and you're gonna have to find a place for him.

This challenge in finding appropriate placement for aging IPs in the community will be explored in greater detail in a following sub-theme. In the case of an IPs warrant expiry, there is no guarantee of appropriate placement upon release, or the placement found, such as a shelter, may not be deemed suitable to the IP. From a halfway house environment, Participant 3 described this challenge:

> Q: If they get to a point where they're basically done their parole, you basically can't keep them any longer? That's it?
>
> Mm-hmm.
>
> Q: They're out.
>
> Yep, and if they don't wanna go where they've been trying to get them set up with and placed, they could walk out the front door and go wherever they want.
>
> Q: So, it's conceivable that they could end up on the streets?
>
> Yep.

Compassionate Release

Though participants did describe multiple forms of release for which IPs are eligible, and how the challenges of aging IPs related to these forms, the primary focus of this study was on the process and granting of compassionate release for aging IPs, including those convicted of sexual

offences. Participants noted that compassionate release is rarely pursued by CSC, or granted by the PBC, and that the process can be very lengthy. They also noted that this form of release is typically only pursued where an IPs death is imminent, and other forms of release, such as parole or statutory release are not possible. As such, those most likely to apply for such a release, according to participants, were those serving life sentences or those designated as dangerous offenders, which often consisted of those convicted of sexual offences.

Many participants noted limited understanding of the specifics of compassionate release, because it was so rare, and they had limited experience with the process. As Participant 1 noted:

> It's based on medical, you have to be terminal, you have to be palliative, you have to have, you know, so many months left. It hardly ever happens. Those are the familiarities I have with it – I have never set someone up for that release.

Participant 11 also stated "yes, I'm familiar with it, but I've never seen it done, no." This was particularly true in maximum security settings. As Participant 8 stated "you don't see that in a maximum prison." Participant 12 added:

> So, in terms of compassionate release, I can tell you that from the institutional environment, it doesn't happen very often. That I can tell you, number one… people that would be wanting some kind of community release over the long-term because there is some kind of medical need, something like that. But that is not happening that often. It is pretty, pretty unusual… the institution would be much more prone to just literally handcuff people in a hospital bed than to give you that.

Participants, if they had any experience at all with compassionate release, noted that it was rarely pursued or granted.

The process and associated eligibility for compassionate release was described by some participants with greater knowledge of the subject. As noted, in practice, compassionate release is typically reserved for those IPs whose deaths appear imminent. Participant 13 declared "for it to be a true compassionate release they have to be basically end-of-life." Participant 13 continued:

> It's usually once they hit like, like I said – palliative for CSC is some sort of untreatable physical health issue, right? Like cancer or you know like ALS or something like that would be something that they would consider, like, then they're gonna pursue based on that.

Participant 2 described an example of compassionate release:

> The person was in a more palliative care stage and the family asked that he go to a regular palliative care home, so that they could be with him. It was really at the end of like, for the last few days.

Participant 7 mirrored this knowledge of compassionate release, suggesting "it really has to be like end-of-life, right? That person is imminently terminal, and the compassionate release is like of a couple of months duration."

The process of applying for compassionate release was described as both lengthy and complicated, requiring multiple levels of assessment and approval that may require more time than the IP has left to live. Participant 12 described this process in more detail:

> That decision would be made with the national parole board… I think it's a good idea but even if they thought it was a good idea, they'd have to go over not one but two hurdles, and big ones on top of that, and hurdles that, you know, you have to wait a few months in

> order for it to happen. Well, if you only have a few months to live, by the time that paperwork is processed, it's already too late.

Participant 12 continued, noting the time required in this process:

> What I described takes time. It takes, yeah, so, at minimum you're talking months, at minimum, because if they're writing said report, well, yeah, it's gonna take probably a few weeks to write that report, then that report has got to be digested by the prison authorities, then that full reports got to be forwarded on to the parole authorities, then they've got to schedule a hearing. You can see how, you're already up to three months and you haven't even had go.

This waiting time required to schedule a hearing with the PBC for compassionate release was described as too lengthy for some IPs with significant medical conditions to endure. Participant 13 described a situation where "they filed the paperwork – parole board granted his release… and then they literally drove him to the care home and I think like nine days later, he passed away."

Participants described two significant factors associated with successful granting of compassionate release for aging IPs nearing end-of-life: questions of risk and finding a suitable placement in the community. To be granted release from a CSC facility, it must be demonstrated that the individual IP present minimal risk to reoffend, even to receive end-of-life care in a community-based facility. Regarding risk and compassionate release, Participant 12 observed:

> So, they ought to weigh, that ought to be the primary consideration from the perspective of either the parole or the correctional service of Canada: can this particular release be safely managed in the community. That ought to be the primary question and if the answer to that is no, sorry you ought not to be released in the community even on this

> basis… this isn't safe, and it might sound cold and unbalanced but indeed they recommend against it sometimes.

The topic of risk will be explored in greater detail in a following theme, where participants described decision making regarding release to extend beyond simple questions of risk, as the above participant observed. Participant 5 suggested "it's not a simple thing, you know – you're not risk anymore you can go. No, it's not like that."

The second major factor is obtaining compassionate release for an IP is related to securing appropriate care in the community. According to Participant 13 "the only way we can successfully get those completed is if we have a place to send them." Participant 13 described in greater detail an example of attempting to secure compassionate release:

> It boils down to, you know, we don't have anywhere to send him. And he has no family. Like, there's family but they're not very supportive of him because he's messed up too many times for their liking and they're… unwilling to care for him. That's the kind of dilemma we face. So, compassionate releases occur, but usually at end-of-life… I think they pursued one for him as well, the problem is they never really had a release destination for him to go to, so it kind of fell flat at the end because, for them to actually grant the release… they had nowhere to release him.

The challenges of finding family members or community-based placements for release will be explored in greater detail in a following sub-theme. Participants identified the tendency for compassionate release to either not be pursued for those nearing end-of-life or granted by the PBC because no one is willing to accept IPs into their care. In these cases, IPs would either die in CSC facilities or in a hospital while still under CSC authority – as participants described with guards at the bedside. As noted by Participant 13, "we can try to get them out but if nobody will

accept them, well then ultimately… and no family will take them, or is available, then we keep them, and they eventually die in prison." It was also noted that negative attitudes towards IPs, particularly those convicted of sexual offences, may prevent CSC from pursuing compassionate release. Participant 10 stated:

> To be completely honest… they just don't, they don't really care about the inmates at all, so I don't even think they would – if it was even an option I feel like they would put, like the officers and everything like that would put up so many barriers that like, I don't know if that's me being jaded, but I feel like stuff would kind of prevent that from happening on a bigger level.

If an IP nearing end-of-life is in a CSC facility lacking 24-hour nursing care, participants noted that they will typically be sent to a regional hospital or psychiatric facility where more appropriate services exist. Participant 12 noted:

> Most of the time we talk about moving you to some kind of healthcare unit within an institution or to an institution that has some kind of geriatric facility, and that would be how those things would be dealt with.

However, this transfer to a different facility may take the IP to an institution far from what would be considered home, potentially across provincial lines. If family members are involved, this transfer may make visitation even more difficult. As Participant 12 added:

> But even there, so I am, let's say in Saskatchewan in one of those specialized units, well, you might have grown up in northern Alberta – what good is it for you to have a hospice in Saskatchewan? You might as well be in Poland… it's not necessarily an advantage.

If finding suitable care within the community is not possible, or if compassionate release is not pursued, or if the PBC denies a request, then an IP is destined to either die in a CSC facility,

potentially far from what is considered home, or in a community hospital under watch from CSC correctional officers. Even this latter possibility, Participant 12 asked, “is the hospital a highly custodial setting? Of course it is!”

Multiple participants identified deficiencies or issues with how compassionate release is pursued or granted for aging IPs under CSC authority. As earlier discussed, some participants noted a CSC mandate for IPs to not die within CSC facilities, or while under CSC control. Participant 7 offered:

> At CSC it almost feels like they’re letting them out so they don’t have to pay for their funerals, right? Like, why did you have to die, so we don’t have to cover the cost of your dying. I don’t know, maybe I’m just too skeptical… you know, it can be called compassionate release, but it doesn’t seem to be very compassionate.

Participant 13 described a case of granting compassionate release to an aging IP:

> He was considered, quote-unquote, off the books in terms of CSC… he was bed bound, never to recover… they filed the paperwork and essentially got him, you know, a full parole compassionate release. I mean at that stage they were really just doing it for the record. Technically he dies not in custody. And then they pulled the plug, I don’t know, a few hours later, after the paperwork came through.

Situations were described wherein IPs were granted compassionate release as a technicality to minimize the number of deaths within CSC facilities. Administrative tasks are associated with deaths in custody, as Participant 12 noted:

> CSC has its mandate, or one of its mandates says longevity of life: we are responsible for those that are in custody. And their model is one to which if there is, for instance, a death in custody there is… going to need an investigation. Well, these kinds of investigations

> always – I'll be very frank – I found them humorous. Because the goal of the investigation was to come up with recommendations on how to avoid these things in the future, and why I find these humorous is well, if you can find a way to avoid old age, please let me know. If you can find a way of eliminating a heart attack, let me know.

While participants described examples of compassionate release being granted for administrative purposes, other situations were described of IPs who were perceived as very appropriate for the release were denied. A terminal illness, such as cancer, is not guaranteed to make an IP eligible, as Participant 13 noted. Other factors come into play. For instance, when asked about granting compassionate release for those convicted of sexual offences, Participant 9 suggested "I'd say it's less likely." Race was also identified as a factor. According to Participant 13:

> Most of the guys we've gotten out, to tell you the truth are all, have been white, Caucasian. Very few of them have been Indigenous…. Almost every guy… like really older guys that have gotten releases… they were all white. Yeah, so they go live with family. We don't have a lot of older Indigenous men making it to, you know, like a long-term care or anything of the like. So it's definitely, again I think the systematic problem that we're seeing.

The timing of compassionate release was also questioned. The need for an IP's death to be imminent, complicated by the lengthy process of applying for release, before making an application resulted in IPs dying before compassionate release was possible, or giving them very little time in the community before death. As Participant 9 asked "why do we have to wait till they're old and dying?" Participant 12 acknowledged, "in terms of compassionate release, could it have happened more often than it did? Probably could have. But did that happen all that often? No, no, not in my experience." Participant 7 offered "I'd like to see a system whereby

compassionate release at a certain age is a given, and if you want to keep them you have to justify it." Such a proposal reverses the logic of compassionate release, placing the onus on justifying the ongoing detention of an aging IP.

Other Forms of Release

Two additional forms of release were identified by some participants that deserve attention in this sub-theme. These were compassionate temporary release and Section 84 release. Compassionate temporary release was described as a form of escorted temporary absence (ETA) in which an IP is permitted a community outing for instances such as funerals or visiting an ailing family member. Participant 12 described release to attend a funeral as the most common, and outlined the security procedures involved:

> The most common that I've encountered in the Correctional Service of Canada… usually those were: how do we get this person through, you know, 24 to 48 hours to maybe a little longer without hurting anyone. The release could be very restrictive actually and theoretically that release could be more restrictive than it would be in the institution. They can have an officer with them 24 hours a day wearing shackles and all kinds of stuff. In which case then we might ask how meaningful it was – it's a fair question.

These absences require planning related to the security of individuals in the community. Participant 12 continued:

> The other places where you might see compassionate release would be – this happens far less frequently – but someone requesting to see an ailing loved one. So, someone believes that, you know, their loved one is going to die and it's usually a short duration: weeks, months, and they say I'd really like to you know, make my peace with them before they

> go… that would happen a whole lot less often than going to a funeral… I hear people in essence being offered a choice: you can go to one or you can go to the other.

These forms of release are offered on compassionate grounds, but are temporary and, according to this participant, still require the presence of a correctional officer and a focus on security. The second form of release described as available to some aging IPs was a Section 84 release, specifically made available to Indigenous IPs. This form of release was described as "day full parole to their home community" by Participant 1. They continued:

> It's being released to your own community, and they can – because they have some healing lodges and sometimes guys get section released to a healing lodge. They have more freedom, more privileges when they do it that way.

The participant described the pursuit and/or granting of Section 84 as rare, stating "that's once in a blue moon." In these cases, placement deemed appropriate – within the IPs home community – is required prior to granting the release.

In this sub-theme, various forms of release available to IPs were explored, including parole, statutory release, compassionate release and Section 84 release. These forms of release were described as used with aging IPs, particularly those with significant health issues, to grant access to the community, often where more appropriate healthcare options were available. Limitations to these forms of release were described by participants, including lengthy application processes and the difficulty of finding community-based placements.

Site of Release

Where an IP was released from – the type of correctional facility – was described by participants as a factor in how release was achieved or the conditions of this release. Many forms of release for aging IPs, particularly those with more significant health issues, described by

participants occurred from regional hospital or psychiatric facilities. As earlier explored, those IPs with significant health concerns would typically be transferred to these facilities from other CSC sites, such as a maximum-security setting. These individuals may be eligible for release, such as statutory or compassionate, but suitable placement must be secured prior to this happening. Describing these situations, Participant 13 stated "the parole board can, under certain circumstances require that they remain in a psychiatric or medical facility run by CSC until such time as something can be found." The responsibility to find appropriate community-based placement is then placed on these regional hospital or psychiatric facilities; IPs may remain in these settings until placement is found, even if they are eligible for release. IPs released from more conventional settings may face issues with continuity of care, especially those with healthcare needs that are not placed into formal treatment settings, such as long-term care. Participant 2 described these concerns in greater detail:

> The older population, they're more worried about having a follow-up when they leave, like if they have chronic conditions, if they have medications, or something that they could be worried about. Because some people get released directly from the facility…. Like some people get released straight, like, quite a lot, actually. Directly from the facility. So, they, like some of them are worried about where they will go. I would say all of them who are on opioid agonist therapy worry about that, about continuing their treatment, but, as well, the ones with lots of medications and chronic conditions. And that's not easy, because sometimes they go into transition when they get released. So, they transition in a city, like a bigger city, and when that ends they go to another town, like a smaller town where they came from and that's not easy to have a proper follow-up.

The physicians and/or psychiatrists who provide treatment for IPs within correctional institutions may not be responsible for providing care after the IP is released. Continuity of care in this transition was described as a form of stress for aging IPs about to be released. Release from maximum-security facilities was described as least common. Participant 7 noted that "someone in the maximum security is less likely to be released." Questions of risk, including for those convicted of sexual offences, relate to release from these settings. Describing some IPCSOs in maximum security settings, Participant 10 stated that "they would not be eligible for compassionate release, like, they would 100% re-offend." This question of risk will be explored in greater detail in a following theme. But, as described earlier, those IPs deemed lower risk were noted to 'cascade' to lower levels of security, from which release was more likely. Those who remain in maximum-security settings are considered high risk and may only be released to regional hospitals and/or psychiatric facilities if they require more intensive healthcare treatments or get released upon warrant expiry.

Finding Community Placements

An issue described by most participants as a significant obstacle to early release of aging IPs, especially those convicted of sexual offences, was finding appropriate community-based facilities willing to accept IPs where their healthcare needs are properly met. As earlier explored, to obtain compassionate release and other forms of release, CSC staff must secure appropriate placement for IPs prior to release being granted. Without this in place, early release is denied. Participants noted that when attempting to find placement in facilities offering long-term care or palliative care, these facilities are made aware of the IPs convictions. A history of serious convictions, such as homicide and especially sexual offences were described to 'scare away' potential acceptance in community facilities. This sub-theme explores what is arguably the most

significant obstacle aging IPs, especially those convicted of sexual offences, face in being granted compassionate release, and other forms of early release. As Participant 4 candidly asked, "what long-term care place would really want someone… that is a sex offender with dementia? I'm not sure."

When an aging IP with significant health issues is deemed suitable for compassionate release, or early release such as parole, and the individual is not able to live independently or with family members, some form of treatment facility needs to be identified by CSC staff before the PBC will grant their release. In these cases, as Participant 1 suggested, "there's a need for flexibility and creative thinking." Given that those with more significant healthcare needs may not be granted release if no placements are available or willing to accept them, release to family members may be an option. Participant 9 described the efforts made in this regard:

> Staff will go to every length to find someone to contact, whether it's a family member, a long lost cousin, or they'll go to reserves, they'll go anywhere they can to find supports and they just don't find supports, and the parole board doesn't like that.

As noted, these supports are often unavailable, leaving CSC staff to pursue their only other option of finding community care facilities. Regarding the PBC's role in release, Participant 13 observed:

> They want a location. They want a plan. They want all these things in place before they're willing to contemplate in many cases a release. So, they have to set that up before and if they can't set that up, then the parole board just can't, their hands are tied somewhat, because they can't demand that somebody would take one of our guys.

Even though the PBC requires an identified placement, it possesses no authority to secure placements for IPs. Inversely, according to Participant 9, "some places will say your person has

to get parole before we'll consider taking them, but the parole board won't consider granting parole unless they have a place to go." Participants described monumental challenges in finding facilities willing to accept these IPs. Participants noted the extensive work done by CSC staff to find placements willing to accept individuals. Recalling an example of this, Participant 13 stated "eventually he got out on a stat release, and again, they had to literally bully somebody into taking him, because again, nobody wanted to take him." Regarding another aging individual requiring community placement, this same participant observed "I'm surprised that some of our people didn't get charged with harassment to finally get him accepted." Of compassionate release, Participant 13 declared "the only way we can successfully get those completed is if we have a place to send them." Participant 9 noted that "old folks' home or – not that it's a great term for that – they're just reluctant to take the aging offenders, especially if they've committed a sex offence." Participant 9 described this process when asked:

> Q: So, a long-term care facility, for example, if they're getting an application for somebody from CSC, they will see the nature of the offence?
>
> Yeah.
>
> Q: And they can say yay or nay?
>
> Yeah, yep. And they – I think they just have the right to just refuse – they're not required to say why. They just say no.

Participant 13 described the frustration of attempting to secure placement for these individuals, especially if convicted of sexual offences:

> As soon as they see that they're a sex offender, they don't want them. So, the only chance we have of getting guys out to some extent is when they're forced to go out, because they no longer become our responsibility and the community must retake them, because

> they're repatriated. But otherwise, it's virtually impossible to find these guys beds. They can't live independently… and they have no family to take care of them sufficiently. They're not usually approved to go to mental health group homes and they're not approved to go to any other congregate living situations, basically, or long-term care. So, it's a very frustrating process, to say the least.

The participant was describing the repatriation process as when an IP hits their warrant expiry date and can no longer be held in a CSC facility, regardless of circumstances. In these cases, as early described, these individuals may be simply transferred to a local hospital emergency department. Participant 7 suggested:

> The correctional service does not even consider nursing homes as an example for those who might need placement because they know they'll be unsuccessful in getting the sexual offender in. You know, there are even halfway houses that are under contract with the service and – none of this is ever written down – but they refuse to take individuals who are convicted of a sexual offence.

Upon learning of an IPs convictions, as participants described, community placements are entitled to refuse placement, even halfway houses.

When it comes to placement of individuals within long-term or palliative care facilities, as Participant 13 observed, "community members get priority." Participant 9 suggested that "a long-term care home is more likely to take my grandpa or your grandpa rather than, you know, the federal down the hallway." Participant 13 described the challenges of working with community agencies:

> Like telling us there's no beds when we know that… we had heard through someone else that there is, like tons of beds. Because of COVID a lot of passes, people passing on, or

> pulling out of long-term care or whatever. There were tons of beds. And yet, they won't give our guys a bed. Like, ok, we know it's not a bed availability issue. Because we know there's beds. So, what's the deal, right? Well, you know… excuse, excuse, excuse, but nobody wants to really come out a just say, like, we don't want him because he's an offender. They kind of dance around it.

They continued:

> Nobody will take them. Like, they don't even just not want offenders, they don't want sex offenders. So, in terms of long-term care, they are the most difficult, even if they're basically bed-bound. They just simply do not want them in their facility.

If given the choice between accepting and aging individual from the community or accepting an IP from a CSC facility, as participants noted, these facilities prefer individuals not currently incarcerated. Even if granted release, IPCSOs may have restrictions placed upon their residency, depending on the nature of their conviction. Participant 13 described:

> A problem we have with getting people to old folks' homes, long-term care facilities or group homes is access to children. So, in particular, if they're child sex offenders or have any offences against children, it's typical to put at least a warning in place because of potential for grand-children and then great grand-children to be visiting these long-term care facilities. They can't have any contact that's unsupervised with a child under the age of usually sixteen. They're registered sex offenders with the Canadian registry.

The reality of such situations was elaborated by this participant:

> You may take your kids to see their grand-mother in a long-term care facility and sometimes, you know, they run around the halls and you know, they're going and visiting

> with people… and that's the concern is that these facilities they can't control necessarily who they have access to.

Participant 3 elaborated on the types of conditions IPCSOs may be restricted to in the community:

> Because of the sex offences, for sure. Just whether it's because of location of where, say a seniors' facility is, like is it close to a park, close to a school… their conditions are, you know, can't be located near schools, parks, shopping malls, all sorts of things. It really limits where they can go, but if they're in a secure kind of facility and they can't leave, then, but the waitlists for those places are usually pretty, pretty long.

Participant 13 added:

> So, you have to put those warnings in place and then of course as soon as you put those warnings in place, which is the only ethical thing to do, you know, basically destroys any opportunity or chance that they're ever going to get in anywhere… it's sort of a double bind at times, but our job is to ultimately protect society, right?

Previous experiences with released IPs may prevent community agencies from accepting future individuals. It was acknowledged that the sorts of behaviours viewed as acceptable within correctional facilities may not be viewed similarly in community settings. Participant 13 continued:

> What we accept as acceptable behaviour or suitable behaviour, given that we're in an environment of extremes. So, all those sorts of minor things look minimal to us, but in the community, they look big. And so, once you burn a bridge with the community, it's hard to win that back. It's like every time we send somebody out and if it goes wrong, we burn a bridge and then they're like, yeah, no we're not playing that game with you again.

> Even if the person is completely suitable, right, they can be a completely different case, completely different circumstances, but because, you know, it's hard to forget that previous case that went bad, you know, so it gets very difficult.

A time of transition to a new setting, especially after long periods of incarceration, is to be expected, with the potential for behaviours deemed unacceptable by the accepting facility. Participant 12 noted that "the only real release you could recommend would be to an environment that quite frankly is divorced from everything they know." Concerns of IP institutionalization and preparation for release will be explored in following sub-themes. If an aging IP is placed in a community setting and that setting has negative experiences with the individual, participants noted that that facility would be less likely to accept IPs in the future, limiting, over time, the potential placements available to them.

Jurisdictional issues were also identified as an obstacle to securing early or compassionate release for aging IPs. As earlier identified, aging IPs may be transferred to regional hospitals or psychiatric facilities within CSC, and these transfers may take the IP far away from their home and/or parent institution. This may include different health authorities or even different provinces or territories. Participant 13 described this challenge in greater detail:

> So, when they try to go to another province and say we want to release this person to your province, they're like no, no, no, no, no. That's not gonna work. And they're like, yeah but he's from there. It's just because he's under federal mandate that he's considered… So sometimes if they can they have tried to transfer them to an institution or some sort of care within CSC in that province… just temporarily just so they can be classified as an actual citizen of that province, then release becomes easier. So that's

> another complicating factor is like places that just don't want to accept out of province even though they're not fully out of province.

These jurisdictional issues presented further complications to the release of IPs.

Because of these challenges of securing appropriate community-based placement for aging IPs, participants described the importance of early planning. In some cases, as Participant 13 noted, this requires "starting a year in advance or more." Participant 3 described this approach:

> They just start the assessments. Like they know they need to get them to a more secure facility or secure placement, so they just start with all the contacts and placements that they know and just try to get them on the lists for places that have that kind of secure housing.

Even if these facilities are willing to accept IPs into their care, significant wait lists may exist; placing IPs on these lists early was identified as a strategy to better secure placements.

Participants described multiple instances of an aging IP with significant health needs deemed suitable for release, but CSC being unable to find placements. Release in these circumstances, according to Participant 13:

> Tend to be difficult to obtain. Not for the parole board not willing to do it… it's the community acceptance of the individuals. They point out the fact that it's a community problem almost more than it's a CSC problem or a corrections problem. Like, corrections is not perfect… but ultimately, this is a community resource problem.

This participant described a situation with a particular aging IP:

> He's low risk, but cog-wise his dementia is super bad, he gets super confused, he thinks he's leaving, people are coming to pick him up… he doesn't know where he is most days,

> he doesn't understand what's going on. And they say, if we're gonna push for anybody to get out, this is the guy that needs to go. But for some reason, they all just look at him and they're like, oh no, they wouldn't have him anywhere, and it's like, well why not? He's the perfect candidate for long-term care.

Participant 13 added "we're not saying that our guys need anything over and above that's super special in most cases, more than any other regular community member." While waiting to be accepted into an appropriate community placement, participants noted that an IP's health may deteriorate so significantly that transfer may not be feasible. As Participant 13 noted in these cases, "sometimes it's just better for these guys to die in custody." A Final complication to the finding of placements, as noted by participants, was that IPs must be willing to accept the placement found for them and have the right to refuse. Participant 13 suggested "they have to willingly and voluntarily accept… going there, right, which sometimes these guys also say, well, I'm not gonna go there. You know, or I don't want to go there, and then that makes it even more difficult." Such circumstances, in cases where release is not guaranteed, result in these individuals dying in prison. If release is guaranteed, such as warrant expiry, this may result in individuals, as Participant 3 earlier noted, ending up on the streets.

Finally, some participants noted that race could play a factor in finding appropriate community placement, specifically if an IP is Indigenous. As noted earlier, one option for release is for an IP's family to accept their care; the PBC may view this as an acceptable placement for release. Participants noted that a lack of family support was common for Indigenous IPs. Regarding older Indigenous IPs, Participant 7 acknowledged that many "have nowhere to go." Acceptance into treatment facilities was also identified as less common for Indigenous IPs.

Participant 13 not "they don't see a lot of older Indigenous men making it to, you know, like long-term care or anything of the like."

Institutionalization

Participants described the challenges of IP institutionalization in posing obstacles to the release of IPs. The lengthy sentences served by many IPs within CSC facilities, particularly life or indeterminate sentences, were described as institutionalizing many aging IPs. Because of this process, successful transition to the community was hindered, or IPs simply refused to pursue release. This was described as particularly relevant for aging IPs on geriatric units, as well as IPCSOs placed on units specific to those convicted of these offences. In describing this phenomenon of institutionalization, Participant 7 noted:

> You know, maybe they've had some convictions over years and a couple of convictions as an adult and you know, they feel somewhat more familiar with the correctional environment and better able to manage it: they know the hierarchies.

This participant described an aging IP who:

> Denied committing his crimes altogether… they gave him information from the innocence project, the parole officer gave this to him and part of the reason he never filled it out was because he was so institutionalized, he'd been inside for over twenty years, and the world had changed so much.

Participant 5 noted the changes in the world presenting challenges for aging IPs even while incarcerated:

> These people have been inside for so long that they are now, like they don't know how to use a computer. You know sometimes they get to do a little bit of shopping and they struggle with those things, so instead of just them using a computer or whatever resources

> that we give them, they will ask us to do it for them… they're out of time. They don't know what's going on outside.

Participant 13 added:

> When you've been incarcerated for thirty plus years, everything just seems crazy… think of how much the world's changed in the last thirty years. I can't imagine being locked up and having no clue… they don't know computers, I mean, like even plastic, like credit cards, debit cards, paying for stuff, tap… everything is just new to them… they lived a very different life prior to incarceration and since being incarcerated, like everything is so different. Like, the world has moved on and they haven't. They're very much stuck. In some of these old mentalities it can be very overwhelming. And that's one thing we find hard to predict is, what is their behaviour going to look like when they suddenly have access to all this stuff and they're so overwhelmed.

This recognition of significant change in the outside world since incarceration was described as a source of anxiety for aging IPs after long periods of incarceration. Participant 5 added "like the idea of being outside is bigger in their head than actually what it is to be outside, to be a free man." Participant 13 added that "everyone says they want to leave, right? Everyone wants to leave prison, but they also don't recognize or realize what life is gonna be like on the outside."

A comfort with the relative stability of life inside the institution was described as a product of this institutionalization of aging IPs. Participant 7 suggested this occurs "when everything is provided for you and you don't have to do it for yourself." Participant 5 added:

> When you have a nurse 24/7 that you can just call, you can just say I don't feel well, and somebody would rush in to take care of you, or, I'm hungry and we provide food or whatever, and we will do our best to provide, to satisfy your needs.

For aging IPs especially, those who are placed on dedicated geriatric units, this level of comfort was described by Participant 9:

> Those geriatric units keep people too long. They should have left ten years ago, five years ago, because it's not hard to do time there compared to other places… they could have moved on to a medium and maybe even a minimum a long time ago and be out in the community somewhere, but they stay because it's easy time.

The relative ease of incarceration in some settings where needs are well met was described to prevent aging IPs from pursuing release or transition to a lower security setting.

In these cases, according to participants, aging IPs who have spent considerable time incarcerated begin to view the prison environment as home. Participant 12 described this phenomenon for those facing the potential for release:

> Particularly amongst the lifers. What people don't understand is, yes they can be there for decades and the prison does become their home. It really does in a meaningful sense… with this sense of home over a long period of time, well do I want to be closer to home or further from home when this is happening?

In such cases, Participant 12 added, "you can't assume that the person necessarily even wants to go." In this sense, removal of an aging IP from this sense of home can be destabilizing. Participant 13 observed:

> For these guys that have been in for, like, decades, and it's really become their home, we actually find that if we do manage to get them out, that a lot of them pass within a fairly short period of time. Because it's just, I think it's just stress on the body and it's the unknown, everything that they've known for the past, you know, twenty, thirty years is kind of stripped away from them.

The prison environment, on account of a deep level of familiarity and, for some, a sense of comfort, becomes an IP's home in a very meaningful way.

Because of this sense of home, participants described situations where IPs would either refuse to apply for release or would intentionally commit offences to either remain in or return to prison. Participant 13 described such a situation:

> His parole hearing was coming up, his eligibility. He was like, he got really anxious and he started having a lot of issues… they said what would you do in the community after this long and he was like, oh, I don't know. And they could tell he didn't, like he was disconnected from the community… it was not until he decided to wave his parole hearing and then the anxiety just vanished. And he felt better. And for him, prison was home. The idea of going out, the idea of trying to figure out life in the community and the idea of all that was so overwhelming.

This potential for release presents a level of uncertainty. According to Participant 5, "that's when you notice that a lot of people will do something just to stay in for a little longer." Even if institutionalized aging IPs are released, according to Participant 5:

> The first thing they do is, and I'm sorry I know it might sound cruel, but they might reoffend. Do anything to get back in, because that's all they know, it's comfortable. We work really hard making it comfortable for them inside, but when it comes time to be outside, like all that goes away.

If work is done to find community-based placements for aging IPs, participants described a transition period where the placement was tenuous. Participant 13 described such a situation:

> They were ready to like basically send him back after a week, and it was like no, no, no, no, no. And then sure enough he ended up settling in and he was good… Sometimes it

> works, sometimes it doesn't. Sometimes they come back anyways, because there's just no amount of easing concerns, trying to get everybody to understand that it's an adjustment for these guys.

The adjustment to a life outside of prison was described as very challenging for many aging IPs, such that they end up returning – intentionally or otherwise – to the prison environment where they feel most comfortable.

Participants also described the institutionalization that can occur with aging IPCSOs. In these cases, much of this institutionalization was related to a sense of safety found within the prison environment, especially if they had been placed on a unit designated for IPCSOs. Because of the dangers IPCSOs often face within the prison environment, if they find a setting in which they feel safe and/or comfortable, they may be hesitant to leave. Participant 10 described such a situation:

> They were trying to send the person to the regional hospital, but the person wasn't agreeable to going… because they were just super comfortable on the unit, to be honest. Like, they were happy as a peach. Like, they were someone, they'd been in jail for a very, very long time, now, and they were not gonna be happy cascading down in their security level just because of past history… like, just what their offence was… inmates just kind of left him and, you know, didn't really go for him.

IPCSOs who find a level of safety within the correctional system may be hesitant to leave, knowing the potential dangers they face if transitioned to a different setting, even if this setting potentially offers a greater degree of freedom.

Preparation for Release

In an effort to avoid or discourage the level of institutionalization described in the previous sub-theme, and some of the challenges IPs faced after being released, participants described the efforts, or lack thereof, made to prepare aging IPs in advance. They also described preparations made to make obtaining release more plausible as an IP gets older and develops more significant healthcare needs.

The institutionalization described in the previous sub-theme was attributed by some participants to a lack of preparation for the realities of life outside prison walls. Participant 5 noted:

> I do believe that we could do a better job preparing these people to be released. Everybody talks about release and the compassionate release, but we don't prepare the guys to be free, and what it is to be free.

Participant 5 went on to describe the simplest of challenges aging IPs might face upon release:

> So, we work really hard making it comfortable for them inside, but when it comes time to be outside, like all that goes away… like some of these guys don't even know how to go to a hospital if they feel shitty, or how to get, like… to go from a to b… Because minus thirty, minus forty, you know most of the time they wouldn't have access to a car, not even know how to take the bus… like, I've never seen anybody show these guys how to buy a bus pass. I don't know how much is the amount of money they give, like fifty dollars I believe it is at release, and then, well, you know I hope you do well. And that's as far as it goes.

These lack of resources and lack of supports upon release were attributed to aging IPs not wanting to leave correctional facilities. Participant 7 described such a situation:

> He said, well, I have nowhere to go. Like before he was incarcerated, he was alcoholic, had no people at all, and so after twenty-plus years inside, he had nothing in the community and he was quite prepared to continue to stay incarcerated and to die in prison, because if he went through the process, he had nowhere to go. He'd be on the street again.

Participant 5 opined that more could be done in advance of release to prepare IPs for the reality of being outside the prison environment:

> We should invest a little bit more resources in preparing these people to be outside… it becomes a more humanitarian thing, we invest in them being outside – not knowing what to do, calling the ambulance every second day becomes a big burden for the healthcare system… we should invest or have more professionals trained to do that, like what social workers do in the community, help them get back on their feet. The same thing, but we start this before they get out.

Preparing aging IPs, particularly those who have spent considerable time incarcerated, to be better prepared for the realities of life after prison was identified as a deficit within CSC.

Participants also described many of the more logistical challenges faced in preparing aging IPs for potential release, be it parole or compassionate release. Participant 3 described the preparation involved in releasing an IP to a halfway house:

> From the institution the concerns and the issues that they're having from then, so they're kind of expecting when they arrive, so they're sort of prepared for it… criminal history, medical, psychological, psychiatric, kind of everything that they've had.

From a halfway house setting, aging IPs who required more supportive living environments upon warrant expiry faced challenges, not only in finding sites willing to accept them, as previously explored, but also in paying for these services. Participant 3 continued:

> A lot of times funding for it is an issue, too. Hopefully they have enough, like, CPP, or some might have like military fund… because these places aren't cheap, sometimes where they need to go and you have to pay for it yourself, these individuals. CSC doesn't pay for it… And a lot of them don't have families, so, figuring out how it's gonna get paid for.

The cost of a care facility was described as an obstacle for aging IPs released from CSC custody was described as a potential obstacle.

Participants described the amount of preparation required in ensuring and aging IPs needs are met upon release. Much of this has already been explored in the previous sub-theme of finding placements. However, additional tasks or preparations were noted. Depending on an IPs crime, mandatory treatment programs may be assigned in order for release to be considered. This was particularly relevant for sexual offences, regardless of level of risk. Participant 7 described such a scenario:

> So in comes some low risk, geriatric, petrified man with a historical sex offence… who is the lowest of the low risk, and so what they would do in that occasion, as soon as the recommendation is made for an individual to get to a high intensity program, they couldn't reject them… they had to go through it or the board, the parole board would consider them, you know, not sufficiently treated and not release them. So, they had a system for when they got these low risk offenders that they would fast-track them.

Participants described the importance of satisfying the requests or requirements of the PBC in facilitating the release of aging IPs. In some cases, an aging IPs family may be willing and capable of providing care upon release, a condition the PBC may accept. Such arrangements could prove complicated if an aging IP had been transferred away from their 'parent' institution and away from their family. Participant 13 noted:

> Some that want to go home with their families or want to go closer to where they're from and that may mean they are trying to deal with cross-provincial situations, which are harder because like, another provincial health services isn't gonna come and assess this guy, right? They count on the local health authority to assess them and then forward the paperwork. And then they will look at it but then it doesn't exactly, like it's not the same criteria or the same level of stuff… there's so much red tape.

If an aging IP is transferred to a care facility in another jurisdiction, the assessment requirements may not be congruent between agencies. This places additional burden upon those working to arrange releases. Even if an aging IP is released into the community in the same jurisdiction, continuity of care was described by Participant 2 as a concern:

> The older population, they're more worried about having a follow-up when they leave. Like, if they have chronic conditions, if they have medications, or something that they could be worried about… all of them who are on opioid agonist therapy worry about that, about continuing their treatment… they try to plan ahead. What's difficult is like if they don't have a family doctor and they have chronic conditions, then it's difficult… they don't know when they will have access, and the doctors at CSC can't do a follow up after they get released, so they usually have a prescription for 3 months or 6 months… and they have to find someone and that can be very stressful.

This transition of care from institution to community was described as challenging, and not always achieved because of incompatible healthcare jurisdictions.

For aging IPs to be considered for compassionate release, typically if another form of release such as parole is not available, participants noted that the IPs health condition must be particularly dire and death imminent. However, some participants noted that many aging IPs who did not yet meet these criteria should still be considered for early release. Participant 13 considered:

> We start to see the physical and the cognitive problems starting, which, if anything becomes almost more complicated. A lot of our guys have one foot on one side of the line and one in the other. In other words: they can't live independently, but they don't qualify for long-term care. So they're in limbo, and we only say until you're, like, bed-ridden, incontinent, don't know who you are, seemingly here you don't qualify for long-term care. You know, your grandmother might be in partial care, you know, she doesn't need full-time care… she needs help, but she doesn't need it all the time, and yet our guys, even if they met that criterion, they don't qualify.

The long-term care setting was described as similar, in many ways, to what aging IPs experience within correctional settings, what Participant 12 described as a "highly custodial setting." Participant 9 elaborated on this reality:

> Some of them have nothing better, they have nothing else and they don't know any differently and they know where they can get their meals, they have shelter. They get up, they know their meds are provided to them, they don't have to do much. For a lot of them it's probably not different, a whole lot different than an old folks' home.

Nonetheless, for aging IPs, Participant 13 noted a tendency to wait until their health became significantly compromised before release is considered:

> Until they're palliative or until they're bed-bound, end-of-life, then they might get them off the books. And I say that not fictitiously, but like it's literally. A parole officer may say, like, all these guys didn't die in prison, but let's be honest, they died in prison. Like, they didn't really die in the community, laying on a ventilator brain dead, but he's died in the community like, he didn't die in the community. He never got a chance to live in the community. Like, what do we classify as living in the community as well, right? Not being within prison walls? A lot of them are not going to better places and they're not living life, like, I'm going there to die is what they're doing. But as far as CSC is concerned, they're off the books… and so they didn't die in custody. That was a successful full parole or parole to another location or whatever. And so, it's totally skewed, and it's checking boxes when it comes to CSC and it's bonuses and it's numbers and it's for upper management.

The rationale for this delay in considering release was typically related to questions of risk, a topic to be further explored in a following theme. Participant 7 described this tendency as "more risk aversion around releasing someone who poses as a risk as opposed to incarcerating someone who doesn't." Waiting until end-of-life to release aging IPs was described by this participant as insufficient for family members, if involved, to potentially make amends with the IP:

> Think about the position that it puts the family in, for example, if they find out, ok well granddad or dad is finally being released on compassionate grounds because he has terminal cancer and he's got a couple of weeks, so you have no time to process that, no time to get the support that you would need to even decide, do you want to see the

> person, right? We have these social sort of norms that say, if someone is dying, you really should go see them and make amends. But yet we have these very human constraints: I'm still really pissed off at that person for what they did, and I am not ready to forgive them, but then if I don't and they die unforgiven, what's my life gonna be like if I find forgiveness in a few years? So, if you really think about it, it's not very compassionate for the families or maybe even the victims, right?

Participants described the work that is done to obtain early release for aging IPs but noted that such release is often only granted at end-of-life, and may only be done for the optics of fewer deaths within CSC custody. Such an approach may come at the expense of any form of genuine experience outside of prison walls for the IP, even if they're going to a slightly less custodial environment. Participants suggested earlier release such that some form of meaningful existence and potential family involvement may be possible. However, such an approach clashes with the prioritization of risk mitigation within CSC, which will be described in a following theme.

The Parole Board of Canada

Participants with experiences making applications to the Parole Board of Canada described obstacles faced in obtaining early release for aging IPs, be it for parole, statutory release or compassionate release. A rigidity in PBC expectations, concerns over public perception of IP release, and a preoccupation with risk were all noted as potential barriers to release. These concerns were particularly prevalent in the case of high-profile IPs and/or IPCSOs.

Working towards an application for parole or early release with the PBC was described as a multi-disciplinary, collaborative process. As Participant 5 noted "everybody collaborates for the same goal, so like, and then you have the – whoever is really above our heads, making those

decisions, saying ok this person is or is not – can't really be within society." Staff within CSC facilities may conduct assessments and make arguments for why a specific aging IP should be granted release, especially if that IP has significant healthcare needs. However, the final decision is within the authority of the PBC. Participant 13 observed:

> Ultimately most of those decisions are up to the parole board. So, we can only do so much and then the parole board ultimately decides who goes where and under which conditions as long as they're on some form of a CSC sentence. Once they reach the end of that sentence they have no say, but up until that point, you know, it can be up to them. Some parole boards are very strict.

This participant noted, as was explored in an earlier sub-theme, the need for a placement to be secured prior to a consideration of release. Participant 13 continued in suggesting "they have to set that up before and if they can't set that up, then the parole board just can't – their hands are tied." In cases where release is deemed appropriate, but placement in the community cannot be found, Participant 13 described a degree of flexibility in arranging a new parole hearing:

> You might have a guy who is deteriorating very quickly and has a fall hearing and they're like, he's probably not even going to live until then, is there any way to move it up… literally enough to meet the status of compassionate or whatever or they can find him a place, the parole board may say basically you can come to us any time as long as you can find him a place.

A lack of community placements or community supports, such as family involvement, is a barrier to PBC approved release. Participant 9 observed:

> If they just don't find supports and – and the parole board doesn't like that, as the person doesn't have any supports, then they're not likely to be granted any kind of parole. Even

> if their risk is really low. They had a guy, he was, I don't know how old he was, I don't think he was even that old, he just ended up dying here.

The end result of denial of release by the PBC, either due to lack of community placement or perceived risk, is that aging IPs will die within CSC facilities.

These risk factors were described as relevant to the PBC's decision on granting early release, however other factors contributed to their decision making. When asked if risk was the primary consideration of the PBC, Participant 9 responded:

> They can consider other factors. One I once had say, they said basically unless he has access to a mouse on a computer, he's not a risk. And each day going forward – it was in the risk assessment it said – he's gonna be less and less a risk for every week going forward. So, I don't know, I don't know what the concern is there, I have no idea why they would not grant him. He had support, he had a place to go, I can't believe they said no.

The severity or nature of a crime, or the profile of the IP being considered for release was indicated as a factor in PBC decision making. Participant 12 offered:

> Let's say you have a particularly egregious offence or let's say a homicide offence, something that – that is being taken very, very seriously… that decision would be made with the national parole board.

Participant 9 added:

> For the parole board it's like: you did a bad thing a really long time ago. And the parole board stays made for a really long time. And that's like regardless of risk assessments, too. Risk assessments might say the person is actually pretty low risk, they haven't done anything since that event thirty years ago.

Mirroring this observation, Participant 12 suggested:

> Some people would have a very, very hard time getting over it. So, let's say thirty years ago you committed a grisly homicide, that was horrendous, you failed the Globe and Mail test, you're all over the news, all over the country and then the CSC, this is 30 years later and my goodness gracious you've lost the function of your legs and you're – and all this has gone wrong. In practice it's difficult to get over that initial, this is the offence you did, even though statistically speaking in some of those cases they are actually some of the lowest risk people that are in the prison. It's counter-intuitive, but it's factually true. Would that matter? Would a parole board be very interested and all that kind of stuff? Oh yes they will!
>
> Q: And would a similar rationale apply to those convicted of sexual offences?
>
> Oh, for sure. Without question.

This public perception of an IP, what was referred to as the Globe and Mail test – indicating whether an IP's release would attract widespread attention in a national newspaper, was indicated to affect the decision making of the PBC regarding early release. This 'test' was also indicated by Participant 7:

> With federal corrections… you know, with parole officers and managing sexual offenders and the system, you know, with the Globe and Mail test kind of writ large at the top, which is, you know, to look good, so let's not do it.

IPCSOs were noted to be very unlikely to be granted release, even if aging and deemed low risk. Participant 12 noted:

> With aging sexual offenders, and there are actually groups that were admitted beyond the age of 70, actually, where none of them reoffended, but that's partly because they died.

> And how many of them received compassionate release? I'm going with zero. They might have got day parole, but that wasn't compassionate release over and above what they would have.

Participant 13 described such a case:

> His crimes were… on the news and then the guys see it and then he would get harassed and, you know, bringing things to light. Was he ever going to get parole? Probably not, just based on… his crimes and the public perception… it becomes difficult for some of these guys to – even if they qualify, right? And even if they're seemingly appropriate or whatever for them to get out, it's probably just never gonna happen for them.

Even if aging IPs are granted some form of early release, if they remain under the authority of CSC and the PBC, they are subjected to ongoing monitoring of their activities, and may be returned to prison if in violation of release conditions. Participant 9 described such a situation:

> He kept getting himself into trouble. It wasn't like, it wasn't a big deal, however, the board has very, very little room for tolerance for any kind of breach. And so, he would do things like steal tea bags and he was penalized for that, and he came in and out a few times and he eventually just, he died in custody, I think. The board does not tolerate, especially if you are a lifer or you committed a violent offence, they don't have much tolerance. I can kind of appreciate that, but then I think they're doing stuff that none of us would get in trouble for.

Working with the PBC to either obtain early release for aging IPs, or to keep them in the community, was identified as an obstacle. Even if an aging IP was considered to be low risk, the perception of their release in the public was described as a consideration.

Post-Release Monitoring

As just described, some aging IPs may be given a form of early release but be subjected to ongoing monitoring in the community. Participants described forms of surveillance of release aging IPs, but also efforts made by CSC staff to ensure these individuals remain in the community. In halfway house settings, Participant 3 described a process of suspensions:

> The suspensions are more related to – staff are really good at, they suspend before something happens, like before, you know, somebody's gonna reoffend or before somebody's gonna do something. Then they go back to jail, so before something bad is gonna happen they'll get sent back.
>
> Q: So, suspensions would be that something happens that would be considered a violation of their parole?
>
> Not even necessarily – it's more to prevent a violation of their parole. If they see deterioration of their behaviour, or suspect maybe they're using again… they get sent back [to prison] temporarily. Just for a bit and then they come back.

This monitoring was described as an effort to keep IPs from violating conditions of parole, or to minimize the impact of violations to facilitate remaining in the community. Participant 5 described a similar approach:

> It's not like they go into the community and they're completely alone. They do have people monitoring them and who look after them, and if they notice any sign of breeching or whatever, they're not doing what they're supposed to be doing, well they bring them back in.

This monitoring of IPs could also be related to their physical and/or mental health. Participant 13 described a situation with an aging IP released on parole:

> He was a lifer – he eventually came back to prison. He was residing in the community, his dementia was becoming such that they couldn't manage him at a the halfway house… which was essentially a mental health home. They couldn't handle him.

In these cases, if the aging IP is on parole and they cannot be effectively 'managed' in their community placement, they would return to the prison environment. This participant described efforts made to prevent this from happening with an aging IP living with dementia:

> Within a week, like four or five days, some of the staff had to go back and talk to management and talk to him and assure them, like, everything was fine because he was doing his thing and, you know, they were getting a bit like, oh he's inappropriate and this and that. So, they went back and settled things and did a couple of drop in visits, so it wasn't just us dropping him off and leaving him. We had to follow up a couple of time to make sure that he was settled.

The particular efforts made by CSC staff to not only find appropriate community placements for aging IPs, but to maintain a role in ensuring they remain in place go above the expectations of staff members .

Theme 4: Risk

Participants described the theme of risk, and with it, recidivism, as a primary concern for the release of aging IPs, including those convicted of sexual offences. Correlating with empirical findings of risk and aging, participants described aging IPs, and aging IPCSOs as generally low risk to reoffend if released into the community. They described forms of risk assessments utilized to measure or predict this risk, and how, despite findings of low risk amongst these populations, those responsible for granting early release were still reluctant or unwilling to do so. Participants described a culture of risk aversion within CSC facilities and conservative

approaches to risk assessments. Furthermore, public perceptions of risk, often described as incongruent with empirical measures, were noted to significantly affect not only the decision making of release-granting bodies, but also of many CSC staff themselves. This final theme will explore these measures and perceptions of risk, and highlight the culture of risk aversion that permeates the decision making of early release of aging IPs. Three sub-themes are examined here relating to risk: aging incarcerated persons, aging incarcerated persons convicted of sexual offences, and public perceptions of risk.

Aging Incarcerated Persons

Participants described aging IPs as an overwhelmingly low risk population with CSC facilities. Participant 7 suggested that "older is 98% of the time equivalent to low risk." Participant 5 observed "senior offenders, or, like, senior patients… they don't present risk challenges. Like they're not gonna go outside and get in a fight." This participant added "at that point, that age, the threat to society is less. The level of risk is really low." While some of these IPs may have been considered high risk at a younger age, participants generally described them as becoming less risky as they age. As Participant 5 suggested "maybe they were really dangerous offenders at one point, but now they can't really do much anymore." Participant 13 suggested that the risk associated with aging IPs shifts from one of violence or recidivism to one of health concerns:

> There is burnout, right? A lot of guys slowdown in their older age, but then comes other problems, right? So, burnout starts around, you know, forty plus, fifty plus. A lot of these guys their personality settles down a lot, you don't see the same aspects of that, but you do see is a lot of the dementia, right? A lot of the cognitive stuff.

Participant 7 also described this trend as IPs age:

> They're so far removed from the young person who has committed a crime. I mean, they're just not the same person as when they were 21. And if you think like the adolescent brain, the brains of adolescents are about 25. So, if you take someone who is 19, 20, you know that age zone – impulsively committed some sort of crime, like let's say it's manslaughter or something. And then they age in prison, and you know, through the aging process alone, become more mature and just sort of ease back their impulsive ways.

In addition to a described decrease in impulsive behaviours, participants noted that many aging IPs simply lack the physical capacity to cause harm to others. Participant 12 was asked about this form of risk:

> Q: When we think of more, kind of, you know, physically violent offences, that kind of thing?
>
> Yeah, if we're talking about, you know, do you have enough sustained effort to pulverize someone with your bare hands, well, that's actually a different threshold.

As aging IPs begin to develop more significant chronic or acute health issues, this concern continued to decrease. Participant 2 described an aging IP who was granted early release, stating "the person is obviously not a threat at all for society. Because the person might not even be conscious at some point. Or very, very ill, not able to move a lot."

Not only might these physical effects of illness decrease an aging IPs level of risk, but cognitive declines were also noted by some participants. Participant 13 described such a scenario with a particular IP: "like, severe dementia. They did testing on him and a risk assessment. One, he's low risk, but cog-wise his dementia's super bad… he's the perfect candidate for long-term care." This participant continued:

> Some of the other problems temper with age. We then start to see the physical and cognitive problems starting, which, if anything, becomes almost more complicated. I'd say 90 percent of our guys have one foot on one side of the line and one on the other. In other words: they can't live independently, but they don't qualify for long-term care.

This concept of risk shifts from one of concern over violence or recidivism to one of whether these individuals can take care of their basic needs any longer. However, with the onset of cognitive concerns, such as dementia, Participant 7 cautioned:

> The notion of people onset with dementia, and the belief that… offenders who are more likely to become violent or they're violent – is more likely to be severe with the onset of dementia: it would make them really harder to manage.

This participant continued, suggesting that the symptoms of dementia may be attributed to the individual's criminal history:

> With the dementia issue… they had one, they're starting to act out a couple of times against the nursing staff. Not necessarily in a sexual way, but they were becoming – they were losing executive control over what they were saying, losing the executive function with their verbalizations. So, they were starting to say things to the staff that made the staff quite uncomfortable. And they treated that person more as an offender than as a person with dementia.

Even with the onset of dementia or other cognitive issues associated with aging, it was suggested that these behaviours continued to be related to the IP's criminal conduct, and not to their dementia.

Risk assessments were described as a central mechanism for determining the level of risk an aging IP might pose, particularly for the consideration of those responsible for pursuing or

granting early release. Regarding these decisions for early release, Participant 5 stated “it’s always about assessment.” Participant 12 added “it’s always based on risk.” Risk assessments are, as this participant declared, a “highly individualistic decision on this particular person, this particular time and this particular place.” When asked about the specific risk assessment tools utilized by CSC staff, Participant 9 offered:

> The VRS-SO [Violence Risk Scale: Sexual Offenders], for the most part. They predominantly use the VRS [Violence Risk Scale] and the VRS-SO. Some use the VRAG [Violence Risk Appraisal Guide], but you need a lot of files for that they don’t have, so you can use the VRAG but you probably only get a portion doing it.

These risk assessment tools provide a score or general level of risk that an IP could pose if released into the community, related to the likelihood they may reoffend in a violent and/or sexual manner. IPs designated as dangerous offenders receive this designation based on risk assessments and the determination that an individual presents an ongoing risk to society. However, the criteria for this designation were described to have changed over time. Participant 13 observed that “a lot of these guys that were DO’d back in the 80s when the legislation was very different would not meet criteria to be DO’d today.” Despite this observation, these designations remain for these aging IPs, complicating efforts at any form of release.

Aging and cognitive decline, such as the onset of dementia, were described as complicating this process of risk assessment. If the intention of these risk assessments is to protect the public from potentially dangerous individuals, prediction was described as more challenging with aging IPs, as Participant 13 observed:

> Our job is to ultimately protect society, right? And protect the public and so, it just gets increasingly difficult to find that balance, right? And we can’t necessarily predict their

> behaviour going forward as they potentially decline further into either dementia or physical health issues or whatever. It's difficult because some become more inappropriate, I guess you can say, and some become less so. And so then, you can't necessarily go based on past behaviour when you're looking at a dementia onset.

This concern with a future-oriented prediction of potential for recidivism primarily based on past behaviours is complicated by aging. In cases of compassionate release, as earlier explored, the PBC was described to typically only grant this release for those IPs where end of life is immanent. Prediction of this, however, can prove complicated, as Participant 12 observed:

> The problem is doing it in foresight. That's the problem. So, in foresight, how the heck do I know how long you're actually going to live for? How do I actually know this… I might actually have a great algorithm to say yes, it's probably going to be about this long – you're still talking about a mean prediction. It could be short, it could be long… it's not just as simple as, yeah let's, you know, give a bunch of people compassionate release.

Age alone was described as an insufficient measure for considering early release for aging IPs. Participant 12 continued:

> Let's say we have someone that's 85. Well, do we assume that all 85-year olds are the same? Why would you assume that? Why would we assume that simply because you're 85 you're not gonna live, that you're not gonna be a centurion… it's also possible that you might die in a week. Why would we assume that simply because you're X age that you're all equivalent… Sure, statistically with every passing year the likelihood of death goes up. That's not rocket science… so how does that translate into real time with this person, this place at this time?

If life expectancy is a consideration in an early release, participants described the challenges associated with making such predictions.

The information considered when assessing risk of aging IPs was described by participants as coming from multiple sources and professions. In particular, correctional officers were noted to have a degree of input. Participant 5 described this process:

> So, the CO will talk to them, they will take notes about how, like, their behaviour, what their goals are, where they want to be, all these little things… those reports will go to the parole officers… and the other part of that will be the nurse. The nurses will do interviews with the patients, then the doctors will take part… all that goes into a hearing and they are the ones who make the decisions.

This was described as a collaborative approach to better understand the individual needs and risks of aging IPs. However, participants also warned that IPs may present differently during these assessments, contrary to their day-to-day interactions, specifically with correctional officers. Participant 6 observed:

> The officers deal with them every single day, and managers, parole officers, programs people don't get to see them every day. And those inmates are kind of presenting their best sides because they don't see those people very often and they are the ones who can get things done if they want something or want out. It's really frustrating for the officers because these guys treat them like *crap* all day, calling them names, demanding things… threatening to throw feces on them or whatever it is. And then they turn around and, you know, oh good morning parole officer, good morning warden, how are you doing, and like trying to shake hands and being presentable.

These differences in presentation by IPs between correctional officers and other CSC staff were described as a source of tension, highlighting the often-antagonistic relationship between officers and IPs.

Though the measured and assessed level of risk of an aging IP was described as a consideration for early release, it was noted by multiple participants as one of many considerations. An assessment of low risk did not necessarily equate to successful applications for early release. As Participant 5 observed, "it's not a simple thing, you know, you're no risk anymore, you can go. No, it's not like that." When asked how heavily questions of risk weigh in the consideration of early release of aging IPs, Participant 12 offered:

> That ought to be the primary consideration from the perspective of either the parole of from the Correctional Service of Canada: can this particular release be safely managed in the community? That ought to be the primary question, and if the answer to that is no, sorry, you ought not to be released in the community, even on this basis.

This participant expanded:

> Assuming it could be done safe… but there, then, lies the issue. Assuming it could be done safely and what does safe look like and what are the ultimate goals here, and those questions all need to be answered. Very much so.

These considerations about how an aging IP might be released to the community were described as decided by those above the level of institutional CSC staff. Participant 5 observed "and then you have the, whoever is really above our heads making those decisions, saying ok this person is or is not – can't really be within society."

This pre-occupation with the risk associated in granting early release of aging IPs and a fear of recidivism was described as leading to a culture of risk aversion within CSC. Of

particular concern were the optics of having an individual engage in recidivist actions after release, or the early release of an aging IP considered to be high profile, as earlier explored. Participant 7 described this tendency:

> It comes with not understanding risk, but I think it's further than that… a lot of it is about risk aversion… it creates a system of risk aversion and the system of internal investigation creates, you know, you feel that if an incident happens you're going to be held personally responsible… and people don't seem to be concerned with, you know, incarcerating people who would not need to be incarcerated… it's more risk aversion around releasing someone who poses as a risk as opposed to incarcerating someone who doesn't.

In addition to the concerns of negative public attention, participants described concern over being held personally and professionally responsible if an aging IP – who they advocated for – were to reoffend after release. Participant 13 observed "they're kind of on the hook if something happens." This participant described the tension that exists when CSC staff advocate for an aging IP to be placed in community facility:

> They're trying to say, you know, give this person a chance… like what if they go and they do a reoffence? Then it's, then it's everyone, you know, who wants to put their name on it? So, it's always a fine balance. The parole board has to be careful; parole officers have to be careful, psychologists have to be careful if they're writing a risk assessment, which is why they're always sort of a bit on the conservative, cautious side. Because they want to be able to lean their head on a pillow at night knowing that they didn't say, oh yeah, this guy can go out and then does something to somebody, right?

The scrutiny associated with this perceived failure of a release, when an aging IP is released and then reoffends, was described as discouraging CSC staff from pursing early release. As Participant 13 offered, “there’s a lot of cover your own ass.” This creates an ethical tension amongst CSC staff, as this participant continued:

> It’s a fine line toward saying, trying to voice some support for people without overstating, you know, how safe or whatever they’re gonna be. Because we can’t predict the future, right? They can’t just say that everybody’s low risk and time to go out, right?

When assessing the level of risk an aging IP may pose upon release, participants described the tension that existed between advocating for early release, which they considered to be appropriate, and the fear of reprisal if that individual were to reoffend; blame for which, it was described, would be placed back on them.

Aging Incarcerated Persons Convicted of Sexual Offences

Participants described aging IPs as an overall low risk population, and this was also the case for aging IPCSOs. However, this sub-population of aging IPs was discussed as being viewed differently both within CSC facilities and in the community. Despite empirical measures and risk assessments suggesting individual aging IPCSOs were low risk, participants described the task of applying for and securing early release as much more challenging. This included a refusal of most community-based facilities to accept these individuals, as previously discussed, but also the restrictions often placed upon these individuals upon release. Such obstacles, as well as negative perceptions of this sub-population, were described as contributing to an even greater tendency to risk aversion as compared to their peers not convicted of sexual offences.

In referring to empirical measures of risk and recidivism in aging IPCSOs, participants described this sub-population as among the lowest risk of all IPs. In describing the risk to

reoffend, Participant 9 stated “with sex offenders, it is quite low.” Participant 7 echoed this conclusion:

> Individuals who committed sexual offences, there’s a lot of data showing that, as they age, they become less risky. They’re not very risky to begin with as a group, and as they age, they become less and less risky.

In comparing this sub-population to other categories of IPs, this participant noted that “the only lower recidivism rate was murderers, right? And those are the groups we don’t want to let out.”

Risk assessments were described by multiple participants as a means to illustrate the typically low level of risk that aging IPCSOs presented. As described above, formal assessment tools, such as the VRS-SO, may be utilized by CSC staff to assess risk of reoffence in aging IPCSOs. The nature of an aging IPCSO’s offences may complicate what is otherwise considered an objective and empirical risk assessment tool. Participant 9 elaborated on this tendency:

> There’s just this stigma behind it… behind, you know, what they did and even if you look at the research that says that they’re – the likelihood that they will recidivate isn’t actually higher, it’s just because of what they’ve done… You might have someone who, on paper what he did was really bad, but his risk – I don’t think it can get any lower.

Participants described many of the aging IPCSOs as becoming more agreeable and pleasant as they aged. Participant 13 described such a situation:

> He was a sex offender, he was low functioning… he was a dangerous offender so he had an indeterminant sentence, but he was, he was lovely. I mean, he was ok. He was never like a threat, you know, he was just this old guy that wandered around.

If an aging IPCSO did pose a risk to reoffend if released into the community, participants noted that such risks were apparent and well known by staff. Participant 10 described such a situation:

> Some of the offenders that I'm thinking over, they were sex offenders and like, they would not be eligible for compassionate release. Like, they just – they would 100 percent reoffend, and that's why it would not be an option for them, at least at this point in their life of, like, where their health is.

Participant 7 echoed this sentiment, but also added that the available risk assessment tools are less accurate with aging IPCSOs:

> We know that there are folks who continue to offend into older age, but we know that they are the rarer ones when they're older, especially if it's a sexual offence, you know. If they offend again at 50, 60, we're pretty sure they're pretty high risk, right? Because usually we've determined that already. And our risk assessment instrument we keep tweaking the age items because we keep over-estimating the risk when we do our projections.

A factor included in risk assessments is an individual's willingness to accept responsibility for their actions, and a subsequent willingness to participate in programing. As explored previously, participants described an unwillingness to engage with CSC staff as a commonality for aging IPCSOs. This refusal to participate can result in a higher risk classification on assessment. The result of this, as Participant 9 explained, is "a number of males who just refuse to accept responsibility or refuse to talk about what they did, and so, then they just stay in prison for a very long time." Participants described most aging IPCSOs as low risk to reoffend, describing this sub-population as being statistically low risk, and that even risk assessment tools themselves may over-estimate their level of risk. Those who do present as high risk were described by participants as transparent in their risk, and ineligible for early release because of this. Nonetheless, myriad obstacles to early release were described.

Many of these obstacles to release were previously explored, including negative attitudes towards this sub-population, and an unwillingness of community-based placements to accept their transfer. Related to individual risk, in addition, participants described the various conditions that may be placed on aging IPCSOs if they are released into the community, and the ways in which they could potentially reoffend. For instance, if an aging IPCSO had convictions against children, restrictions on where they could be placed could reside, as Participant 3 described:

> Whether it's because of, like, location of where a senior's facility is. Like, is it close to a park, close to a school, close to something like – if they're still on parole and they're being supervised and their conditions are, you know, can't be located near schools, parks, shopping malls, all sorts of things.

Even within facilities, warnings may be put in place if being occupied by an aging IPCSO, as Participant 13 described:

> In particular, if they're child sex offenders or have any offences against children, it's typical to put at least a warning in place because of potential for grand-children and then great grand-children to be visiting these long-term care facilities.

This requirement to limit released aging IPCSOs from access to the potential for reoffence was described as challenging. Participant 13 continued, stating "there's access to things like the internet… how do you cut off access, how do you monitor access?" Participant 9 described a similar situation, asking "unless he has access to a mouse on a computer, he's not a risk." This nature of a potential sexual reoffence, not necessarily limited to the physical capacity to cause harm, was described as a concern regarding early release. Participant 12 described this potential:

> What difference does it make if your neurological functioning doesn't work in the way it used to… the bar, the threshold of, the quote-unquote of what it takes is very, very low.

> So, you can see why even in situations where things might look dire for the person in terms of medical well-being, that there still could be legitimate concerns of is this person going to hurt someone else? So, for instance, it doesn't take much at all to touch a breast, it doesn't take that much at all to do that.

Whereas the concerns for aging IPs not convicted of sexual offences may be limited by their physical capacity, such that they may not have the ability to cause harm to others, with aging IPCSOs, the threshold for reoffence and the capacities required to do so were described as a major concern in cases of early release. In such cases, the potential for early release was described as almost nonexistent. Participant 13 described such a situation with an individual, stating "he's a sex offender. Plus, he's a child sex offender. Plus, he has, like, no-contact offences like child pornography stuff, so he's kind of got everything stacked against him." In these cases, even if empirical risk assessment tools and the assessments of CSC staff very familiar with these individuals suggest the individual presents minimal risk to reoffend, the potential for the individual to be released was very low.

The tendency for risk aversion described with aging IPs was described as even more prevalent for those convicted of sexual offences. Not only did participants express concern about the potential for recidivism, but also the stigma attached to those convicted of sexual offences, and the potential for public backlash to the early release of aging IPCSOs. Participant 7 outlined the nature of this aversion:

> You throw some risk aversion in there, you throw in whatever is so awful in people's mind about individuals who have committed sex offences, and they stay. I think the compassionate release comes only if you say, well, you know, we won't have any objections from the public, we won't have any objections from other organizations, you

> know, such as the UCCO [Union of Canadian Correctional Officers]. The public might, but we can say, well, the guy's gonna die in a few weeks, anyway. That's the ultimate risk aversion, in my mind.

In discussing the potential of releasing an aging IPCSO into the community, Participant 13 reflected:

> You've got to explain that to the community. It's like saying, you know… well we're going to put this sex offender next door to you, but don't worry. They're told they're not supposed to do this, and they're not supposed to do that… I totally get the community side of it, it's just frustrating from our side of it, right? We're saying, you know, give this person a chance, right… but what if they go and do reoffend… who wants to put their name on that, right?

As with aging IPs convicted of non-sexual offences, participants noted that CSC staff are hesitant to suggest an aging IPCSO should be granted early release and that they pose minimal risk to reoffend, resulting in conservative risk assessments. This fear of reprisal and personal responsibility should the individual reoffend, or simply not meet expectations when released, was described to contribute to this risk aversion.

Risk: Public Perception

Participants described public perception of IPs, and IPCSOs particularly, as a highly relevant factor in the potential for early release. Participants described both their personal experiences with these populations and empirical and statistical data suggesting that most of this population poses minimal risk to the general public, but also acknowledged that these perspectives differed from those of the general public. Participant 7 described as pervasive

"some sort of desire to see every offender as dangerous." Public access to information about individual IPs was described as an obstacle to early release. Participant 13 offered:

> With social media and access to certain legal decisions that are public record… anything that has occurred in the last, you know, 30 years, 35 years is pretty much – if it was high profile enough to make the news or whatever, it's, you know, the information's out there and it makes it hard.

This ability to publicly search or Google an individual IP was described as a challenge for CSC staff even to allow aging IPs access to community-based activities while still incarcerated. Participant 13 described such a situation, where community members learned of an IP's history:

> They were taking offenders to volunteer under CSC escort… this guy was a sex offender. The decisions are available in the public record, like CanLII [Canadian Legal Information Institute] and places like that. So, they went, and they searched him up and they read his decision, which was thorough. Some of them are like a hundred plus pages, describe behaviour in depth. Good, bad, and ugly. And they basically wrote a very direct and non-pleasant email basically saying are you *fucking kidding* me? Like, you basically lied to us or you didn't like – if we had known about this we would have never agreed to even have him volunteer here. They felt very betrayed.

Such negative perceptions of IPs, particularly IPCSOs, were described as widespread in the public by participants, contributing to the significant hesitation of community-based agencies or settings to accept these individuals, even as volunteers. Participant 7 elaborated, stating "it seems with individuals who have committed sexual offences, even though the research is very, very clear that aging out happens, people seem to operate on the basis of stigma or pre-conceived

notions or anything but evidence-based." This participant noted that such attitudes also existed amongst correctional professionals:

> There is a tendency to see all of those who've been convicted of sexual offences as high risk, and lots of correctional professionals still believe this sort of general media piece you know, they believe like the public, and don't realize how low the risk is. Anyone that you remind how low the risk is, it's still, I don't know what it is about having committed a sexual offence, if it's just because it's so, can be so personalized to people that they don't – they don't want to believe.

Participant 3 added, regarding aging IPCSOs, that people in the community are a "little leary to have to work with them, for sure." Even amongst IPCSOs, participants described different levels of perceived risk. Participant 9 observed, "the particular type of sexual office, too. Like, if it involves children or family, that usually seems to be – there's more stigma even with that. And the risk is perceived to be higher." As IPs age and develop cognitive issues, such as dementia, participants described a perception that their dementia would lead them to reoffend in a similar manner. Participant 7 stated:

> Add the aging and the risk or, you know, potential onset of dementia and what that means in terms of them acting out, and I think people become afraid and they make decisions based on fear, rather than, you know, the risk of the events re-occurring.

This public perception and this fear of reoffending, even if the offence occurred decades earlier and the aging IP is considered low risk. These public perceptions were linked to a question of whether an aging IP was *deserving* of early release, not whether they would be suitable or safe for release. On this perception, Participant 7 offered:

> When you think of compassionate release, it seems to be hooked up with the notion of whether or not the person deserves it. And if we could get the deserving out of it, I think we might make some progress. And I think yes, these people have caused harm. So how can we convey that in spite of the harm caused, from a human rights perspective, you know – because in Canada at least, our folks do not lose their human rights be virtue of being incarcerated, right? They do in the United States, they don't here. You know, they still have a right to a job, they still have a right to education, they have a right to vote, and they still have a right to be treated humanely when they're ill.

Participants described a wide range of experiences and challenges in working with aging IPs and aging IPCSOs within CSC facilities. These populations themselves present specific challenges related to their physical and mental health concerns and the risks and vulnerabilities they face within the prison environment. This prison environment itself was described as presenting challenges in the provision of healthcare to aging IPs. Not only do most CSC facilities lack appropriate infrastructure for the provision of healthcare, they also often lack appropriate levels of healthcare staff or adequate knowledge on how to treat physical and mental health conditions prominent with aging IPs. Participants described at length the significant challenges faced in pursing release from CSC facilities for aging IPs. While compassionate release is rarely accessed, other forms of early release are also difficult to navigate and obtain. Community-based facilities are hesitant to accept aging IPs, and even if placements are found, many aging IPs are heavily institutionalized and struggle to adapt to a new environment. And finally, conceptions of risk weighed heavily in the consideration of early release for aging IPs, especially for aging IPCSOs. Negative public perceptions of risk for these populations were described to inhibit

efforts at early release. All of these themes will be analyzed in greater detail in the following chapter.

Chapter 6: Discussion

The results of this research highlighted the myriad challenges aging IPs and aging IPCSOs face within CSC facilities, and the significant obstacles they face in being granted early release. Aging IPs exist within correctional institutions better suited to the abilities and needs of younger individuals. CSC staffing levels, knowledge of care regimes for geriatric individuals, and prison infrastructure and architecture hostile to the abilities of aging IPs all present challenges to the physical and mental health needs of these populations. When efforts are made to pursue and grant early release of aging IPs and aging IPCSOs, concerns of risk – regardless of empirical data regarding these populations or individual risk assessments conducted by CSC staff – overshadow these efforts. Negative perceptions of IPs, particularly those convicted of sexual offences, overrule assessments of risk. Community-based facilities, more capable of meeting the needs of aging IPs, bear no obligation to accept these individuals, and typically reject them based on their criminal histories. The observation that nobody wants to die in prison underlies this topic. Nonetheless, many aging IPs do die in prison, or handcuffed to a hospital bed under surveillance of CSC correctional officers.

This chapter permits critical analysis and discussion of the themes and topics described by participants in this study. Participants offered frank and, at times, candid insights into the realities of aging IPs in CSC facilities, and the professionals who work with them. Much of this analysis is based on the face-value offerings of the participants. However, a thematic analysis methodology permits further interrogation of the data and the context in which it was produced; consideration of power relations, social structures and the production of IP subjectivities is integral to this analysis. Multiple topics of discussion emerge here, resultant of this thematic analysis methodology. As previously noted, very few studies have examined this aging prison

population in CSC settings; where applicable, links to these studies will be made. However, the present study provides insight into this population not previously explored.

Thematic Analysis

A thematic analysis methodology, as outlined by Reissman (2008), and framed within a poststructuralist epistemology, permits the interrogation of data – interviews – produced in this research. As Reissman (2008) indicated, this methodology permits an examination of the 'macro' context in which the data is produced, an analysis of the assumptions made, and permits interpretation from critical perspectives (Ewick & Silbey, 2003) such a poststructuralist epistemology. And while thematic analysis focuses on the 'what' has been said by participants, it also permits consideration of the unspoken and unstated assumptions being made by those producing the narratives, going beyond simple content to identify the power relations at work in the production of specific discourses (Cheek, 2004). Furthermore, this research examined the experiences of participants in their work with aging IPs. As Scott (1992) and Butler (1993) cautioned, experience is typically considered a phenomenological concept, which may be viewed as pre-discursive. Following Stoller (2009), the analysis of data here does not abandon the concept of experience entirely, but instead situates it within the context of power relations and the discourses of the prison environment, permitting a critical consideration of experience. As such, the experiences relayed by participants are not taken at 'face value', but are instead situated within this context – it is recognized that participant experiences themselves are produced within this context of power relations and discourses. Though power relations exist in all contexts, in prison environments they are particularly relevant to the production of practices and subjectivities (Holmes, 2002, 2005; Holmes et al., 2014; Mercer & Perkins, 2018, Perron & Holmes, 2011). While the descriptions within the data described the significant challenges faced

by aging IPs and IPCSOs in prison environments and in gaining access to early release, thematic analysis highlights the significant power relations of CSC settings, how they influence the practices of staff, and the production of aging IP subjectivities, particularly in how they relate to perceptions of risk.

These power relations, outlined in the theoretical framework, and illuminated by this thematic analysis methodology will be examined in greater detail in this discussion. In particular, the tension that exists between the operation of different forms of power is apparent. The population level, statistically guided operation of governmentality – and, with it, biopolitics – a form of power that focuses on efficiencies over micro-management clashes with the individualizing disciplinary power widespread in correctional settings. This latter individualizing form of power permits nothing to escape, creating circumstances where early release of aging IPs is less likely, despite CSC's governmental mandate to expedite and further facilitate the release of aging IPs (CSC, 2019b). And while the tension between these operations of power account for much of the hesitancy, or even resistance, to the early release of aging IPs, particularly those convicted of sexual offences, it is insufficient to fully describe this phenomenon. Examination from a poststructuralist perspective of the production of IP subjectivities, how they are perceived by CSC staff and the public, and the subsequent practices associated with their early release (or lack thereof). Power relations, as previously outlined, are productive in the shaping of these subjectivities, but it is a consideration of abjection and monstrosity that permits a more complete understanding of IP subjectivities. The crimes for which aging IPs have been convicted, particularly sexual offences, produce a sense of abjection, and the subsequent need to protect the clean and proper from these transgressive persons via continued incarceration. Risk assessments based upon empirical measures and upon individual practitioner knowledge of IPs were

frequently described as one of many considerations for early release of aging IPs. The nature of the individual IPs convictions and public perception were described to overrule even the most favourable assessments of risk.

Discussion of the various challenges faced by aging IPs in gaining access to appropriate health services and in pursuing early release comprise of the basic thematic consideration of participant contributions, but also upon greater interrogation of data. Consideration of these elements cannot be separated and are instead interwoven into analysis of aging IP and CSC staff circumstances.

Aging in Prison

Care Within CSC Facilities

Federal correctional institutions in Canada were never built to accommodate the aging IP. The various deficiencies and obstacles identified by the CIC and CHRC (2019), such as multi-level units, stairs, long distances between units and medical facilities, and the requirement to mobilize (and often wait) outside in winter conditions to access services were also identified by participants as architectural concerns for the aging IP. The physical layout of prison environments necessitated the potential interaction of incompatible IPs – such as IPCSOs and non-IPCSOs – in common areas should aging IPs need to access services, such as the infirmary for a scheduled physician appointment. This is especially relevant for aging IPCSOs; these individuals are frequently targeted with violence within CSC facilities; it was noted that physicians and psychiatrists, who may only visit facilities one or two times per week, could wait for long periods between appointments while the safe passage of an aging IPCSO was arranged, contributing to already extant waitlists for appointments. While IP medications are delivered to individual cells by nurses in some facilities, others require IPs to ambulate to healthcare areas to

receive medications. Previous studies have also indicated the impact these basic design deficiencies have on aging IPs. Iftene (2017b), in their examination of aging CSC prison populations, reported that some aging IPs would simply forgo their pain medications because such ambulation was too difficult or painful for them. This requirement for aging IPs to mobilize from their cells, potentially long distances and/or outdoors during the winter, also applied to visitation opportunities. For aging IPs with considerable medical issues, including those nearing end-of-life while in the prison environment, the expectation to travel to designated visitation areas remained. Burles and Peternelj-Taylor (2019) described the importance of (re)connection with family members for IPs at end-of-life, with the potential to make amends and resolve interpersonal differences as critical elements to dying with dignity. Such opportunities were described as not possible for many aging IPs within correctional settings if they could not ambulate to visitation areas. The prison environment was designed for the movement and observation of able-bodied, young male IPs, not for aging IPs living with mobility issues or dementia (Beckett et al., 2003).

A poststructuralist perspective permits critical examination of these deficiencies for aging IPs, and the forces at play in creating them. Disciplinary power requires the physical separation of individuals for its operation, what Foucault (1997) described as partitioning. He stated that "disciplinary space tends to be divided into as many sections as there are bodies or elements to be distributed" (p. 143). Such partitioning permits ongoing surveillance "of each individual, to assess it, to judge it, to calculate its qualities or merits" (p. 143). The individual cell of an IP serves this exact purpose. Participants described the role of correctional officers in this ongoing surveillance, checking IPs within their cells to ensure appropriate behaviour, and documenting conduct in their reports. Such documentation contributed to individual risk assessments of IPs

and could influence decision making on pursuing or granting early release. Holmes (2005) described similar practices in his study of a Canadian federal institution, noting that nurses also participated in this partitioned surveillance of IPs. Individual IPs must be always accounted for the proper function of disciplinary power. This includes aging IPs, even if they are living with medical or mental health concerns that present obstacles to this functioning. They, too, are expected to ambulate to various locations in the prison to access services. They are to remain in their cells at designated times, where participants described correctional officers shifting the focus of their inspections from that of security to simply ensuring the IP is not in medical distress. Even when IPs are taken out of the prison environment to appointments or to a hospital of ETAs, they must do so with at least one correctional officer always supervising them, what one participant described as 'within sight and sound' of the IP. Disciplinary power is a totalizing form of power, affecting all elements of an IPs existence. It allows nothing to escape. It does not permit privacy, and negatively affects the dignity of aging IPs accessing healthcare services. When exceptions to the strict rules of partitioning were described by participants, such as allowing aging IPs to phone in for count instead of ambulating to a security station to do so, participants described these exceptions are rare and requiring special permissions and advocacy.

The prison settings, particularly the maximum-security settings, were described as spaces of violence and aggression, with aging IPs as frequent targets, an observation mirrored by previous examinations of these settings (CIC & CHRC, 2019; Iftene, 2017b). Aging IPs were described as regular targets of aggression and coercion, with desirable or valuable medications or simply money as the focus. Those who no longer possessed the physical capacity to defend themselves were described as vulnerable; an observation also made by Iftene (2017b), wherein aging IPs in CSC facilities were regular targets of violence, manipulation, and theft. In this

study, aging IPCSOs were described as particularly vulnerable, as their convictions made them widespread targets amongst the general prison population, and the negative attitudes of many CSC staff did not facilitate their protection. Such targeting of this population required, in some cases, the designation of specific units for IPCSOs, a further partitioning of IPs aimed at their protection. Mobility aides, such as wheelchairs, walkers and canes are typically forbidden within higher security settings, as such items may be used as weapons. Security is prioritized. The comportment of an IP was described as important, especially within maximum-security settings, where IPs are expected to carry themselves in a manner that conveyed strength and a lack of vulnerability. Foucault (1997) described the necessity, in disciplinary power, of "the correlation of the body and the gesture" (p. 152). The overall use and positioning of the body for proper functioning within the disciplinary apparatus. Aging IPs who could no longer fulfil this expectation find themselves vulnerable, they can no longer adhere to the corporeal gestures necessary to maintain appropriate levels of functioning, and thus find themselves targeted. Such expectations were described to ease with a decrease in security level. In the halfway house environment, for example, aging IPs who displayed signs of dementia or confusion were described to be given permission to break from the expectations of partitioning and gestures by younger IPs. In these lower security settings, the tight grip of disciplinary power is lessened, with some exceptions made for aging IPs. This examination of the differences between levels of CSC facility of security the functioning of aging IPs had previously been addressed in the recent literature.

The provision of healthcare services for aging IPs proved challenging, with institutions relying heavily upon regional hospitals and regional psychiatric facilities, or ETAs to community providers to meet the needs of this population. Outside of these regional hospital and psychiatric

facilities, the primary focus of healthcare services is the reactive treatment of acute concerns, such as treating the victims of prison violence, the outcomes of self-harm, drug overdoses, and the care of suicidal individuals. Such acute concerns were described to overrule the more chronic concerns, such as diabetes, chronic pain, COPD and dementia that more commonly afflict aging IPs. Nurses in many facilities were described to be primarily occupied with the daily tasks of medication administration and responding to mental health crises as opposed to treatment of chronic conditions or proactive interventions. These brief moments of medication administration were described as, in many cases, the only regular interaction aging IPs may have with healthcare professionals, and the best opportunity to address any concerns. However, aging IPs may not have the capacities necessary to do so, or the prison culture is such that admission of concerns is verboten. Correctional officers, with whom IPs typically have the most contact, were described to often not take seriously the concerns expressed by aging IPs. Especially with IPCSOs, any prolonged engagement with healthcare staff could be perceived by fellow IPs as indicative of being a 'rat,' a highly disrespected status within prison settings (Meeham et al., 2018; Trammell et al., 2021). Instead, where specific units for IPCSOs existed, participants described the emergence of a single spokesperson for the unit, through whom healthcare concerns were addressed.

These patterns of behaviour, these internal rules of the prison setting align with the operation of disciplinary power. Normativity is prioritized, via the function of normalizing judgement in these settings, and strict adherence is required, lest an individual be deemed abnormal, or deviant (Foucault, 1997, 2006). But this mobilization of normativity does not function entirely in a top-down manner, from nurses or correctional officers to IPs. For Foucault, power flows in all directions, and is not necessarily possessed by those in places of authority.

This power may flow horizontally, amongst IPs to enforce inter-IP expectations of conduct. Furthermore, this operation of disciplinary power and its associated systems of classification produce hierarchies within the IP population, with IPCSOs placed at the bottom. These individuals were described to adhere very strictly to these expectations, violation of which could have serious consequences. While Holmes (2002, 2005) described the operation of sovereign power within correctional facilities as the potential use of force by correctional officers to ensure IP compliance, this study has indicated that sovereign power can be mobilized by IPs as well. The identification of specific individuals as 'heavies,' capable of ruling by force highlights this operation of sovereign power. Where disciplinary power fails, sovereign power steps in, enacted not only by CSC staff, but by other IPs.

These internal rules of conduct amongst IPs negatively affect an aging IPs access to healthcare services and are especially relevant to aging IPCSOs. Even when aging IPs do attempt to access healthcare services for non-emergent or non-acute medical or mental health concerns, they face considerable waitlists and wait times, a finding mirrored by both Iftene (2017b) and the CIC and CHRC (2019). Participants in the present study described aging IPs waiting weeks, even months to have their healthcare needs addressed. Physicians and psychiatrists who held infrequent clinics in correctional facilities saw the triaging of IP concerns, with more acute or emergent issues, such as physical injuries resulting from prison violence taking precedence. The more chronic concerns of aging IPs subsequently fail to get addressed, further highlighting the realities that prison settings are designed and operated with a focus on a younger IP population. Furthermore, a lack of familiarity with geriatric health concerns amongst CSC healthcare staff present further obstacles. Participants described frequent confusion around how to best treat the concerns of aging IPs, such as dementia, with conflicts between mental health and medical

practitioners over who is better suited to provide care. Such disorder only perpetuates the long waits aging IPs experience for treatment of their healthcare issues.

When emergent or exacerbated healthcare concerns of aging IPs cannot be adequately addressed within CSC facilities, heavy reliance upon escort to community-based facilities is required. Participants described several scenarios in which this may occur. Given that many CSC facilities are not staffed 24-hours by nurses, the emergence of any concerns that cannot be safely addressed by correctional officers requires transport of IPs, in ambulances, to community-based facilities. And given that some CSC facilities are remotely located, delays may occur in transporting these individuals for care. Even if concerns do emerge during hours when healthcare staff are present, they may exceed the capacities of these staff, requiring transport via ambulance. These emergency transports of IPs, known as ETAs, place considerable strain on correctional officer staffing levels and may negatively affect the safety of the remaining officers and/or result in the canceling of prison programming. One to two correctional officers are required to supervise IPs on ETAs, effectively monitoring them while in the hospital, continuing the operation of disciplinary power. Participants described situations in which aging IPs may be in a community-based hospital for weeks, even months, with ongoing supervision by correctional officers the entire time. Aging IPs may also be granted ETAs for scheduled community-based healthcare appointments, such as to see specialists. In such cases, supervision by correctional officers is still required, but IPs are transported in CSC vehicles. The OCI (2020) described these vehicles as inappropriate for the transport of aging IPs, particularly those with mobility issues. IPs are typically restrained with handcuffs and leg-shackles during transport and expected to sit in vehicles inappropriate for those with chronic pain, musculoskeletal concerns or other mobility issues. The appropriate treatment of many healthcare concerns common to aging IPs ‘in-house’

is not possible in many CSC facilities. Transport to outside facilities places strain on institutional staffing levels and may not meet the mobility needs of aging IPs.

Participants in this study described multiple factors and situations in which appropriate and timely access to healthcare services for aging IPs, including IPCSOs was not provided. Not only do aging IPs face obstacles in accessing services, but the setting itself produces situations in which physical and mental health issues may be exacerbated and/or accelerated. These contribute to the accelerated aging phenomenon identified in prison settings, wherein IPs physiologically age faster than their non-incarcerated peers (CITATIONS). Ben Moshe (2020) described the disabling effects of the prison environment:

> Even if an individual enters prison without a disability or mental health diagnosis, [he] is likely to get one – from the sheer trauma of incarceration in enclosed, tight spaces with poor air quality and circulation… to circulation of drugs and unsanitary needles as well as the spread of infectious diseases… to lack of medical equipment and medication, or at times overmedication. (p. 8)

Such factors and conditions contribute to an acceleration not only of aging, but also of death. Simply stated, incarcerated persons die faster. The environment itself and the (lack of) medical services contributes to an early death. Of note amongst the data collected was a lack of acknowledgment amongst participants that such was the case. In fact, one participant joked about the necessity for CSC to conduct investigations into the death of aging IPs in custody due to non-violent causes. Herein a cognitive dissonance was apparent amongst participants in not recognizing that the prison itself was responsible for the early death of IPs, via years or decades of exposure to its disabling environment. And while improved access to healthcare services may address the health concerns of aging IPs as they become more severe, they do not address the

factors that contribute to this accelerated aging in the first place. Proposed remedies to this issue lie not in an improvement of prison conditions, but in decarceration of IPs and abolitionist perspectives (Ben Moshe, 2020), which will be explored in greater detail below.

Regional Hospitals and Regional Psychiatric Facilities

When the ongoing healthcare needs of aging IPs could no longer be adequately met by their 'parent' institution, widespread reliance of regional hospitals and regional psychiatric facilities was described. Of note, despite the presence of two units specifically for aging IPs – located in the prairie and pacific regions, and described by Martin (2021) – none of the participants in the present study identified these as options for aging IP care or transfer. This study is the only recent study of CSC facilities that identified a heavy reliance on these regional hospital and psychiatric facilities in the provision of care. And the results also suggest that access to these two specialized units is very limited, such that they do not represent a viable option for aging IP transfers. Regional hospitals may be located within one of the five regional psychiatric facilities operated by CSC, or in other institutions. While the intention of these facilities is to provide the treatment an IP requires and then return them to their parent institution, participants noted that with many aging IPs, especially those with more significant and chronic or terminal health concerns, these individuals would never be deemed appropriate to return. With the exception of two units dedicated to aging IPs in CSC facilities described by the CIC and CHRC (2019), these facilities often become 'home' for aging IPs. Participants also described circumstances where an aging IP would receive extended treatment on an ETA in a community hospital, but could not be discharged back to the parent institution because they lacked the necessary facilities or staffing levels to provide the ongoing care required. In these cases, aging IPs would instead be discharged to one of these regional CSC facilities. And while the regional

psychiatric facilities are intended to provide care and treatment to those IPs with mental health concerns, participants described the use of these facilities for aging IPs as well, even if their concerns were not specifically mental health related. Aging IPs living with dementia are frequently transferred to these facilities. As noted, this study is the first to identify this widespread dependence on psychiatric facilities to provide care for aging IPs, particularly those living with dementia.

The care provided within regional hospitals and regional psychiatric facilities is better suited to the needs of aging IPs. Such facilities feature 24-hour nursing care, multi-disciplinary care teams, and more regular attendance of physicians and psychiatrists. They also feature prison design and facilities better suited to the mobility and cognitive issues of aging IPs. Though the quality of care for aging IPs has been described as lesser within many CSC facilities, both here and by Shaw and Driftmier (2021), participants in this study described a high level of care in these settings, in some cases described as better than what the IP may receive in the community. However, these facilities still presented issues for aging IPs. Visitation of family members remained a concern, given some of these individuals could not ambulate to visitation areas. Even if ambulation is not a concern, these regional facilities may be located far away from the IPs parent institution, presenting significant barriers to family visitation. And despite the quality of care provided in these settings, participants described circumstances in which the healthcare needs of aging IPs were too significant for the setting. This included the advanced onset of terminal illnesses, such as cancer, or highly advanced dementia. Such challenges presented obstacles to dying with dignity for IPs at end-of-life. Burles and Peternelj-Taylor (2019) described the barriers the prison environment present in the provision of palliative care to aging IPs. Elements viewed as necessary for dignity in dying, such as autonomy and shared decision-

making, as well as reasonable access to family members and opportunities to make amends may not always be possible within the correctional environment. Here the operation of biopower, the individualized power to make live and let die (Foucault, 2003), is most transparent. Healthcare staff in these setting mobilize the power and ability to prolong the life of dying IPs. Though the use of medical assistance in dying (MAiD) was only briefly discussed by participants, it has been utilized a limited number of times within CSC settings (CIC & CHRC, 2019; Shaw & Driftmier, 2021). Again, the mobilization of biopower is most transparent in the provision of MAiD in prison settings: the power to let die. Participants described significant efforts made to transfer aging and dying IPs to community-based facilities prior to this point, the delegation of biopower to another agent. This topic will be explored in greater detail below.

Release to Community Facilities

Staff working with aging IPs, particularly those nearing end-of-life, described the significant efforts made to secure placements for these individuals in the community, where their healthcare needs and opportunity to die with dignity are better met. In some cases, if family members are willing and capable, aging IPs are released into their care. However, in most cases, participants described efforts to transfer aging IPs to long-term or palliative care facilities. The significant challenges CSC staff face in securing these placements will be explored in greater detail below. Even though some CSC facilities, according to participants, can provide this care, it was viewed as preferable for aging IPs to die, with dignity, outside a prison facility. As noted above, the provision of quality palliative care is highly restricted by the prison environment (Burles et al., 2016; Burles & Peternelj-Taylor, 2019; Shaw & Driftmier, 2021). Where release to a community facility is not possible, and the needs of the individual IP cannot be met within CSC facilities, community hospitals are relied upon. However, without being granted some form

of early release by the PBC, these individuals are transported to hospitals via ETAs, even if is apparent that they will not return. The protocols of ETAs continue to apply in these situations, including the ongoing supervision of IPs by one or two correctional officers. In these cases, end-of-life care and eventual death occur with the individual literally handcuffed to their hospital bed, within 'sight and sound' of correctional officers. Certainly, such circumstances do not constitute dignity in dying.

The operation of both biopolitics and biopower are especially evident in the provision of end-of-life care and the eventual death of aging IPs. Participants indicated internal pressures by CSC management to secure release for aging IPs prior to their death. The bureaucratic necessity for CSC to conduct investigations into every death in custody, even if such deaths occur due to 'natural' causes, is, as one participant noted, a comical administrative act. Beyond this reality, participants noted that CSC is concerned with reducing the number of IPs who die while still in custody. Such a mandate reflects the governmental and biopolitical operation of power. Governmentality operates via data and statistics and the efficient management of populations, and the results of this study suggest that CSC works to manipulate these statistics to minimize the negative perception of deaths in custody. Such a mandate also applies to MAiD within prisons. Though MAiD is accessible to any Canadian citizen, including IPs, other authors have noted the negative perception such a procedure offers (CIC & CHRC, 2019; Shaw & Driftmier, 2021). Participants in this study described CSC's strong mandate to not provide MAiD in prisons, preferring individuals receive this treatment outside of CSC facilities. Such efforts reflect CSC's desire to not be perceived as exercising sovereign power. In contrast to biopower and its associated ability to make live and let die, sovereign power bears the ability to let live and make die (Foucault, 2003). Very specifically, CSC does not want to appear to possess the ability

to make IPs die, akin to perceptions of the death penalty, so famously associated with sovereign power by Foucault (1997). Instead, CSC operates via biopolitics, the power to make live and let die applied to a broader population, for the purposes of satisfying what participants described as 'the numbers game.' The most transparent – and arguably egregious – example offered by participants was that of the aging IP being kept alive (making live) in the hospital until release was granted by the PBC, at which point life support was almost immediately terminated (let die), such that the IP did not officially die while in custody.

The Production of Incarcerated Person Subjectivities

A poststructuralist theoretical framework permits interrogation of the production of aging IP subjectivities via the data provided by participants. As Foucault (2002) stated, discourses are viewed "as practices that systematically form the objects of which they speak" (p. 54). In the narratives collected in participant interviews, the subjectivities of aging IPs were produced by those who worked with this population in CSC settings. A consideration of both the power relations of the prison environment and Kristeva's (1982) concept of abjection permits critical analysis of these subjectivity formations, and subsequent consideration of how these subjectivities affect the pursuit and granting of early release. Integral to these considerations is the question of risk – what risk these aging IPs are perceived to pose if and when released. As noted previously, empirical notions of risk are insufficient to describe this phenomenon, as aging IPs, including aging IPCSOs typically represent the lowest risk of all IP populations (Ambroziak et al., 2021; Cornelius et al., 2017; Crookes et al., 2022; Piquero et al., 2015; Ray & Jones, 2023). While such assessments are influenced by the power relations of the institutions, it is abjection (Kristeva, 1982) and Shildrick's (2002) conceptualization of monsters that produce the elements of aging IP subjectivities that present such obstacles to early release.

Power Relations and Subjectivities

Disciplinary power relations feature prominently in correctional institutions (Holmes, 2002, 2005; Schlosser, 2013), such a reality was apparent via analysis of participant narratives from this study. As Foucault (1997) described, disciplinary power relies upon constant surveillance and assessment of individuals achieved via partitioning, documentation of their behaviours, classification of individuals based upon these observations, and correction for deviations from strict rules and expectations. The target of this mechanism of power is not only the body of the individual, but their soul, and the correction of abnormalities. Disciplinary power is ultimately a normalizing power. While other forms of power, such as pastoral and sovereign, are present, the correctional setting remains predominantly a disciplinary space, aimed at the correction of abnormal behaviours. IPs are placed within these institutions for this very purpose: they failed to adhere to the social contract of self-governance via commission of their crimes and are subsequently removed from the primarily governmental realities of public life. In prison, an individualizing form of power is mobilized to correct these (mis)behaviours. This is the normal/abnormal dichotomy of disciplinary power. Thus, IPs must be normalized before they can re-enter society. The subjectivity of the IP is produced in this nexus of power: the constant surveillance and assessment of IP activities produce knowledge of the individual and subsequent classification. As Foucault (1997) observed, “in a system of discipline, the child is more individualized than the adult, the patient more than the healthy man, the madman and the delinquent more than the normal and the non-delinquent” (p. 193).

This classification or ranking of individuals, via the disciplinary power apparatus, further relegates individual IPs into this normal/abnormal mode of subjectivity. Perron and Holmes (2011) described this production of IP subjectivities, specifically amongst those deemed mentally

ill within the institution. Those individuals who failed to meet expectations of behaviours and conduct were perceived as deviant, or abnormal, and required subsequent discipline to correct their (mis)behaviours. Those who adhere to institutional expectations are rewarded, as Foucault (1997) described, via privileges. In the CSC realm, movement (or cascading) to a lower level of security represents these privileges for appropriate conduct. In the disciplinary model, according to Foucault, those placed in the lower ranks – here, in higher levels of security – are capable of movement to more favourable ranks when "they will be recognized as having made themselves worthy of it by the change in their conduct and by their progress" (p. 182). According to this logic, eventual release back into the community is achieved via demonstration of correction of abnormal behaviours and an ongoing adherence to expected conduct. Such is the stated mandate of CSC, which "contributes to public safety by actively encouraging and assisting offenders to become law-abiding citizens" (CSC, 2015b, Mission, para. 1). The goal of CSC is to produce law-abiding subjects.

Of course, such a transition is not so simple as basic demonstration of appropriate conduct. Prison sentences, mandatory minimums, and regulations on the granting of parole and other forms of release complicate this process. Integral to the progress of an IP is demonstration of low level of risk. Within the disciplinary power apparatus, Foucault (1997) identified the criticality of the examination. In practice in CSC settings, as identified in this study, this is achieved via risk assessment. As described by participants, assessment of risk is based upon extensive observation and documentation of individual IPs. Formal assessment tools, such as the VRS and VRS-SO, were identified by participants as the specific form of examination utilized. The more that was known about an individual, the more 'accurate' their assessment of risk. The constant surveillance of IPs by correctional officers and other professions and the ongoing

documentation of conduct provides the knowledge base on which, as Foucault (1997) defined, the "constitution of the individual as a describable, analyzable object" (p. 190) is possible. This knowledge, in concert with the individual's criminal history, produces a measure – a ranking – of risk, by which the IP is defined. The subjectivity of IPs is produced via this ongoing observation and examination under the disciplinary apparatus.

When asked about the aging IPs with whom they worked, participants in this study frequently described individuals in terms of their level of risk. Aging IPs were overwhelmingly described as a low-risk group of individuals. Pleasant and positive descriptors were typically used when discussing individuals. In many cases, participants could look past the criminal convictions of aging IPs and describe them as 'lovely' or 'pleasant'. These individuals were typically perceived in terms of their healthcare needs, not their security needs. The role of correctional officers with these individuals shifted from one of custody to one of support. CSC staff concerns with this population focused more on their physical and mental health needs than level of dangerousness within the institutions. Not all aging IPs fit this profile; participants described some individuals in terms of their level of risk, suggesting they were not suitable for release, despite their age. However, overall, within CSC settings, the production of aging IP subjectivities is favourable. Even within a disciplinary power framework, they were ranked as not requiring significant correction of behaviours or conduct. Most shifted away from an abnormal subjectivity. However, when describing the production of aging IP subjectivities by those outside of correctional settings, such as those responsible for admission to long-term care homes, perceptions shifted significantly, particularly for those convicted of sexual offences, a finding mirrored by Poulin et al. (2023).

Persons Convicted of Sexual Offences

While the productions of aging IP subjectivities were typically favourable amongst CSC staff, these differed with those convicted of sexual offences. The convictions of these individuals clouded perceptions in those interviewed. Foucault's (1990) writings in *The History of Sexuality*, as well as abjection and monstrosity, which will be explored in a later section, facilitate better understanding of this subjectivity production. As Taylor (2019) indicated, while the disciplinary apparatus of the prison ostensibly works to 'correct' (hence the term 'corrections' in penological settings) the conduct of IPs and produce law-abiding citizens, in reality "these disciplinary measures do not so much fashion the subject away from their crime as constitute them in terms of it… Getting to know this object of knowledge has produced that very object" (pp. 2-3). The person convicted of crimes becomes the criminal, to be studied by the social sciences. Simultaneously, as Foucault (1990) argued, an individual's sexuality also came to define their very existence. This sexuality, too, became an object of scientific knowledge, to be studied and understood. Under a disciplinary power apparatus, sexuality becomes a category of knowledge by which an individual can be defined. To be a sexual offender is to be perceived as abnormal with regards to sexuality. Here, the IPCSO has offended twice-over, both on account of their convictions and their sexuality. Taylor (2019) offered:

> In an effect of the sexual sciences that is remarkable today, we see that as sex became essential to identity, law came to think of interfering with the very body of the criminal—through…life-long detention and surveillance. An individual's sexual practices have ceased to be something that could change with circumstances, and 'perversions' are now seen as (and are thus constructed to be) permanent (p. 5).

The permanence of this sexually deviant subjectivity was evident in the present study. Even though participants recognized that, empirically speaking, aging IPCSOs represent a very low risk to reoffend, and individual risk assessments supported this low-risk categorization, many still expressed concerns over their conduct if released. There remained a hesitancy amongst many participants in this study to fully accept that an aging IPCSO could be successfully and safely released into the community. Baker et al. (2021) described a similar outcome, wherein re-entry concerns were higher for those convicted of sexual offences versus those convicted of other offences. An aging IPCSO may have been convicted of their offence several decades previous and showed no indication of further (mis)behaviours, yet their sexual deviance continued to define their subjectivity. This subjectivity permanence had profound implications for the successful release of aging IPCSOs, to be discussed in a later section.

Indigenous Incarcerated Persons

Though this study did not explicitly examine CSC staff experiences in working with aging Indigenous IPs, this population was voluntarily described by some participants. In a thematic analysis methodology, participants offer narratives about their experiences, and these may not always adhere to the expected topics outlined by the researcher (Reissman, 2008). Nonetheless, these potentially unexpected themes provide useful additional insight into the topic being studied. As noted, non-Indigenous researchers are cautioned to address research involving Indigenous populations with care and respect, and to acknowledge that such research may perpetuate colonial approaches (Aveling, 2012; Datta, 2018). The discussion by multiple participants of the specific difficulties faced by Indigenous IPs in accessing healthcare services and early release, however, cannot be ignored. According to Public Safety Canada (2023), in 2019-2020, 26.1% of all IPs in CSC facilities are Indigenous. Furthermore, Indigenous IPs were

more likely to remain in custody (versus being released on parole or other forms of release) than non-Indigenous IPs. The OCI (2023), in their most recent annual report, highlighted the ongoing – and growing – overrepresentation of Indigenous persons in CSC facilities. Furthermore, as Stoliker et al. (2022) proposed, what constitutes 'old age' amongst Indigenous IPs in Canada is the age of 45, given the significant health disparities resultant from colonial forces.

In the present study, participants noted the high proportions of aging Indigenous IPs, and suggested these individuals face more obstacles in gaining release. A high proportion of aging Indigenous IPs declared as dangerous offenders was also noted, with these designations applied several decades previous. The suggestion made by participants for this phenomenon was that Indigenous persons were, historically, viewed as more dangerous – or higher risk – than their non-Indigenous peers. Their subjectivities were produced based on concerns of risk. The OCI (2023) noted "the persistently high number of Indigenous peoples who only gain release from prison at mandatory or warrant expiry" (p. 58). Participants offered that family or social supports for aging Indigenous IPs were less likely, attributed to colonial forces and the ongoing effect of residential schools. When conducting risk assessments for the purpose of release to the community, access to social supports informs these measures, resulting in Indigenous IPs as scoring as higher risk than their non-Indigenous counterparts. Furthermore, participants noted that many of the aging IPs who remained incarcerated for long periods – as long as several decades – were those identified as Indigenous, as dangerous offenders, and as those convicted of sexual offences. This compounding of multiple factors resulted in individuals who were least likely to be granted early release – including compassionate release. However, participants suggested that current subjectivities have shifted. Recognition of historical processes such as residential schools, the 60s scoop, and the widespread use of administrative segregation with

Indigenous IPs resulted in subjectivities being produced based on perceptions of victimhood and tragedy. Aging Indigenous IPs were described to have come from difficult lives, continued difficult lives while incarcerated, and less likely to find supports upon release. Nonetheless, as indicated by participants in this study, as well as the OCI (2023), Indigenous IPs as more likely to remain incarcerated and not access forms of early release compared to other IP populations. The Parole Board of Canada (2019) has indicated that board members have received training on such factors as the Gladue principles, but also acknowledged that Indigenous IPs continue to be granted release at a lower level than non-Indigenous IPs (

Dementia

A common diagnosis attributed to aging IPs by participants was dementia. Participants noted that the onset of dementia in IPs resulted in challenges within conventional correctional facilities and typically required transfer to regional hospitals or psychiatric facilities, especially when the symptoms of dementia became more severe. Dementia becomes a new form of abnormality to be managed within the disciplinary power apparatus and comes to be part of an aging IPs subjectivity. Frequently, when described aging IPs, participants would mention the perceived severity of their dementia. Within the public, as Naue and Kroll (2009) offered, dementia is perceived as the loss of self, or, as Harper (2020) described a form of 'vanishing.' One's subjectivity begins to shift with the onset of dementia, to something other than the former sense of self. In contrast, participants in the present study suggested that the onset of dementia in aging IPs, particularly those convicted of sexual offences, only solidified, and exacerbated their existing subjectivities. Any aggressive or sexually inappropriate behaviours were attributed to the aging IP's criminality and sexual subjectivity, and not to the dementia process itself. Aggressive behaviours have been associated with the onset of dementia, which Torrisi et al.

(2016) attributed to “a combination of neurological, psychological and social factors” (p. 865). These authors noted that aggressive, even criminally aggressive behaviours have been associated with dementia processes, however evidence does not link previous criminal activities to this phenomenon. Sexually inappropriate behaviours were described as far less common in dementia, and typically linked to frontotemporal dementia, which only represents 5-10% of all dementia cases. Regardless of this empirical evidence, participants in this study suggested that the onset of dementia in aging IPs only solidified their existing subjectivities, and any aggressive or sexually inappropriate behaviours would be linked to these subjectivities and not to the dementia process itself. Again, this perception stands in stark contrast to views of the dementia process in non-criminal populations, where the illness is perceived to ‘take away’ from the ‘true’ selves of those living with the illness (Naue & Kroll, 2009). The permanence of this subjectivity significantly affected public perceptions of aging IPs and the likelihood of securing early release via placement in a community-based facility, a finding mirrored by Poulin et al. (2023) in their study of aging IPs in Canadian halfway house settings.

Abjection and Monstrosity

Power relations, particularly disciplinary power and its normal/abnormal dichotomy, figure prominently in the production of aging IP subjectivities (Taylor, 2019). The perceived criminal deficits of aging IPs, including those convicted of sexual offences, are to be assessed, documented, and corrected for an individual to be deemed appropriate for early release. An aging IP’s sexuality, here linked to the commission of sexual offences, becomes a permanent component of subjectivity. The health concerns of aging IPs also contribute to the production of their subjectivities; these, too, are to be assessed and documented, though the focus here shifts from correction to management. Both the criminal and health deficits of aging IPs contribute to

perceptions of risk. Yet these power relations are insufficient to fully explain the production of subjectivities. Participants in this study regularly described individual aging IPs as low risk yet identified a hesitancy – or complete unwillingness – to consider early release, either from the perspective of CSC or the PBC, often based on the specific crimes for which they had been convicted.

Kristeva's (1982) concept of abjection, and Shildrick's (2002) subsequent concept of monstrosity facilitate a broader understanding of aging IP subjectivities. As described above, abjection is the psychoanalytic process of rejecting or expelling that which threatens to disrupt the (perpetually fragile) borders of the clean and proper self. As part of this process, one works to construct and maintain the borders of the self to protect against the intrusions of the abject. These borders may be physical, such as creation of distances or separations between the self and the abject, or mental, such as a lack of engagement. That which constitutes the abject, according to Kristeva (1982), can extend beyond physical objects to that of transgressive persons. Any thing or person who threatens to disrupt the general order of things may constitute the abject and must be rejected or isolated to minimize this threat. In conjunction with Foucault's conception of criminals as those who have disrupted the social contract and require correction within prison settings, a psychic confinement is also necessary of these abject persons: a reminder that they are safely locked away in prisons where they cannot affect either social order or the boundaries of the self. Jacob et al. (2009) described this phenomenon in forensic hospital settings. Many of the aging IPs described by participants in this study were serving life or indeterminate sentences for convictions such as homicide or a designation as a dangerous offender, or they had entered prison later in life for convictions of sexual offences. Participants described some aging IPs as 'high profile' individuals, whose criminal acts were so objectionable as to gain local or even

national media attention. Such crimes (and criminals) represent some of the more abhorrent offences imaginable, persons who have grossly violated both the social order and the boundaries of (presumably) clean and proper victims.

Shildrick (2002), built upon Kristeva's (1982) concept of abjection to describe those individuals perceived as most abject, most dangerous as monsters. She described these monsters as "a deeply disruptive force" (p. 1), particularly those who physically resemble the 'clean and proper' members of a society, in contrast to those whose monstrosity takes a visible form, such as physical deformities or injuries. Historically speaking, "the monster has often functioned as a scapegoat, carrying the taint of all that must be excluded in order to secure the ideal of an untroubled social order" (p. 3). Incarcerated. persons who have been convicted of particularly egregious crimes, such as homicide and/or sexual offences, constitute the monster, a phenomenon explored in depth by Jacob et al. (2009) and Jacob and Holmes (2011). Knowledge of an IPs criminal convictions affect the approaches taken by nurses in these studies, related to both fear and abjection. Participants in the present study frequently referred to individual 'high profile' IPs, or IPCSOs as 'sex offenders' and noted the stigma associated with these individuals. Even if risk assessment tools and CSC staff perceptions – based on expectations of conduct – recognized that these individuals constituted a low risk to reoffend if released, they still described reservations about their release. As Shildrick (2002) reminds us, the abject cannot be fully externalized – it forever remains part of us, "a trace embedded within" (p. 54). The monster reminds us – the supposed clean and proper – that we are forever vulnerable to abject monstrosity.

This concept of vulnerability is critical to a consideration of monsters. The abject monster serves as a constant reminder that the borders of subjectivity are forever porous. In fact, they are

perceived as contagious, contaminated, capable of spreading their own monstrosity to others. They do not respect boundaries. As Shildrick (2002) noted:

> We understand that a contaminated object is one to be avoided or kept at a safe distance, lest we too become affected, our bodies opened up to the forces of disintegration. Our well-being, our very lives, are dependent then on the maintenance of a self-protective detachment, an interval not only between ourselves and evidently dangerous others… but also between ourselves and the mere potential of risk (p. 69).

This conceptualization is particularly relevant to IPCSOs. Participants in the present study identified a tendency for CSC staff to avoid this population, if possible. In facilities where entire units were dedicated to IPCSOs, some participants noted that staff actively avoid these units, and prefer not to work on them, or even visit them. In cases where interaction with an IPCSO was unavoidable, multiple participants noted a specific avoidance of knowledge of their individual convictions and criminal histories. Either implied or explicitly stated, participants suggested that knowledge of individual crimes could negatively affect the way they worked with or cared for the individual. Here the operation of borders or boundaries in attempts to maintain the clean and proper self is transparent. CSC staff attempt to create a physical distance between themselves and IPCSOs by avoiding them (and their units) when possible. When this is not possible, psychic borders are instead erected. Harris et al. (2015), in a study of nurses working with IPs convicted of serious offences, described the psychic contamination of nurses, wherein nurses began to imagine the individual crimes of their patients, and even began to view themselves as capable of acts such as homicide. The monstrous subjectivities of IPs come to infect or contaminate the subjectivities of the nurse. To not know the details of an IPs convictions is to protect the clean and proper borders of the self, to avoid contamination by the monstrous other.

A failure to protect oneself, according to Shildrick (2002), is to expose one's vulnerability, an opening of one's boundaries to the abject infiltrator. Some participants in the present study admitted to such acts. Here this comprised of working to better understand individual IP histories, including their offences, to engage in a more therapeutic manner. This was particularly true for aging IPCSOs. While some participants described a distancing from this population, others worked to better understand them. This approach represents the mobilization of pastoral power, using confession (Foucault, 2021) and therapy (Holmes, 2002, 2005), to better understand, and potentially shape the conduct of individual IPs. It also represents an intentional vulnerability. Shildrick (2002) described the reality that all bodies are vulnerable, that subjectivities are never fully formed, and to accept our intrinsic vulnerability is to undo the clean and proper/other divide of monstrosity. Participants described the histories of IPCSOs, recognizing that many themselves had been victims of sexual assaults, or that many Indigenous IPCSOs had been victimized within residential schools. Participants spoke more favourably of these individuals – the production of the IP subjectivities shifting away from one of monstrosity. Waldram (2007, 2012), in studying IPCSO populations, described the openness and relative kindness of this population once trust was established. However, he also warned of the consequences of showing an openness, or vulnerability, to this population to those outside the prison setting. Association with IPCSOs was described as potentially contagious, such that the researcher was an apologist for sexual offences, or even a sexual offender himself. The subjectivity of persons working with IPCSOs becomes infected by this vulnerability (Asher, 2014). In the present study, the culture of the correctional settings was described as hierarchical, with IPCSOs being placed at the bottom of this hierarchy by both IPs and CSC staff. Participants described the tensions that existed when advocating for IPCSOs, especially amongst correctional

officers. Holmes and Federman (2006) described the correctional environment as a particularly masculine space, where displays of kindness to IPs are not permitted, this being particularly relevant for IPCSOs. Even when CSC staff work to step outside of typical IP subjectivity productions, the disciplinary nature of the setting, wherein CSC staff themselves are also subject to surveillance and normative judgement, presents significant obstacles. Furthermore, IPs who have been convicted of egregious crimes, especially IPCSOs, are perceived as monstrous, abject others, best avoided lest they contaminate the very subjectivity of CSC staff themselves. Such perceptions of these populations facilitate an understanding of the hesitancy to pursue or grant early release by CSC, even where they do not present an empirical risk to reoffend.

Public Perceptions

Participants described a significant distance between CSC staff perceptions of aging IPs and aging IPCSOs and those of the public, particularly in the agencies and facilities with whom aging IPs could potentially be placed. It was acknowledged that the reality of working with IPs, many of whom had been convicted of serious offences, on a day-to-day basis shifted CSC staff perceptions to a better understanding of these individuals and the fact that many of them were, as participants described, ‘nice’ people, a finding mirrored by Waldram (2007). However, even when attempting to communicate this perception to members of the public, it is not well received. Waldram (2009) described the significant opposition faced in even attempting to discuss his research on IPCSOs with those unfamiliar with correctional environments. Similar to the results of this study, he noted that the public perceived all IPs as inherently and permanently dangerous, regardless of empirical and anecdotal evidence to the contrary. Even if index offences had occurred decades previous and an IP had demonstrated no inclination for further offending, such messaging was refuted by the public. Similar to the findings of Poulin et al. (2023),this

study highlights the unwillingness of community-based facilities, such as long-term or palliative care homes, to accept an aging IP eligible for early release and in need of more appropriate care.

Perceptions of aging IPCSOs are particularly negative, with a significant unwillingness to accept that these individuals may present limited risk to reoffend if released to the public. As Taylor (2019) described:

> It is striking that known recidivism rates of sex offenders are relatively low, and yet the idea of the sex offender as a predator lurking in alleys who is compelled to act due to perverse impulses beyond their control remains prevalent, has captured the contemporary imagination, is perpetuated by the media and results in crime bills and public policies that lead to an ever-increasing surveillance of sex offenders (p. 7).

Here the concepts of abjection and monstrosity, again, help describe this perception, regardless of empirical data on risk (Ambroziak et al., 2021; Crookes et al., 2022). Persons convicted, or even suspected of sexual offences increasingly occupy a particularly negative space in public perceptions, and are described as monsters (Jacob et al., 2009, Werth, 2023). Glina et al. (2022) described the particularly negative public perception of those involved, or perceived to be involved, in child sexual offences. They described the significant stigma and myths around an offence that is frequently met with fear and disgust. High profile cases involving IPCSOs, what Carrier (2023) described as ‘the dangerous few’ dominate these perceptions of the so-called monsters who perpetrate these offences. Shildrick (2022) noted that ‘monsters’ act as scapegoats, “carrying the taint of all that must be excluded in order to secure the ideal of an untroubled social order” (p. 3). The monster is the abject other that remains embedded within the subjectivity of the clean and proper self, a reminder of fragility and vulnerability, and must be expelled with great force. The person convicted of sexual offences represents this abject monster who must be

excluded, segregated, hidden away. The description of an IPCSO from the present study who had been volunteering without incident in the community until the agency at which they were placed learned of their offences by searching their name on the internet illustrates this point. The individual was known to be an IP and was accepted. Only upon learning of their offences did this visceral and violent rejection of the individual occur.

Risk

According to Castel (1991), modern conceptions of risk dissolve the subject. Within a governmentality framework (Foucault, 2004), a population level conceptualization and management of risk occurs. The measurement of specific risk factors, applied to the population, permit the efficient management of otherwise self-governing individuals. No longer is the individual the target of policies, which Rose (2000) described as a post-disciplinary society. Here, experts and specialists manufacture policies based on prevention: an individual need not present as imminently dangerous, but simply correlate with a series of risk factors to be deemed at risk. The purpose of risk assessment then becomes a task of predicting the potential for violence and reoffence based upon probabilistic measures (Rose, 1998). In this manner, all IPs possess some level of risk, their very subjectivity being produced, in part, based on this level of risk. The purpose of risk management is then to focus therapeutic interventions at individual risk factors (O'Malley, 2008).

In the present study, questions of risk dominated the data collected. Aging IPs were described – often primarily – in terms of their measured or perceived level of risk, with most being described as low risk individuals. Participants described the use of various risk assessment tools to measure and predict individual levels of risk. These risk assessment tools, of course, being based upon empirical studies and statistical measures of populations: a function of

governmentality. In the pursuit or granting of early release of aging IPs, risk was described as the primary consideration utilized by both the CSC and PBC. Simply stated, if an individual aging IP was measured to pose a predicted risk to reoffend, early release would not be granted. However, participants described several circumstances in which aging IPs were measured as low risk to reoffend but were still denied early release, similar to the findings of the CSC and CHRC (2019). Despite stated mandates by CSC to provide release of aging IPs and to minimize the number of IP deaths in custody – a mandate rooted in a governmental approach – an intense reluctance to do so was described. Despite suggestions that society has become post-disciplinary, especially with regards to risk, this is not the case within CSC facilities. Significant tension between the operation of governmental power and disciplinary power occurs, with aging IPs at the epicentre of this tension. This operation of disciplinary power in the consideration of risk leads to what several participants described as the practice of risk aversion.

Risk Aversion

Despite an overarching governmental mandate of CSC to pursue release of aging IPs and minimize the number of IP deaths in custody, the operation of disciplinary power dominates the day-to-day conduct of both CSC staff and IPs. This affected not only CSC staff ability to conduct the work necessary to assess levels of risk, but also resulted in a conservative approach to risk assessments, as their conduct was also subject to scrutiny. For IPs, particularly IPCSOs, the operation of disciplinary power discouraged engagement with CSC staff and their attempts to assess levels of risk. Further complicating matters, conceptions of risk based on abjection and monstrosity and, particularly, public perceptions of IPs affected notions of risk and subsequent desires to pursue early release.

When conducting risk assessments and making recommendations on suitability of release for aging IPs, participants described a conservative approach. Here, measurements of risk may be overinflated to suggest the individual poses a higher risk than the assessment tools actually predict. Participants described significant anxieties in making predictions of risk to reoffend, suggesting they would be held personally accountable if an individual IP was released, based upon their recommendation, and subsequently reoffended. In the carceral operation of disciplinary power, not only are those who are detained under constant surveillance: those who staff the facility are also under constant observation (Foucault, 1997). The operation of normalizing judgement applies to staff, as well. Any failure to adhere to panoptic rules and expectations results in castigation. The CSC staff in this study described this exact phenomenon. Despite working in a multi-level apparatus, where decision making on early release of aging IPs involves the functioning of multiple professions and agencies, blame for failure, even if based on predictions, occurs at the individual level. As Rose (1998) stated:

> It appears that it is no longer good enough for such a professional to say that behaviour is difficult to predict and 'accidents will happen.' In different ways in different jurisdictions, every untoward incident can be seen as a failure of expertise: someone must be held accountable (p. 185).

Participants described the inherent uncertainty of making future predictions of aging IP risk of (mis)behaviours yet felt personally responsible for the future conduct of these individuals if released.

The operation of disciplinary power also affects CSC staff abilities to conduct individual risk assessments. Participants described the use of risk assessment tools, including the Violence Risk Scale (VRS) and the Violence Risk Scale-Sexual Offender (VRS-SO). These assessment

tools rely upon both static and dynamic factors in the evaluation of future potential of violence and/or reoffence (Olver et al., 2007; Wong & Gordon, 2006). Of note, age of individual is one of the measured static risk factors, with the recognition that as age increases, level of risk decreases. The dynamic – those that can change – risk factors include elements such as interpersonal relationships, treatment adherence and insight into convictions. To score favourably on these risk assessment tools, development of interpersonal relationships, engagement in treatment, and acceptance of convictions is necessary. Yet these requirements operate in conflict with the operation of disciplinary power within the correctional institution, particularly for IPCSOs.

Participants described the reluctance of many IPs, particularly those convicted of sexual offences, to engage with CSC staff and other IPs, or to even admit to and take personal responsibility for their offences. Sexual offences are highly stigmatized within correctional environments. Participants described acts of aggression and violence, even homicidal intentions towards IPCSOs if and when their convictions were learned by other IPs. Waldram (2007) described the efforts made by IPCSOs in CSC facilities to keep their convictions secret. However, the offences of individuals may be found on the internet, or participants in this study even suggested that correctional officers, many of whom hold negative attitudes towards IPCSOs, would intentionally expose this information to other IPs. Here operate both disciplinary and sovereign power. The in-depth knowledge of captives, and the power to enact punishment upon the body – and even kill – those who are ranked at the bottom of the institutional hierarchy. In order for an aging IPCSO to score favourably on a risk assessment tool, taking responsibility for their offence(s) is required. Yet doing so may place them at significant danger within the prison. Furthermore, prolonged engagement with CSC staff, such as nurses, to address concerns or mental health needs was described as potentially dangerous to IPs, particularly IPCSOs. In the

constant surveillance of disciplinary power, also conducted by other IPs, to be observed doing so could suggest that the individual is ‘snitching’ or ‘ratting’ on other IPs, an act that is highly forbidden within prison environments (Meeham et al., 2018; Trammell et al., 2021). As such, IPs were described as hesitant or unwilling to engage in therapy – or pastoral power enacted by CSC staff – out of fear of consequences. Connor et al. (2011) described the negative perceptions of IPCSOs towards treatment programs, including the necessity to disclose their offences and a recognition that refusal to participate resulted in personal sanctions. Incidentally, participation in programming and therapy is considered a dynamic factor of risk assessment tools. Yet the disciplinary and, at times, sovereign operation of power within the prison environment discourages demonstration of the very participation required to be considered for release. To be considered low risk by assessment tools requires conduct that may place individual IPs at higher risk of victimhood: a form of IP risk aversion.

Both CSC staff and individual IPs engage in forms of risk aversion, shaped by normalizing judgement, and aimed at the protection, either professionally or physically, of the self. Despite this, participants described findings of low risk amongst a number of individual IPs discussed in this study. This low risk assessment was described as the foundation for a pursuit of early release for aging IPs. Rose (1998) suggested a reliance on numbers occurs when assessments of risk are brought under scrutiny or criticism. Thus, CSC staff may recommend early release of an aging IP, even if convicted of a particularly egregious crime and/or sexual offences, and rely upon the ‘objective’ number or level or risk calculated via risk assessment tools to justify their decision or deflect criticism. This persistent focus on risk was of more concern in discussions with participants than a consideration of whether the healthcare needs of

an individual IP were being met within the institution. Only with an identification of low risk could the subsequent needs of an aging IP be addressed.

However, even in these cases where the risk of an aging IP was acknowledged to be low, reservations persist on their release, especially in the IP was convicted of sexual offences and/or if they were considered to be a high-profile offender. These high-profile offenders – the dangerous few (Carrier, 2023) – are those whose crimes capture the public attention, with regular features in news media, particularly gruesome details of violence, or victims such as children or well-known individuals. Even if, empirically, these individuals are deemed low risk and would benefit from early release into the community to better address healthcare needs, participants recognized that the granting of release would result in widespread public condemnation. The recent example of Paul Bernardo, a high-profile IP responsible for the kidnap, sexual assault and murder of two teenaged girls in the 1990s, highlights this reality. Bernardo was simply transferred from a maximum to medium security facility, but when the public learned of this transfer, significant backlash occurred, with significant political consequences (Taylor, 2023). In these cases, the psychic risk that individuals posed becomes a factor in release. The potential early release of 'sex offenders' or 'monsters' into the community, before their sentence end, results in a form of abjection that requires the ongoing detention of individuals lest they disrupt the clean and proper boundaries not only of the self, but of public order (Shildrick, 2002). Though not explicitly stated as such by participants in this study, it was clear that such factors played into conceptualizations of risk. Participants described individual IPs whom they had assessed as low risk, yet voiced reservations about them being released into an environment where their own family members may be present. As Shildrick (2002) noted, "monsters constitute an undecidable absent presence at the heart of human being" (p. 54). As a result, these

individuals remain in prison, with early release either not pursued or not granted, regardless of whether their healthcare needs can be met within the institution. These individuals represent what Castel (1991) described as the "iatrogenic aspects of prevention" (p. 289).

Early Release

The primary focus of this study was to examine access to early release of aging IPs to better meet their healthcare needs. Original study design aimed to examine compassionate release specifically, based on the findings and recommendations made by the CIC and CHRC (2019). However, in conducting this research and via the thematic analysis methodology it emerged that aging IPs face obstacles in accessing multiple forms of early release, beyond compassionate release. These forms of release include parole, statutory release, and Section 84 release for Indigenous IPs. In all cases, IPs pursue release into the community before they are otherwise eligible, based on their individual sentence or designation, such as for dangerous offenders. However, participants also described cases of aging IPs eligible for release such as parole or statutory release but remaining incarcerated past their date of eligibility on account of their significant healthcare needs. In these cases, the PBC required an approved placement to which the IP is transferred, but no placements were available, so the individual remained incarcerated until suitable placement was found, if at all. In all these cases, aging IPs faced similar obstacles in accessing release: either the CSC and/or PBC would not approve their release or, if approved, suitable placement in the community could not be found. The production of IP subjectivities, on account of their criminal histories and, in the case of IPCSOs, perceived deviant sexuality, and subsequent notions of risk account for these barriers.

In situations where an aging IP begins to develop significant health concerns, release into the community becomes far more complicated than for an otherwise able-bodied IP (CIC &

CHRC, 2019; Iftene, 2017a; Poulin et al., 2023). Chronic illnesses, such as diabetes, COPD, chronic pain, arthritis and others may affect and aging IP's ability to perform their activities of daily living in an independent manner. Mobility concerns, medication requirements and other related issues may require an aging IP to have assistance in their day-to-day functioning. Mental health and cognitive concerns, such as psychotic illnesses or dementia, also present challenges in the day-to-day functioning of aging IPs. Participants in the present study described the aging prison population, here defined as aged 50 and older, as one requiring a greater focus on healthcare needs than security. If these individuals are to be released into the community, unless they are being released into the care of family members, they typically require placement in facilities such as long-term care homes. For aging IPs living with more serious acute or terminal healthcare concerns, such as severe cardiac issues or cancer, similar obstacles exist; they cannot be released into general community and are more in need of facilities such as palliative care homes, a finding mirrored by Shaw and Driftmier (2021). As was described by participants in this study, release into the community without adequate healthcare supports is inappropriate. Even for IPs reaching warrant expiry, participants described releasing these individuals to hospital emergency departments. The efforts of CSC-enacted biopower extended to the very end of an aging IPs prison sentence, simply shifting responsibility for maintaining this biopower from one institution to another. For IPs released on parole, some halfway houses were described to be capable of accommodating some basic supports with ADLs but relied on outside assistance to do so, as was also described by Poulin et al. (2023). Furthermore, aging individuals with mobility issues face obstacles in most halfway house settings. If aging IPs do require release into some form of supportive community facility, participants described significant challenges in securing placements.

Applying for Release

Participants in this study described the significant efforts required to apply for early release of aging IPs. These were described as multi-disciplinary endeavours, assessing risk to reoffend, medical and mental health needs, navigating inter-jurisdictional relations, and preparation of application for the PBC. The complications of preparing and conducting individual risk assessments of aging IPs were explored above. Disciplinary concerns result in a professional hesitation to identify individuals as low risk and to recommend early release. Identification of the healthcare needs of aging IPs was described, such that accurate information is provided to accepting agencies (if found) to ensure appropriate placement is made. Aging IPs with significant healthcare needs are typically transferred to the care of regional hospitals and/or regional psychiatric facilities, which may exist in different jurisdictions or provinces/territories than the IP's 'parent' institution. In these cases, in order to release individuals to care facilities in their home province/territory/jurisdiction, administrative obstacles exist. A clash between the administration of federal and provincial or other jurisdiction healthcare systems was described to present delays and complications in organizing the specific circumstances of IP release. Participants described the necessity to begin these processes up to a year in advance of the predicted release of an aging IP, in recognition of the significant obstacles and delays that exist. In cases of compassionate release, where there may be a sudden onset of terminal illness or rapid decline of IP health status, this process becomes more challenging. And finally, the preparation and subsequent consideration of applications for early release was described as a lengthy process, taking, at minimum, several months for an application to reach the point at which the PBC makes a ruling.

Applications for early release made to the PBC have no guarantee of being approved. Participants described several circumstances in which members of CSC staff advocate for release, present a favourable application to the PBC, only to have it denied, even in cases where aging IPs are living with significant health concerns. In many cases, aging IPs were described to lack the physical capacity to reoffend, even if they intend to. A semi-conscious aging IP requiring the use of a ventilator presents minimal risk to reoffend. The PBC, who bears the authority to grant early release, was described as a significant barrier to the early release of aging IPs deemed, from the perspective of CSC, suitable for release. In a Government of Canada (2023b) document addressing the 'myths and realities' of PBC decision making, the notion that granting of release is influenced by political decisions and public opinion is dismissed. It noted that decisions on release are based upon "criminal history; institutional behaviour and benefit from programs; and release plan" (Reality 6). The results of this study contradict this assertion and are the first to illustrate this phenomenon. Participants described the PBC as being highly influenced by perceptions of IPs and fear of negative attention related to potential recidivism of released IPs. Risk, a governmental power concept, should be, according to participants, the primary consideration of the PBC: does this individual pose a risk to reoffend if released into the community. However, participants noted that high profile IPs, IPCSOs and Indigenous IPs are less likely to be granted release by the PBC, even if deemed low risk. Disciplinary power extends outside the prison setting and into the functioning of the PBC. The constant observation and normalizing judgement of public opinion and perception of IPs was described to influence decision making. The 'Globe and Mail Test,' referring to a Canadian national newspaper, was described to influence PBC decision making. If the release of an aging IP is likely to receive media attention, and generate subsequent public outrage, the PBC is less likely to grant early

release. The panoptic gaze of disciplinary power traverses multiple settings, from the prison to the PBC to the general public.

Finding Placements

If the PBC does deem an aging IP as suitable for early release, or if they are already eligible on account of their sentence conditions but have remained incarcerated due to healthcare requirements, they cannot be transferred into the community until a suitable facility is found. These facilities must be willing to accept the transfer of aging IPs from CSC institutions. Of the myriad obstacles faced by aging IPs in gaining early release, this obstacle is perhaps the most significant. Participants described the healthcare needs of aging IPs as typical of those of the general public, other than the accelerated aging that does occur with IPs. The application for admission of an aging IP to a long-term or palliative care setting is no different than that of a non-incarcerated person. The only difference is the criminal history. And it is this criminal history that presents obstacles. Community based facilities are simply unwilling to admit aging IPs. And they have no obligation to do so. Furthermore, the PBC will not grant release of aging IPs with more intensive healthcare needs until a suitable placement can be found. What this creates is a backlog of aging IPs (CSC & CHRC, 2019) in CSC regional hospitals and regional psychiatric facilities who have healthcare needs beyond those that can be offered by CSC and who are eligible for release but instead remain incarcerated, where, according to one participant, they languish and ‘rot.’

The nature of an aging IPs convictions affects a community-based facility’s willingness to accept them into their care. Both high profile IPs and sexual offences were described by participants as significant barriers to acceptance. According to participants, potential receiving facilities are provided with an aging IP’s history, including convictions, and can reject an

application based on these histories. Neither the CSC nor PBC can influence or direct the decision making of these sites. Participants described finding placements for aging IPCSOs as 'almost impossible' and cited both safety and release conditions as concerns. For instance, if an aging IPCSO with convictions related to children is released into a facility where children may be present, warnings must be put in place to all residents and visitors. The significant stigma attached to such measures prevent acceptance of these individuals.

Public perceptions of risk were described as contributing to an unwillingness to accept aging IPs, particularly those convicted of sexual offences. Participants expressed frustration in attempts to relay the limited risk an individual IP may pose, based on their own knowledge and assessment, to potential accepting agencies. These assessments and assurances of individual aging IP safety are insufficient to influence decision making. The produced subjectivities of IPs, based on their criminality and, for IPCSOs, their deviant sexuality, are perceived as permanent. Furthermore, the concepts of abjection and monstrosity illustrate this reluctance. The abject person – the monster – exposes the inherent vulnerability of subjectivities and social spaces (Shildrick, 2002). By permitting the transfer of a monstrous aging IP, one who has, for example, been convicted of sexual offences, is to illuminate these vulnerabilities and an associated failure of self-protection. As noted by participants, the threshold for sexual recidivism is much lower than that of physical violence. Inappropriate touching or access to the internet may constitute reoffence. The perceived ease of these actions and limited ability to prevent them affects community-based facilities perceptions of the risk aging IPCSOs may pose, despite assurances from CSC staff. Hence, these monsters, as outsiders, must be kept external. If given the choice to admit an aging IPCSO or a 'normal' citizen, community-based facilities, according to participants, will always choose the citizen.

Many IPs, when granted parole, are released to halfway house facilities for eventual transition into community living. However, as described by participants, few of these facilities possess the infrastructure or staffing levels to appropriately meet the needs of aging IPs. Poulin et al. (2023) conducted research in a halfway house in Ontario, Canada, that specifically serves the needs of aging IPs. However, similar to findings from the present study, these researchers identified the significant challenges faced by the halfway house staff to transition aging IPs into long-term care facilities. Obstacles identical to those described in the present study were identified, such as stigma towards IPs, and fear that aging IPs pose a risk to victimize the vulnerable residents of these facilities. The researchers described an appeal process that exists within the province of Ontario when an individual is denied access to long-term care, but added that engagement of such a process added lengthy delays to the transfer of aging IPs, if at all successful. If transfer to long-term care is not possible, aging IPs were indicated to be transferred to hospitals, where they typically resided for long periods, if not indefinitely. These findings correlate with those of the present study, where participants described circumstances in which aging individuals who were no longer under the authority of CSC would be transferred directly to hospitals from prison or halfway houses. Or, if the aging IP's health concerns were less significant, transfer to shelters – effectively transfer to homelessness – occurred.

Compassionate release was described by participants as effectively an option of last resort, typically for individuals who were not eligible for any other form of release, such as those serving life or indeterminate sentences. In these cases, however, the death of the IP must be deemed as immanent for release to be granted by the PBC. Such a definition of immanence complicates matters. Participants described the challenges associated with predicting life expectancy for those with terminal illness, expressing concern that the individual may live longer

than predicted, which violates the intention of this form of release. In contrast, the lengthy application process for compassionate release may not be compatible with rapid onsets of illnesses and/or rapid declines in health status. The reality of compassionate release, as described in this study, is that aging IPs are granted this form of release within days to weeks of death. By the time release is granted, aging IPs may be unconscious, living with extreme pain, or unable to effectively communicate with others. One participant questioned just how compassionate such a form of release can be. If the intention of compassionate release is to permit the individual access to services and family members without CSC restrictions, such an approach does not permit the time necessary to prepare for a meaningful death with dignity (Burles & Peternelj-Taylor, 2019; Shaw & Driftmier, 2021). The CIC and CHRC (2019) described two applications for compassionate release of aging IPs. In the first case, a terminally ill individual secured space in a palliative care facility, however the application process was longer than life expectancy. An ETA was suggested, which required correctional officers to supervise at the bedside, a provision the facility did not support. Here, the panoptic disciplinary power apparatus follows the individual to the very point of death. In the second case, a terminally ill IP in a medium security facility applied for compassionate release, only for the PBC to suggest transfer to a minimum-security facility before considering release to the community. In this case, release was eventually granted, though the individual was reported to have died two hours after release. In some cases, compassionate release was described as an administrative effort, an act of governmentality aimed at manipulation of statistics related to deaths in custody, the operation of both biopolitics on a population level, and biopower on the individual level.

Access to medical assistance in dying (MAiD) is available to all Canadian citizens, even those incarcerated in CSC facilities. As Driftmier and Shaw (2021) noted, some cases of MAiD

have occurred with federal IPs. As of 2020, according to their report, 11 applications for MAiD were received and 3 were granted. Of note, two procedures occurred outside of CSC facilities, and one inside. The study indicated that accessing release to the community for the procedure presented significant barriers and delays, far beyond those typically experienced by non-incarcerated persons. Additionally, those interviewed regarding the provision of MAiD indicated CSC's significant resistance to the procedure occurring within CSC facilities, a transparent attempt to avoid perceptions of sovereign power: the power to kill. Participants in the present study described the added complexity of the provision of MAiD for IPs, noting CSC resistance. In a subsequent study by Shaw and Driftmier (2021), access to IPs in CSC custody was approved to examine perceptions of MAiD amongst aging IPs. Limited success in approval of compassionate release was described to contribute to suicidality of aging IPs, associated with a recognition that death in custody is assured.

Institutionalization

The institutionalization of individuals incarcerated for several years to decades presents additional obstacles to early release. Participants described aging IPs who refused application for release, or even for parole for which they were eligible, due to a level of familiarity and comfort within CSC facilities, and fear and anxiety of the realities of existence outside the institution. Furthermore, participants described aging IPs with no meaningful connections outside the prison environment: family or friends not present, and no perceived opportunity for a meaningful existence. The prison, in these cases, becomes home, and fellow IPs and CSC staff become family. Cabana et al. (2009), in examining federally incarcerated persons in Canada who refused application for parole, found that these individuals were more likely to be Indigenous, be serving longer sentences, and have low education levels. A lack of support and preparation for release

were identified as factors contributing to this refusal to pursue release. The present study mirrors these findings; participants described Indigenous IPs as more likely to remain incarcerated, even if eligible for release. They also identified a lack of planning and preparation for release as contributing to institutionalization. In some cases, transfer to a facility in which the healthcare needs of an IP could better be met was refused. Disciplinary power is all-encompassing and operates on both the body and the soul of subject (Foucault, 1995). It works to shape and regulate the behaviours of all subjects such that the expected behaviours become natural, ingrained. The result of long-term situation within a disciplinary setting is institutionalization (Cooper et al. 2008): the subject is unable to 'undo' these behaviours. For aging IPs, as discussed by Shaw and Driftmier (2021), a meaningful death is one in which family and friends are present. For those who have been incarcerated for decades, have no meaningful preparation for transition to the community and/or a lack of connections outside the prison setting, a death in custody is viewed as favourable. According to participants in the present study, however, a more meaningful commitment to preparation for release and efforts to undo this institutionalization would avoid these perceptions amongst aging IPs.

Death in Custody

For those aging IPs not granted early release into the community, death in custody occurs, despite the suggestion that, according to one participant, 'nobody wants to die in prison.' These deaths in custody may occur within correctional facilities themselves, or in the hospital, with the IP on an ETA, while still under CSC jurisdiction. Participants in the present study presented a sense of resignation over deaths in custody, recognizing that significant efforts amongst CSC staff to secure release prove unsuccessful. Palliative care is provided in limited CSC facilities, as reported by Shaw and Driftmier (2021). None of the participants in the present

study offered insight into this process. However, the aforementioned authors described the provision of palliative care as involving fellow IPs in the provision of some forms of care. The participants in this study described a higher quality of care compared to that otherwise provided in CSC facilities, but still identified limitations. In many cases, those IPs receiving palliative care remain in their cells, often alone and without the ability to access rapid assistance. IPs offer peer support, however, dying alone was described as a common occurrence. In one case, participants described an aging, palliative IP dying alone in their cell on their toilet, and a fellow IP tasked with removing the body. Here the work of biopower – the power to make live and let die – has ultimately failed with an IPs death in custody. As Taylor (2017) noted, it is only in death where the subject can escape power. In other cases, as described by participants in the present study, aging IPs at end-of-life not granted early release are taken to hospital facilities, under supervision of correctional officers, to receive treatment. In these cases, aging IPs were described to die in the hospital, handcuffed to the bed, within the disciplinary power's 'sight and sound' of correctional officers. Neither of these circumstances – death in prison or death in the hospital – present meaningful opportunity for meaningful or dignified death (Burles et al., 2016).

After Release

For those aging IPs granted early release to facilities where provision of healthcare is more appropriate, participants described the necessity to maintain contact with the receiving agency to ensure the individual remained. They noted that the behaviours and conduct of these released individuals are under constant scrutiny and surveillance, and the presence of any perceived (mis)behaviours could result in a return to CSC facilities. The subjectivities of aging IPs transferred to community facilities remain focused on past convictions and/or perceived deviant sexualities. In many cases, participants described CSC staff travelling to the accepting

facilities with the newly released aging IPs in an attempt to both ease the anxieties of their staff and facilitate the transition with the IP themselves. The difficulty of transition to a new setting, particularly for those who experienced lengthy incarcerations and subsequent institutionalization, was described. This was particularly challenging for individuals living with dementia. The challenges of transition outside of prison settings for IPs is well documented (Binswanger et al., 2011). The institutionalization that occurs after lengthy incarceration, a product of disciplinary power, contributes to these challenges. Participants in the present study described concerns from accepting facility staff, especially in the first weeks after release, about the conduct of these individuals. Any (mis)behaviours viewed as unacceptable by accepting facility staff are attributed to the criminality of the released IP, and not to this transition process or the symptomology of their diagnoses. Even in halfway house settings, participants described the ongoing surveillance and monitoring of IPs, and the early intervention at even the potential of a breach of parole conditions. In some cases, IPs are returned to prison even without violating the conditions of their parole, a proactive measure aimed at the prevention of (mis)behaviours before they even occur: the operation of disciplinary power (Foucault, 1997).

As noted above, aggressive behaviours are associated with dementia, as are, to a lesser degree, behaviours deemed sexually inappropriate (Torrisi et al., 2016). Caregivers in long-term care and similar facilities struggle with the management of these behaviours. Aging IPs living with dementia may be released to these facilities. However, as noted by participants, unlike the non-IP residents of the facilities, staff attribute these behaviours to the criminal histories of the released IPs. Contrary to notions of dementia ‘taking away’ from the self, aging IPs are perceived to become somehow more concentrated in their criminal subjectivities with the onset of dementia. These subjectivities, based on their criminal histories, power relations, and

abjection and monstrosity, remained fixed, static. The functioning of disciplinary power and normalizing judgement follows these released IPs to the community setting: all conduct is carefully observed and scrutinized, and the smallest of infractions provide evidence that the individual should be returned to prison. Participants described such situations, requiring CSC staff to continue visiting the accepting facilities well after an IP is released to negotiate ongoing permission for them to remain. Nonetheless, small infractions, such as the theft of tea bags, were described as sufficient violation of expectations to warrant return to CSC custody.

This transition from prison to long-term or palliative care facilities, however, represents a movement to similarly institutional settings. Participants acknowledged the similarities between the prison environment and that of a long-term care setting. The partitioning of residents, strict adherence to schedules, and ongoing observation and documentation of conduct exist in both settings. Ben-Moshe (2020) included nursing homes as part of the same carceral apparatus as prisons, suggesting the carceral logic that dominates practices in prisons also operates in facilities dedicated to the care and management of geriatric populations. Participants in the present study noted that the care needs of aging IPs are similar to those of any other resident of long-term care and similar facilities, and that most individuals, after the destabilizing period of transition, functioned well within this new environment.

Abolitionist Perspectives

The options proposed by participants and explored in greatest detail in this project lie within what Ben Moshe (2020) described as reformist measures. Such measures, they argue, wherein changes are made "ends in demands to expand existing frameworks to accommodate marginalized populations… but not in changing the status quo" (p. 10). Guenther (2013) noted that when attempts are made to address the basic rights of IPs – in this case improved access to

healthcare services for aging IPs – they have a tendency "to reproduce and legitimate that minimum as a new *normal* standard for confinement" (p. 133). Many participants in this study argued that healthcare services in CSC facilities should be improved for aging IPs, and that community-based agencies should be more open to accepting aging IPs. And while these measures would certainly result in improvements to the quality of life of many aging IPs, they fail to address the reality that the prison itself – its design, its infrastructure, its services and its inhabitants – is debilitating and produces conditions that accelerate the aging and death of IPs. Ben Moshe (2020) described the concept of carceral humanism, wherein the welfare of IPs becomes a focus without a questioning of carceral logic itself. Such humanist – and with them humanitarian proposals – are, as Guenther (2013) concluded "inadequate to address the vital concerns of prisoners as living, relational beings" (p. 128). Agamben (1998) offered that humanitarianism "can only grasp human life in the figure of bare… life, and therefore, despite themselves, maintain a secret solidarity with the very powers they ought to fight" (p. 133). In considering such critiques in the context of this research project, calls to improve services within prisons do not challenge the carceral logic of the status quo. They simply maintain an existing framework wherein IPs are reduced to what Agamben (1998) described as bare life.

In contrast, and in alignment with a poststructuralist theoretical framework, abolitionist perspectives offer more radical proposals that move beyond the maintenance of the status quo. An abolitionist framework questions the necessity of prisons themselves. Ben Moshe (2020) described such aims as nonreformist reforms, which aim to "imagine a different horizon and are not limited by a discussion of what is possible at present" (p. 16). Abolitionist perspectives question the logic of carcerality itself and its proposals that prisons and punishment are the only solutions to criminal behaviours (Coyle & Nagel, 2022). Such perspectives permit a recognition

that the prison itself reduces, via sovereign power (Agamben, 1998), the lives of its inhabitants to those of bare life, that this environment is debilitating and only accelerates death (Ben Moshe, 2020). The long term goal of abolition is elimination of the need for prisons entirely, in favour of more constructive alternatives. As Ben Moshe (2020) acknowledged, abolition is a project not likely to be fulfilled in our lifetimes. As such, a strategy within abolition is a focus on decarceration: the removal of some individuals from the prison environment. In the present research project, the release of aging IPs, particularly outside the conditions of their sentencing, represents a form of decarceration. In recognizing the harms caused by the prison environment, aging IPs are moved to non-carceral settings more likely to meet their needs and perhaps provide them with a quality of life beyond that of bare life. As indicated by several participants, this process – if it occurs at all – typically commences as the aging IP is nearing end-of-life. Why wait, however, until this is the case? Why not commence this process far in advance? As one participant suggested, why not make the release of aging IPs at a certain age the rule, with continued detention an exception that must be justified? Such approaches are more in alignment with these abolitionist perspectives, as a process of decarceration that includes – but should not be limited to – aging IPs. As Ben Moshe (2020) argued, these nonreformist reforms can work in concert with more humanitarian reforms; they acknowledged that abolitionists can advocate for improved healthcare services within prisons while also pursing more radical changes.

Strengths and Limitations

Participants in this study offered candid insight into the day-to-day realities of working with aging IPs within CSC facilities, the healthcare challenges faced, and the obstacles to early release. Limited recent research on these topics exists in the Canadian context. The work of the CIC and CHRC (2019), Iftene (2017b), Shaw and Driftmier (2021), and Poulin et al. (2023)

highlight recent studies of those who have gained access within CSC and affiliated facilities to examine the challenges faced by aging IPs. The present research adds to this limited body of knowledge and offers key insights into the struggles that CSC staff face in meeting the healthcare needs of aging IPs. Participants offered experiences from a wide range of CSC facility types, including maximum, medium and minimum-security institutions, halfway houses, and regional hospitals and psychiatric facilities. Such perspectives offered insight into the entire trajectory of potential IP pathways, from admission to release. The specific experiences of many participants in working with aging IPCSOs, as well as those of making applications to early and compassionate release provided a wide range of data for consideration and analysis.

In qualitative research, ensuring rigour is achieved is of importance, both in data collection and analysis, though this question of the importance of rigour is debated (Freshwater et al., 2010). A thematic analysis methodology relies upon the examination of participant narratives – not only on the 'what' that has been said, but on the 'macro' context in which it is said (Reissman, 2008). In this study, these narratives were collected via participant semi-structured interviews. Data collection occurred until a wide range of perspectives was collected. Though this study permitted up to 20 interviews, the data collected in the 13 interviews offered a broad range of perspectives and significant insight into the research questions. Analytical rigour, as outlined by Finlay (2021) was assured via thorough analysis of data based on the poststructuralist theoretical framework. Verbatim quotations are provided to illustrate various themes. And finally, the research findings do not differ in any significant manner from those of other similar studies. However, many of the topics explored in this study have not been previously examined in other studies, and several unique contributions have been made. Questions of rigour in qualitative analysis have been raised, including by Freshwater et al.

(2010). These authors question the necessity of rigour in this methodology, suggesting that a focus on rigour is to focus on the existence of one specific truth and a subsequent 'closing down' of debate. In contrast, the aim of a poststructuralist perspective should instead seek to 'open up' discussion, particularly when examining marginalized voices and populations. If we are to accept this position and abandon prioritization of rigour, this research has achieved this goal; the rarely heard voices of CSC staff are presented here in an examination of a highly marginalized prison population. As suggested by Freshwater et al. (2010), this has permitted an opportunity "to take account of underpinning socio-political and organizational power practices that influence practice" (p. 502).

A public recruitment approach, as opposed to receiving official CSC approval to work within their institutions, provided both strengths and limitations. The primary researcher's status as an 'outsider' and assurances that neither participant identity nor data collected would be shared with CSC provided participants opportunity to speak openly and frankly about their experiences. Furthermore, this approach permitted the recruitment of individuals who had recently worked in CSC facilities but were no longer employed. In these cases, participants expressed less concern for the implications of their identity being learned by CSC through dissemination of data. The presentation of the data collected in this study exists outside the authority or guidance of CSC, offering an unmitigated and uncensored window into the experiences of staff working with aging IPs. However, as explored above, many participants had significant reservations about both participation and presentation of their data. Fear of reprisal, as significant as termination of employment, resulted in some participants limiting the details in which they described their experiences. Others required assurances that data presented would be modified in such a manner that identities could not be discerned. A thematic analysis

methodology, which does not pursue an in-depth consideration of individual participant contexts (Reismann, 2008), facilitated this necessity to generalize much of the data collected. Nonetheless, the data presented here represents the primary researcher's best efforts to maintain the spirit of data collected while working to protect participant identity. In some cases, modification of presented data to obscure identities resulted in a masking of data richness, particularly when describing specific aging IP circumstances. In some interviews, participants were more forthcoming in discussions after recording had stopped. These discussions are not included in the data presented, of course, but did provide additional context for exploring the research questions.

The challenges described in recruitment resulted in fewer participants than the research design permitted. Participants from all four professions were included in this research, but identification of participants based on their profession was omitted to ensure confidentiality. This inhibited opportunity to compare experiences and perspectives between the professions. Future research on this topic may permit this analysis. Furthermore, because public recruitment relied upon voluntary participation, those who chose to participate, it was suggested by some, may have skewed towards more open and transparent participants. A closed and secretive culture of practice within prisons was described by some participants, including an unwillingness of those who 'bought in' to this culture to participate in public research. As such, perspectives from this 'old school' sector of CSC staff, whom some participants described as more punitive in practice, have likely been omitted from this research. Nonetheless, participants did provide insights, captured in the data, describing these tendencies.

Finally, the aim of this research was to better understand the healthcare needs of aging IPs and aging IPCSOs, yet these needs were explored via interviews with service providers, not

the IPs themselves. Given the challenges faced in conducting prison research already discussed, access to IPs themselves would have required formal approval from CSC to enter their facilities and seek participants. The challenge and complexity of this approach was beyond the scope of this research project, but should not be discounted. Few researchers have conducted studies with this population in Canada, and future research should include this perspective, particularly with accessing compassionate release and with aging IPCSOs.

Implications and Recommendations

Several implications and recommendations emerge from the results of this study, from practical considerations for CSC staff to nursing education to broader social and political implications. Clearly, the holistic needs of aging IPs, particularly those with more significant healthcare needs, are not being met by CSC. The care provided is often insufficient and does not permit death with dignity. Access to compassionate and other forms of early release is a lengthy process, where a focus on risk overshadows consideration of the individual IP's healthcare needs. Of greater concern than meeting these healthcare needs, it appears, is the management of CSC and PBC public perception. This section will examine implications and recommendations for clinical nursing, research and education.

Clinical Nursing

Many CSC facilities in which aging IPs are incarcerated lack the healthcare staff, knowledge and infrastructure required to meet their healthcare needs. Of note is the lack of 24-hour nursing staff in several facilities. Such limitations present multiple challenges, from the appropriate administration of medication, monitoring and management of aging IP chronic illnesses, and addressing healthcare concerns at all hours. Certainly, the provision of 24-hour nursing care in all CSC facilities would address many of these deficiencies. Furthermore, limited

access to physicians and psychiatrists within CSC facilities prioritizes the acute and emergent healthcare needs of IPs, deprioritizing chronic health concerns. As a result, aging IPs face considerable delays in accessing basic services. Expanded access to physicians and psychiatrists specifically for aging IPs is required. The healthcare services that do exist within CSC facilities cater to the needs of a younger population. A lack of healthcare staff knowledge and capacity to treat the physical and mental health needs of aging IPs results in unmet healthcare needs, or significant delays in accessing care. Furthermore, prison facilities are not built for the needs of aging IPs living with chronic pain, mobility issues, significant mental health concerns, or cognitive illnesses, such as dementia. Yet the rigidity of the prison disciplinary apparatus does not permit flexibility in rule compliance for these aging IPs. Instead, they continue following the same rules as younger, more able IPs. Some facilities, such as regional hospitals and psychiatric facilities, and the two units in Canada that do cater to aging IPs, do exist, however, transfer to these facilities typically occurs when an IPs needs become so severe that they can no longer be met in the parent institution. Furthermore, transfer to these facilities may take aging IPs far away from what is considered home, limiting access to family and friend support. A reconfiguration of prison architecture is necessary to alleviate these concerns, which proves costly (CIC & CHRC, 2019) and would likely come at the expense of the perceived security requirements of the facilities.

A more appropriate solution to meeting the healthcare needs of aging IPs, beyond a reconfiguration of extant CSC healthcare services, is expanded access to early release. The pursuit and granting of release were described to occur only when the healthcare needs of aging IPs become so significant that they can no longer be adequately met in CSC facilities. At this point, aging IPs typically require transfer to long-term or palliative care facilities, where limited

capacities are further complicated by the significant negative perception these individuals face amongst receiving agencies. Furthermore, in these cases, especially in applications for compassionate release, consideration of risk remains paramount to the PBC (Iftene, 2017a). As indicated by Jefferson-Bullock (2015), “the medical virtue of compassionate release is grounded in basic humanity, and commands that we treat dying prisoners as people, worthy of a dignified death” (p. 521). Participants described multiple circumstances in which compassionate release was denied on account of perceived risk. As Iftene (2017) described, the PBC rationale for granting compassionate release remains rooted in that of all other forms of release: IPs must indicate rehabilitation before reintegration. Yet a terminally ill IP is incapable of demonstrating successful rehabilitation. Such expectations were described for aging IPs in applications for parole as well. Iftene (2017a) concluded that “they were not seen as good candidates for parole because they were old, unemployable, and difficult to house” (p. 935). This author proposed changes to the Corrections and Conditional Release Act (Government of Canada, 1992) such that health status is the only criteria for consideration of compassionate release, and that compassionate release is made available to all IPs “regardless of length or type of sentence, or of duration of time already served” (p. 950). Such measures would expand access to compassionate release, an action also recommended by the CIC and CHRC (2019). Nurses are uniquely suited to understand the holistic needs of their patients, and recognize when these needs are not being met, including at end-of-life (Burles & Peternelj-Taylor, 2019). Expanded advocacy from nurses for expansion of access to compassionate release and improvements in the delivery of healthcare services to aging IPs in CSC facilities is necessary. As noted by Burles & Peternelj-Taylor (2019), the provision of healthcare to IPs is rarely a consideration of the non-incarcerated

population; exposure of the realities of (inadequate) healthcare provision by nurses constitutes a critical component of nursing advocacy, both within CSC and externally.

An additional consideration in the long-term detention of aging IPs is the considerable cost of incarceration. As indicated above, in 2019-2020 the average annual cost of incarceration in a CSC facility is $126,253, while the cost of maintaining an individual in the community is considerably lower: $34,214 (Public Safety Canada, 2023). The CSC and other agencies in Canada do not report the healthcare costs of IPs, but in jurisdictions where such data is reported, the costs of maintaining aging IPs with health concerns are estimated as two to four times higher than for younger IPs (Baidawi et al., 2011; Chiu, 2010). If these estimates are to be applied to CSC populations, they suggest that the cost of maintaining a single aging IP in CSC facilities may exceed half a million dollars per year. In addition, meeting the needs of these individuals, particularly for ETAs to community services, places significant strain on already limited staff within CSC facilities.

Research

The experiences of aging IPs, particularly those receiving palliative or end-of-life care have received minimal attention in nursing research and literature, especially outside the United States (Burles & Peternelj-Taylor, 2019). As noted throughout, very few studies have looked specifically at the experiences of older IPs in Canadian correctional facilities, including CSC institutions, and none of these have done so from a nursing perspective. This study represents the only effort to do so with a nursing focus within Canada and, as explored above, only does so from the perspective of CSC staff working with this population. Critical for future research endeavours is an examination of the experiences and perspectives of aging IPs themselves, despite the challenges such research may face. This research and future research should aim to

improve the provision of healthcare services to aging IPs within CSC facilities, but also highlight the extant deficiencies that exist. In doing so, improvements in healthcare services, including palliative and end-of-life care to aging IPs may occur within CSC facilities, but also facilitate expanded access to early release of this population when appropriate.

While the above recommendations and implications suggest measures aimed at the reform of CSC healthcare and early release provisions, more radical recommendations are prudent. As Ben-Moshe (2020) observed, reformist efforts aimed at the accommodation of marginalized populations may improve circumstances for these populations, but only maintains the status quo of the system in which they exist. More radical measures focus on the decarceration of aging IPs. As questioned by participants in this study, why must consideration of early/compassionate release have to wait until the aging IP is seriously or terminally ill? At this point, the significant obstacle of finding community-based placements both capable and willing to provide care results in most aging IPs either dying in prison or in a hospital under CSC supervision. Instead, consideration of release of aging IPs should commence before they reach these stages of significant healthcare concern. In such cases, the needs of aging IPs in the community are more likely to be met through less intensive supports. As one participant offered, early release should be mandated at a certain age, reversing the obligation of CSC and the PBC to one where they must justify the continued detention, if deemed necessary. As described by Millemann et al. (2017, 2021), the widespread release of aging IPs is possible, and, with sufficient supports provided, with limited negative social consequences or recidivism. Such a focus on the decarceration of aging IPs avoids the costly and onerous tasks of reforming and, in some cases, rebuilding correctional services and facilities and instead permits the humanitarian release of IPs where they can age and die with dignity.

Education

The results of this research and the limited previous research on aging IP populations in CSC facilities highlight the need for expanded education across multiple professions and locations. As indicated by multiple participants in this study, nurses and other professions in CSC facilities lack the understanding or education on how to provide care to an aging population. Correctional healthcare focuses on the needs of an otherwise younger population and the types of medical needs more typically associated with the prison environment, such as substance use, physical injuries, and pharmacological needs. Knowledge of geriatric healthcare is typically lacking amongst correctional services nurses (Burles & Peternelj-Taylor, 2019). Certainly, increased education for nurses and other healthcare providers on geriatric care is required across all CSC facilities. Furthermore, this education should include correctional officers. Though they are not officially tasked with the provision of healthcare, as indicated in this research and other studies (CIC & CHRC, 2019; Iftene, 2017b), they often provide care regardless, especially during times when other healthcare staff are not present. Education on the needs of geriatric IPs would not only improve the ad hoc care often provided, but also expand understanding of the specific needs and abilities of this population, such that correctional officers may alter their approaches accordingly. Finally, as noted by Burles and Peternelj-Taylor (2019), education on palliative and end-of-life care should be provided to all nurses working in CSC; though these services are typically only provided within specific CSC facilities, nurses in all settings may be required to provide this care.

Education on the healthcare needs of aging IPs should also expand beyond correctional settings. As noted by Sutherland et al. (2021), undergraduate nursing programs lack instruction on incarcerated populations – not only their healthcare needs, but also the associated stigma.

Nurses entering practice settings possess minimal knowledge of these populations and, as noted, may not receive additional education when commencing work in a correctional setting. Inclusion in nursing curriculum of education on incarcerated populations, their healthcare needs, the concept of accelerated aging, and questions of both stigma and risk would address these shortcomings.

Based on the results of this study, where education on the healthcare needs of aging IPs is most required is within community-based care facilities, such as long-term or palliative care settings. As explored, these facilities often represent the best opportunity for aging and dying IPs to receive appropriate healthcare services, yet they are strongly resistant to admitting these individuals. The healthcare needs of aging IPs are, as noted in this research, typically no different than those of the general population requiring care in these community-based facilities. Yet the stigma, fear and abjection towards IPs presents a significant obstacle to the acceptance and provision of care. Education for nurses and other staff within these facilities on aging IP populations would help alleviate many of the concerns that prevent admission in the first place. Of note is the question of risk with this population – that, empirically speaking, they represent a low risk to reoffend and that, if they have been deemed eligible for release, that CSC and the PBC have already deemed them to pose minimal risk. Necessary in this education is the concept of institutionalization – a recognition that transition from a correctional facility to a community-based setting may present challenges for aging IPs, but that these are typically overcome.

Nonreformist Reforms

Nurses and other professionals working within CSC facilities, and any other prison environment may benefit from the proposals offered here, aimed at greater understanding of aging IP needs, improved training in geriatrics and the need for continued research on this topic.

Such approaches align with what Ben Moshe (2020) described as reformist approaches. Indeed, any changes made that improve the lives of aging IPs within prisons are welcome. However, as Ben Moshe (2020) concluded, reforms to existing frameworks can occur simultaneously with abolitionist efforts. Nurses and other professionals working with prison populations are well situated to advocate for more radical solutions to meeting the needs of their patients. Included in these solutions is work towards decarceration, wherein work is done to remove or release IPs from prison to settings where they may enjoy a greater quality of life beyond the bare life (Agamben, 1998) provided within prison. Some participants in this study did, in fact, argue for such measures.

Chapter 7: Conclusion

The Canadian federal prison population is aging. Aging IPs serving life or indeterminate sentences, mandatory minimum sentences, and those admitted to prison at a later age make up a large and growing proportion of those in CSC facilities. The rigours and difficulties of prison life contribute to the accelerated aging of these individuals, such that physiological age presents as 7 to 15 years older than chronological age (Burles et al., 2016; Loeb et al., 2008; Maschi et al., 2012). In such facilities, those over the age of 50 are considered old or aging and live with a wide array of physical and mental health ailments. Afflictions such as chronic pain, diabetes, arthritis and associated mobility issues, and dementia disproportionately affect this population (CIC & CHRC, 2109; Iftene, 2017b; Peacock et al., 2018). Yet the prison setting is not designed for an aging population. They physical environment fails to meet the needs of aging IPs, strict prison rules and expectations prohibit special treatment, and healthcare staff is both insufficient and ill-equipped to meet the needs of these individuals. Limited facilities exist for the provision of care appropriate for this population but may be located great distances from an aging IP's home and support network. Community-based healthcare facilities, such as hospitals, provide much of the care that CSC cannot, using escorted temporary absences (ETAs), wherein aging IPs are handcuffed to hospital beds under the constant gaze of correctional officers. Many die this way. Others die in prison, a death neither desired nor dignified.

Nurses are responsible for the provision of healthcare services to IPs in correctional settings, including CSC facilities. They provide medical and mental health services, administer medications, treat illness and injuries, and offer support to all IPs. Yet the needs of aging IPs, including aging IPCSOs are often not met. Participants in this research acknowledged the various deficiencies in the provision of care for aging IPs in CSC settings and indicated multiple areas

for improvement. This research highlights these deficiencies, which nurses, nursing research and nursing advocacy are uniquely situated to improve.

Early release of aging IPs via such mechanisms as parole, statutory release, section 84 release, and compassionate release offer alternatives to a death in custody. However, access to these forms of release presents significant obstacles. Consideration of release typically occurs when the aging IP is nearing end-of-life, and the application process itself is lengthy, taking months to proceed. Concerns over risk overshadow health needs, as do negative perceptions of incarcerated persons, particularly those convicted of sexual offences and/or those considered high profile. The subjectivities of aging IPs, produced by the power relations of the prison setting and the perceived abject monstrosity of criminality, including sexual offences, are viewed as permanent. The Parole Board of Canada is hesitant to release aging IPs who may produce public backlash upon knowledge of release. Of greatest concern is not the wellbeing of the aging IP upon release, but the potential that they may reoffend. Even if early release, via the various options available, is granted, the healthcare needs of these aging IPs typically require placement within healthcare facilities such as long-term or palliative care homes. However, these facilities are under no obligation to accept individuals from correctional institutions, and most refuse based on fear and negative perceptions of IPs, particularly IPCSOs, despite empirical evidence suggesting these populations represent amongst the lowest risk to reoffend (Ambroziak et al., 2021; Cornelius et al., 2017; Crookes et al., 2022; Piquero et al., 2015; Ray & Jones, 2023). CSC staff make considerable efforts to secure release, to convince community agencies to accept aging IPs, to assuage their fears about the (minimal) risk these individuals pose. Yet few successful releases are secured. And if they are, the smallest of infraction may return an aging IP to custody.

As one participant in this study succinctly noted, nobody wants to die in prison. Such is not a dignified death. Regardless of criminal convictions, all IPs in Canada have the right to access to appropriate health services equivalent to those available to non-incarcerated persons (United Nations, 2015). Yet, in reality, many aging IPs experience significant obstacles and delays in having their basic healthcare needs met. Early release, including compassionate release, presents opportunity to better access these necessary services outside the prison environment. But successful release is both challenging and rare. A preoccupation with risk and negative public attention minimizes the likelihood of early release being granted. This system of early and compassionate release is, as Iftene (2017a) noted, both insufficient and inappropriate. Though the CIC and CHRC (2019) recommended expanded access to early release, no progress is apparent. Future efforts to secure the release of aging IPs should not focus on reformations to existing systems that only maintain the status quo. Instead, a focus on decarceration of aging IPs, particularly those with growing healthcare needs, should be prioritized.

References

Addo, M. A. (2006). *The unseen abyss: Registered nurses' experience in working with sex offenders – a hermeneutic phenomenological study.* University of Aberdeen.

Agamben, G. (1998). *Homo sacer*: *Sovereign power and bare life*. Stanford University Press.

Agger, B. (1991). Critical theory, poststructuralism, postmodernism: Their sociological relevance. *Annual Review of Sociology, 17*(1), 105-131.

Aiyegbusi, A., & Kelly, G. (2012). Introduction. In A. Aiyegbusi & G. Kelly (Eds.), *Professional and therapeutic boundaries in forensic mental health practice* (pp. 7-12). Jessica Kingsley Publishers.

Allen, M. (2017). *Mandatory minimum penalties: An analysis of criminal justice system outcomes for selected offences*. Juristat: Canadian Centre for Justice Studies. https://www150.statcan.gc.ca/n1/pub/85-002-x/2017001/article/54844-eng.htm

Ambroziak, G., Kahn, R. E., Mundt, J., Keiser, K. L., & Thornton, D. (2021). Are civilly detained and committed sexually violent persons released after age 60 low risk? *Criminal Justice and Behaviour, 48*(7), 981-998. doi: 10.1177/0093854820972448

American Psychological Association. (2020). *Publication manual of the American Psychological Association: The official guide to APA style* (7th ed.). American Psychological Association.

Apa, Z. L., Bai, R. Y., Mukherejee, D., Herzig, C. T., Koenigsmann, C., Lowy, F. D., & Larson E. L. (2012). Challenges and strategies for research in prisons. *Public Health Nurse, 29*(5), 467-472.

Armstrong, S. (2020). At risk of rights: Rehabilitation, sentence management and the structural violence of prison. *Critical Criminology, 28*, 85-105. doi: 10.1007/s10612-020-09503-7

Asher, J. A. (2014). *Dirty work and courtesy stigma: Stigma management techniques among professionals who work with juvenile sex offenders*. University of Cincinnati.

Auerhahn, K. (2013). Sentencing policy and the shaping of prison demographics. In J. J. Kerbs & J. M. Jolley (Eds.), *Senior citizens behind bars: Challenges for the criminal justice system* (pp. 21-41). Lynne Rienner Publishers.

Aveling, N. (2012). Don't talk about what you don't know: On (not) conducting research with/in indigenous contexts. *Critical Studies in Education, 54*(2), 203-214.

Baidawi, S., Turner, S., Trotter, C., Browning, C., Colier, P., O'Connor, D., & Sheehan, R. (2011). Older prisoners – a challenge for Australian corrections. *Trends and Issues in Crime and Criminal Justice*, (426), 1-8.

Baker, T., Zgoba, K., & Gordon, J. A. (2021). Incarcerated for a sex offense: In-prison experiences and concerns about re-entry. *Sexual Abuse, 33*(2), 135-156. doi: 10.1177/1079063219884588

Beckett, J., Peternelj-Taylor, C., & Johnson, R. L. (2003). Aging matters: Growing old in the correctional system. *Journal of Pyschosocial Nursing & Mental Health Services, 41*(9), 12-18.

Ben-Moshe, L. (2020). *Decarcerating disability: Deinstitutionalization and prison abolition*. University of Minnesota Press.

Bentham, J. (1995). Panopticon letters. In M. Bozovic (Ed.), *Jeremy Bentham: The panopticon writings* (pp. 29-96). Verso.

Berring, L. L., Pedersen, L., & Buus, N. (2015). Discourses of aggression in forensic mental health: A critical discourse analysis of mental health nursing staff records. *Nursing Inquiry, 22*(4), 296-305. doi: 10.1111/nin.12113

Binswanger, I. A., Nowels, C., Corsi, K. F., Long, J., Booth, R. E., Kutner, J., & Steiner, J. F. (2011). "From the prison door right to the sidewalk, everything went downhill," a qualitative study of the health experiences of recently released inmates. *International Journal of Law and Psychiatry, 34*(4), 249-255. doi: 10.1016/j.ijlp.2011.07.002

Boothby, J. L., & Overduin, L. Y. (2007). Attitudes regarding the compassionate release of terminally ill offenders. *The Prison Journal, 87*(4), 408-415.

Brown, P., & Straker, J. K. (2012). Criminal offenders in Ohio nursing homes: Facility practices, prevalence and problems. Scripps Gerontology Center. https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/4465/Criminal%20Offenders%20in%20Ohio%20Nursing%20Homes%20FINAL.pdf?sequence=1

Burles, M. C., Peternelj-Taylor, C. A., & Holtslander, L. (2016). A 'good death' for all?: Examining issues for palliative care in correctional settings. *Mortality, 21*(2), 93-111. doi: 10.1080/13576275.2015.1098602

Burles, M. C., & Peternelj-Taylor, C. A. (2019). When home is a prison: Exploring the complexities of palliative care for incarcerated persons. In L. Holtslander, S. Peacock, & J. Bally (Eds.), *Hospice palliative home care and bereavement support: Nursing interventions and supportive care* (pp. 237-252). Springer.

Butcher, L. (2020). Psychological issues surrounding faecal incontinence: Experiences of patients and nurses. *British Journal of Community Nursing, 25*(1), 34-38.

Butler, J. (1990). *Gender trouble*. Routledge.

Butler, J. (1993). *Bodies that matter*: *On the limits of* '*sex'*. Routledge.

Cabana, T., Beauchamp, T., Emeno, K., & Bottos, S. (2009). Waivers, postponements and withdrawals: Offenders, parole officers and National Parole Board perspectives. Research

report no. R-193. *Correctional Service of Canada*. https://publications.gc.ca/site/eng/407782/publication.html

Carrier, N. (2023). Monstrosity, correctional healing, and the limits of penal abolitionism. *Crime, Media, Culture, 19*(1), 95-113. doi: 10.1177/17416590221086536

Castel, R. (1991). From dangerousness to risk. In G. Buchell, C. Graham, & P. Miller (Eds), *The Foucault effect: Studies in governmentality* (pp. 281-298). University of Chicago Press.

Cheek, J. (2004). At the margins? Discourse analysis and qualitative research. *Qualitative Health Research, 14*(8), 1140-1150. doi: 10.1177/1049732304266820

Chiu, T. (2010). It's about time: Aging prisoners, increasing costs, and geriatric diseases. *Vera Institute of Justice*. https://www.vera.org/publications/its-about-time-aging-prisoners-increasing-costs-and-geriatric-release

Connor, D. P., Copes, H., & Tewksbury, R. (2011). Incarcerated sex offenders' perceptions of prison sex offender treatment programs. *Justice Policy Journal, 8*(2), 1-22.

Cooper, D. J., Ezzamel, M., & Willmott, H. (2008). Examining 'institutionalization': A critical theoretic perspective. In R. Greenwood, C. Oliver, R. Suddaby, & K. Sahlin-Anderson (Eds.) *Handbook of organizational Institutionalism* (pp. 673-701). Sage.

Cornelius, C. V., Lynch, C. J., & Gore, R. (2017). Aging out of crime: Exploring the relationship between age and crime with agent based modeling. *Proceedings of the agent-directed simulation symposium,* 1-12. doi: 10.22360/springsim.2017.ads.006

Correctional Investigator Canada and Canadian Human Rights Commission. (2019). *Aging and dying in prison: An investigation into the experiences of older individuals in federal custody.* https://publications.gc.ca/collections/collection_2019/bec-oci/PS104-17-2019-eng.pdf

Correctional Service Canada. (2015a). Commissioner's directive: Health services. https://www.csc-scc.gc.ca/acts-and-regulations/800-cd-eng.shtml

Correctional Service Canada. (2015b). CSC's profile and mandate. https://www.csc-scc.gc.ca/publications/005007-8606-eng.shtml

Correctional Service Canada. (2018a). Security classification and penitentiary placement. https://www.csc-scc.gc.ca/acts-and-regulations/705-7-cd-eng.shtml

Correctional Service Canada. (2018b). Commissioner's directive 710-2: Transfer of inmates. https://www.csc-scc.gc.ca/acts-and-regulations/710-2-cd-en.shtml

Correctional Service Canada. (2018c). Promoting wellness and independences of older persons in CSC custody: A policy framework. https://www.csc-scc.gc.ca/publications/005007-1601-en.shtml

Correctional Service Canada. (2019a). Types of release. https://www.csc-scc.gc.ca/parole/002007-0002-en.shtml

Correctional Service Canada. (2019b). Response to the office of the correctional investigator's report – aging and dying in prison: An investigation into the experiences of older individuals in federal custody – February 2019. https://www.csc-scc.gc.ca/publications/005007-1509-en.shtml

Correctional Service Canada (2020). Health Services. https://www.csc-scc.gc.ca/health/index-eng.shtml

Correctional Service Canada. (2021a). Facilities and security. https://www.csc-scc.gc.ca/facilities-and-security/index-eng.shtml

Correctional Service Canada. (2022). Institutional profiles: Prairie region: Stony mountain institution. https://www.csc-scc.gc.ca/institutions/001002-4013-en.shtml

Coyle, M. J., & Nagel, M. (2022). Introduction: Penal abolitionism as a challenge to carceral logic. In M. J. Coyle & M. Nagel (Eds.), *Contesting carceral logic: Towards abolitionist futures* (pp. 1-13). Routledge.

Crookes, R. L., Tramontano, C., Brown, S. J., Walker, K., & Wright, H. (2022). Older indiviuals convicted of sexual offenses: A literature review. Sexual Abuse, 34(3), 341-371. doi: 10.1177/10790632211024244

Datta, R. (2018). Decolonizing both researcher and research and its effectiveness in Indigenous research. *Research Ethics*, *14*(2), 1-24. doi: 10.1177/1747016117733296

Driftmier, P. & Shaw, J. (2021). Medical assistance in dying (MAiD) for Canadian prisoners: A case series of barriers to care in completed MAiD deaths. *Health Equity, 5*(1), 847-853. doi: 10.1089/heq.2021.0117

Ewick, P., & Silbey, S. (2003). Narrating social structures: Stories of resistance to legal authority. *American Journal of Sociology, 108*(6), 1328-1372. doi: 10.1086/378035

Fedoroff, J. P. & Moran, B. (1997). Myths and misconceptions about sex offenders. *The Canadian Journal of Human Sexuality*, *6*(4), 263-276.

Finlay, L. (2011). Thematic analysis: The ‘good’, the ‘bad’ and the ‘ugly’. European Journal for *Qualitative Research in Psychotherapy, 11*, 103-116.

Foucault, M. (1990). *The history of sexuality: Volume 1 – an introduction*. Vintage Books.

Foucault, M. (1991). Governmentality. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault effect: Studies in governmentality* (pp. 87-104). The University of Chicago Press.

Foucault, M. (1997). *Discipline and punish: The birth of the prison*. Vintage Books.

Foucault, M. (2002). *The archaeology of knowledge*. Routledge Classics.

Foucault, M. (2003). *Society must be defended: Lectures at the Collège de France, 1975-1976.* Picador.

Foucault, M. (2004). *Security, territory, population: Lectures at the College de France, 1977-1978.* Picador.

Foucault, M. (2006). *Psychiatric power: Lectures at the Collège de France, 1973-1974.* Picador.

Foucault, M. (2008). *The birth of biopolitics: Lectures at the Collège de France, 1978-1979.* Picador.

Foucault, M. (2021). Confessions of the flesh: *The history of sexuality, volume 4*. Pantheon Books.

Freshwater, D., Cahill, J. & Muncey, T. (2010). Qualitative research as evidence: Criteria for rigour and relevance. *Journal of Research in Nursing, 15*(6), 497-508. doi: 10.1177/1744987110385278

Ginn, S. (2012). Elderly prisoners. *British Medical Journal, 345*, e6263.

Glina, F., Carvalho, J., Barroso, R., & Cardoso, D. (2022). Lay people's myths regarding pedophilia and child sexual abuse: A systematic review. *Sexual Medicine Reviews, 10*(4), 596-619. doi: 10.1016/j.sxmr.2022.06.010

Government of Canada. (1992). *Corrections and Conditional Release Act:* S.C. 1992, c.20. https://laws-lois.justice.gc.ca/eng/acts/C-44.6/FullText.html

Government of Canada. (2021). How sentences are imposed. https://www.justice.gc.ca/eng/cj-jp/victims-victimes/sentencing-peine/imposed-imposees.html

Government of Canada. (2023a). Mandatory minimum penalties in Canada: Analysis and annotated bibliography. https://www.justice.gc.ca/eng/rp-pr/jr/mmp-pmo/p1.html

Government of Canada. (2023b). Parole decision-making: Myths and realities. https://www.canada.ca/en/parole-board/corporate/publications-and-forms/parole-decision-making-myths-and-realities.html

Gray, R., & Brown, E. (2017). What does mental health nursing contribute to improving the physical health of service users with severe mental illness? A thematic analysis. *International Journal of Mental Health Nursing, 26(*1), 32-40. doi: 10.1111/inm.12296

Guba, E. G., & Lincoln, &. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 105-117). Sage.

Guenther, L. (2013). *Solitary confinement: Social death and its afterlives.* University of Minnesota Press.

Handtke, V., Wangmo, T., Elger, B., & Bretschneider, W. (2017). New guidelines for an old problem : Early release for seriously ill and elderly prisoners in Europe. *The Prison Journal, 97*(2), 224-246. doi : 10.1177/0032885517692805

Hanson, R., K., Harris, A. J., Letourneau, E., Helmus, L. M. (2018). Reductions in risk based on time offense-fee in the community: Once a sexual offender, not always a sexual offender. *Psychology, Public Policy, and Law, 24*(1), 48-63. doi: 10.1037/law0000135

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*(6), 1154-1163. doi: 10.1037/0022-006X.73.6.1154

Harper, L. C. (2020). *On vanishing: Mortality, dementia and what it means to disappear*. Catapult Books.

Harris, D. M., Happell, B., & Manias, E. (2015). Working with people who have killed: The experience of attitudes of forensic mental health clinicians working with forensic

patients. *International Journal of Mental Health Nursing, 24*(2), 130-138. doi: 10.1111/inm.12113

Harris, A. J., & Socia, K. M. (2016). What's in a name? Evaluating the effects of the "sex offender" label on public opinions and beliefs. *Sexual Abuse, 28*(7), 660-678. doi: 10.1177/1079063214564391

Hayes, A. J. (2017). Aging inside: Older adults in prison. In B. S. Elger, C. Ritter, & H. Stöver (Eds.), *Emerging issues in prison health* (pp. 1-12). Springer. doi: 10.1007/978-94-017-7558-8_1

Hellzen, O., Asplund, K., Sandman, P. O., & Norberg, A. (2004). The meaning of caring as described by nurses caring for a person who acts provokingly: an interview study. *Scandinavian Journal of Caring Sciences, 18*(1), 3-11.

Henning, C. (2021). The physical and mental health of incarcerated persons: A Canadian perspective. *Journal of Multidisciplinary Research at Trent, 3*(1), 1-17.

Holmes, D. (2002). Police and pastoral power: Governmentality and correctional forensic psychiatric nursing. *Nursing Inquiry, 9*(2), 84-92.

Holmes, D. (2005). Governing the captives: Forensic psychiatric nursing in corrections. *Perspectives in Psychiatric Care, 41*(1), 3-13.

Holmes, D. & Federman, C. (2006). Organizations as evil structures. In T. Mason (Ed.) *Forensic psychiatry: Influences of Evil* (pp. 15-30). Humana Press.

Holmes, D., Jacob, J. D., & Perron, A. (2014). *Power and the psychiatric apparatus: Repression, transformation and assistance.* Ashgate.

Huynh, L., Henry, B., & Dosani, N. (2015). Minding the gap: Access to palliative care and the homeless. *BMC Palliative Care, 14*(62), 1-4. doi: 10.1186/s12904-015-0059-2

Iftene, A. (2017a). The case for a new compassionate release statutory provision. *Alberta Law Review, 54*(4), 929-954.

Iftene, A. (2017b). The pains of incarceration: Aging, rights and policy in federal penitentiaries. *Canadian Journal of Criminology and Criminal Justice, 59*(1), 63-93. doi: 10.3138/cjccj.2016.E03

Iftene, A. (2020). Life and death in Canadian penitentiaries. *Canadian Family Physician, 60*(10), 759-760.

Iftene, A., & Downie, J. (2020). End-of-life care for federally incarcerated individuals in Canada. *McGill Journal of Law Health, 14*(1), 1-50.

Jacob, J. D. (2012). The rhetoric of therapy in forensic psychiatric nursing. *Journal of Forensic Nursing, 8*(4), 178-187. doi : 10.1111/j.1939.3938.2012.01146.x

Jacob, J. D., Gagnon, M., & Holmes, D. (2009). Nursing so-called monsters: On the importance of abjection and fear in forensic psychiatric nursing. *Journal of Forensic Nursing, 5*(3), 153-161. doi: 10.1111/j.1939-3938.2009.01048.x

Jacob, J. D., & Holmes, D. (2011). Working under threat: Fear and nurse-patient interactions in a forensic psychiatric setting. *Journal of Forensic Nursing, 7*(20), 68-77. doi: 10.1111/j.1939-3938.2011.01101.x

Jefferson-Bullock, J. (2015). Are you (still) my great and worthy opponents? Compassionate release of terminally ill offenders. *UMKC Law Review, 83*(3), 521-564.

Johansson, J. A., & Holmes, D. (2022a). The use of recovery model in forensic psychiatric settings: A Foucauldian critique. *International Journal of Mental Health Nursing, 31*(3), 752-760. doi: 10.1111/inm.13005

Johansson, J. A. & Holmes, D. (2022b). The clean and proper self: The relevance of Kristeva's concept of abjection for nursing. *Research and Theory for Nursing Practice: An International Journal, 36*(3), 1-15. doi: 10.1891/RTNP-2021-0107

Kaiser, M. Kohlen, H. & Caine, V. (2019). Explorations of disgust: A narrative inquiry into the experiences of nurses working in palliative care. *Nursing Inquiry, 26*(3), e12290. doi: 10.1111/nin.12290

Keene, D. E., Smoyer, A. B., & Blankenship, K. M. (2018). Stigma, housing and identity after prison. *The Sociological Review, 66*(4), 799-815. doi: 10.1177/0038026118777447

Klein, J. L., Bailey, D. J., & Sample, L. S. (2018). Researching the registered: Challenges and suggestions for researchers studying sex offender populations. *Criminal Justice Studies, 31*(2), 192-211. doi: 10.1080/1478601X.2018.1430033

Kristeva, J. (1982). *Powers of Horror: An essay in abjection*. Columbia University Press.

Kucirka, B. G., & Ramirez, J., (2019). Challenges of treating mental health issues in correctional settings. *Journal of Psychosocial Nursing & Mental Health Services, 57*(7), 7-11. doi: 10.3928/02793695-20190612-02

Lawton, J. (1998). Contemporary hospice care: The sequestration of the unbounded body and 'dirty dying'. *Sociology of Health & Illness, 20*(2), 121-143.

Loeb, S. J., Steffensmeier, D., & Lawrence, F. (2008). Comparing incarcerated and community-dwelling older men's health. *Western Journal of Nursing Research, 30*(2), 234-249. doi: 10.1177/0193945907302981

Loeb, S. J. (2013). Shifting institutions: Preparing for transfers from prisons to long-term care facilities. *Journal of Gerontological Nursing, 39*(6), 2-3. doi: 10.3928/00989134-20130318-01

Lupton, D. (1999). *Risk*. Routledge.

Maguire, D. (2021). Vulnerable prisoner masculinities in an English prison. *Men and Masculinities, 24*(3), 501-518. doi: 10.1177/1097184X19888966

Mansfield, N. (2000). *Subjectivity: Theories of the self from Freud to Haraway*. Allen & Unwin.

Martin, J. L. (2021). *Assessing the needs of the aging offender population in British Columbia and the Yukon* [Master's thesis, University of the Fraser Valley]. ARCA.

Maschi, T., Kwak, J., Ko, E., & Morrissey, M. B. (2012). Forget me not: Dementia in prison. *The Gerontologist, 52*(4), 441-451.

Mason, T. (2002). Forensic psychiatric nursing: A literature review and thematic analysis of role tensions. *Journal of Psychiatric and Mental Health Nursing, 9*(5), 511-520. doi: 10.1046/j.1365-2850.2002.00521.x

McAfee, N. (2004). *Julia Kristeva*. Routledge.

McCloskey, R. (2008). A guide to discourse analysis. *Nurse Researcher, 16*(1), 24-44. doi: 10.7748/nr2008.10.16.1.24.c6751

Meeham, N., Kelley, C., & McClary, M. (2018). The snitching hour: Investigations and interviewing in a county jail. *Security Journal*, 32, 198-217. doi: 10.1057/s41284-018-0157-y

Mercer, D. & Perkins, E. (2018). Sex, gender and the carceral: Female staff experiences of working in forensic care with sexual offenders. *International Journal of Law and Psychiatry, 59*, 38-43. doi: 10.1016/j.ijlp.2018.05.004

Millemann, M., Bowman-Rivas, R., & Smith, E. (2017). Releasing older prisoners. *Reforming criminal justice: A report for the Academy for Justice, 4*, 325-339.

Millemann, M., Chapman, J. E., & Feder, S. P. (2021). Releasing older prisoners convicted of violent crimes: The Unger story. *U. Md. LJ Race, Religion, Gender & Class, 21*, 185-247.

Mills, S. (2001). *Discourse*. Routledge.

Mills, S. (2003). *Michel Foucault*. Routledge.

Moolman, B. (2015). Ethnography: Exploring methodological nuances in feminist research with men incarcerated for sexual offences. In D. H. Drake, R. Earle & J. Sloan (Eds.), *Palgrave handbook of prison ethnography* (pp. 199-213). Palgrave Macmillan.

Morison, R. S. (2018). A national palliative care strategy for Canada. *Journal of Palliative Medicine, 21*(S1), S63-S75. doi: 10.1089/jpm.2017.0431

Muggleton, J., Guy, H., & Howard, R. (2014). Breaking the taboo: An interpretive phenomenological analysis of healthcare professionals' experience of caring for palliative patients with disgusting symptoms. *BMJ Supportive & Palliative Care, 5*(2), 189-195. doi: 10.1136/bmjspcare-2014-0000654.107

Naue, U. & Kroll, T. (2009). 'The demented other': Identity and difference in dementia. *Nursing Philosophy, 10(*1), 26-33. doi: 10.1111/j.1466-769x.2008.00379.x

O'Byrne, P. (2008). The dissection of risk: A conceptual analysis. *Nursing Inquiry, 15*(2), 30-39. doi: 10.1111/j.1440-1800.2008.00372.x

Office of the Correctional Investigator. (2020). *2019-2020 annual report*. https://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20192020-eng.pdf

Office of the Correctional Investigator. (2023). *Annual report 2022-2023*. https://oci-bec.gc.ca/sites/default/files/2023-10/Annual%20Report%20EN%20%C3%94%C3%87%C3%B4%20Web.pdf

Ollove, M. (2016, March 17). *Elderly inmates burden state prisons*. Pew Charitable Trust. https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/03/17/elderly-inmates-burden-state-prisons

Olver, M., Wong, S. C. P., Nicholaichuk, T., & Gordon, A. (2007). The validity and reliability of the violence risk scale—sexual offender version: Assessing sex offender risk and evaluating therapeutic change. *Psychological Assessment, 19*(3), 318-329. doi: 10.1037/1040-3590.19.3.318

O'Malley, P. (2008). Governmentality and risk. In J. O. Zinn (Ed.) *Social theories of risk and uncertainty: An introduction* (pp. 52-75). doi: 10.1002/9781444301489.ch3

Ostaszkiewicz, J., O'Connell, B., & Dunning, T. (2016). 'We just do the dirty work': Dealing with incontinence, courtesy stigma and the low occupational status of carework in long-term aged care facilities. *Journal of Clinical Nursing, 25*(17-18), 2528-2541. doi: 10.1111/jocn.13292

Parole Board of Canada. (2019). 2019-20 departmental plan. https://www.canada.ca/en/parole-board/corporate/transparency/reporting-to-canadians/report-on-plans-and-priorities/2019-2020/2019-20-departmental-plan.html

Patenaude, A. L. (2004). No promises, but I'm willing to listen and tell what I hear: Conducting qualitative research among prison inmates and staff. *The Prison Journal, 84*, 69S-91S. doi: 10.1177/0032885504269898

Peacock, S., Hodson, A., MacRae, R., & Peternelj-Taylor, C. (2018). Living with dementia in correctional settings: A case report. *Journal of Forensic Nursing, 14*(3), 180-184. doi: 10.1097/JFN.0000000000000194

Perron, A., & Holmes, D. (2011). Constructing mentally ill inmates: Nurses' discursive practices in corrections. *Nursing Inquiry, 18*(3), 191-204. doi: 10.1111/j.1440-1800.2011.00526.x

Perron, A., Rudge, T., & Holmes, D. (2010). Citizen minds, citizen bodies: The citizenship experience and the government of mentally ill persons. *Nursing Philosophy, 11*(2), 100-111.

Perron, A., Holmes, D., & Jacob, J. D. (2015). The politics of threats in correctional and forensic settings: The specificities of nursing research. In J. M. Kilty, M. Felices-Luna & S. C. Fabian (Eds.), *Demarginalizing voices: Commitment, emotion, and action in qualitative research* (pp. 147-172). UBC Press.

Peternelj-Taylor, C. & Younge, O. (2003). Exploring professional boundaries in the nurse-client relationship: professional roles and responsibilities. *Perspectives in Psychiatric Care, 39*(2), 55-66. doi: 10.1111/j.1744-6163.2003.tb00677.x

Piquero, A. R., Jennings, W. G., Diamond, B., & Reingle, J. M. (2015). A systematic review of age, sex, ethnicity, and race as predictors of violent recidivism. *International Journal of Offender Therapy and Comparative Criminology, 59*(1), 5-26. doi: 10.1177/0306624X13514733

Poulin, L. I., Colibaba, A., Skinner, M. W., Balfour, G., Byrne, D. & Dieleman, C. (2023). Lost in transition? Community residential facility staff and stakeholder perspectives on previously incarcerated older adults' transitions into long-term care. *BMC Geriatrics, 23*(1), 180. doi: 10.1186/s12877-023-03807-3

Psick, Z., Ahalt, C., Brown, R. T., & Simon, J. (2017). Prison boomers: Policy implications of aging prison populations. *International Journal of Prison Health, 13*(1), 57-63. doi: 10.1180/IJPH-09-2016-0053

Public Safety Canada. (2023). Corrections and conditional release statistical overview. https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ccrso-2021/index-en.aspx

Ray, J. V., & Jones, S. (2023). Aging out of crime and personality development: A review of the research examining the role of impulsiveness on offending in middle and late adulthood. *Psychology Research and Behaviour Management*, 1587-1596. doi: 10.2147/PRBM.S391406

Riessman, C. K. (2008). *Narrative methods for the human sciences.* Sage Publications.

Ricciardelli, R., & Moir, M. (2013). Stigmatized among the stigmatized: Sex offenders in Canadian penitentiaries. *Canadian Journal of Criminology and Criminal Justice, 55*(3), 353-386. doi: 10.3138/cjccj.2012.E22

Ricciardelli, R., & Spencer, D. (2014). Exposing 'sex' offenders: Precarity, abjection and violence in the Canadian federal prison system. *British Journal of Criminology, 54*(3), 428-448. doi: 10.1093/bjc/azu012

Rocque, M., Posick, C., & Hoyle, J. Age and crime. *The Encyclopedia of Crime and Punishment*, 1-8. doi: 10.1002/9781118519639.wvecpx275

Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing, 53*(3), 304-310.

Rose, N. (1998). Governing risky individuals: The role of psychiatry in new regimes of control. *Psychiatry, Psychology and Law, 5*(2), 177-195. doi: 10.1080/13218719809524933

Rose, N. (2000). Government and control. *The British Journal of Criminology, 40*(2), 321-339. doi: 10.1093/bjc/40.2.231

Sanders, S. & Stensland, M. (2018). Preparing to die behind bars: The journey of male inmates with terminal health conditions. *Journal of Correctional Health Care, 24*(3), 232-242. doi: 10.1177/1078345818780686

Schlosser, J. A. (2013). Bourdieu and Foucault: A conceptual integration toward an empirical sociology of prisons. *Critical Criminology*, 21, 31-46. doi: 10.1007/s10612-012-9164-1

Scott, J. W. (1992). Experience. In J. Butler & J. W. Scott (Eds.), *Feminists theorize the political* (pp. 22-40). Routledge.

Shaw, J., & Driftmier, P. (2021). "Dying with a smile, just knowing that somebody's listened to me": End-of-life care and medical assistance in dying in Canadian prisons. *OMEGA-Journal of Death and Dying, 0*(0), 1-24. doi: 10.1177/00302228211052341

Sheppard, A., & Ricciardelli, R. (2020). Employment after prison: Navigating conditions of precarity and stigma. *European Journal of Probation, 12*(1), 34-52. doi: 10.1177/2066220320908251

Shildrick, M. (2002). *Embodying the monster: Encounters with the vulnerable self.* Sage Publications.

Skarupski, K. A., Gross, A., Schrack, J. A., Deal, J. A., & Eber, G. B. (2018). The health of America's prison population. *Epidemiologic Reviews, 40*(1), 157-165. doi: 10.1093/epirev/mxx020

Speziale, H. S., Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative*. Lippincott Williams & Wilkins.

Stajduhar, K., Mollison, A., Giesbrecht, M., McNeil, R., Pauly, B., Reimer-Kirkham, S., Dosani, N., Wallace, B., Showler, G., Meagher, C, Kvakic, K., Gleave, D., Teal, T., Rose, C. Showler, C., & Rounds, K. (2019). "Just too busy living in the moment and surviving":

Barriers to accessing health care for structurally vulnerable populations at end-of-life. *BMC Palliative Care, 18*(11), Online First. doi: 10.1186/s12904-019-0396-7

Statistics Canada. (2023a). Table 35-10-0022-01: Adult admissions to federal correctional services. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3510002201. doi: 10.25318/3510002201-eng

Statistics Canada. (2023b). Table 35-10-0017-01: Adult custody admissions to correctional services by age group. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3510001701. doi: 10.25318/3510001701-eng

Statistics Canada. (2023c). Table 35-10-0013-01: Operating expenses for adult correctional services. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3510001301 doi: 10.25318/3510001301-eng

Stevens, B. A., Shaw, R., Brewert, P., Salt, M., Alexander, R., & Gee, B. L. (2017). Systematic review of aged care interventions for older prisoners. *Australasian Journal on Ageing, 37*(1), 43-42. doi: 10.1111/ajag.12484

Stewart, D., Burrow, H., Duckworth, A., Dhillon, J., Fife, S, Kelly, S., Marsh-Picksley, S., Massey, E,, O'Sullivan, J., Qureshi, M., Wright, S., & Bowers, L. (2015). Thematic analysis of psychiatric patients' perceptions of nursing staff. *International Journal of Mental Health Nursing, 24*(1), 82-90. doi: 10.1111/inm.12107

Stoliker, B. E., Kerodal, A. G., Jewell, L. M., Brown, K., Kent-Wilkinson, A., Peacock S., O'Connell, M. E., & Wormith, J. S. (2022). Older people in custody in a forensic psychiatric facility, prevalence of dementia, and community reintegration needs: An exploratory analysis. *Health and Justice, 10*(3), 1-11. doi: 10.1186/s40352-022-00168-8

Stoller, S. (2009). Phenomenology and the poststructural critique of experience. *International Journal of Philosophical Studies, 17*(5), 707-737. doi: 10.1080/09672550903301762

Stone, K., Papadopoulos, I., & Kelly, D. (2012). Establishing hospice care for prison populations: An integrative review assessing the UK and USA perspective. *Palliative Medicine, 26*(8), 969-978. doi: 10.1177/0269216311424219

Sutherland, J. L., Palmer, D., Jiang, L., Si, B., Reuther, P. & Collier, R. (2021). Undergraduate nursing students' attitudes towards incarcerated persons and their perceptions of clinical experiences. *Journal of Professional Nursing, 37*(6), 1154-1161. doi: 10.1016/j.profnurs.2021.10.004

Taylor, C. (2017). *Foucault's the history of sexuality*. Routledge.

Taylor, C. (2019). *Foucault, feminism and sex crimes: An anti-carceral analysis*. Routledge.

Taylor, S. (2023, October 25). Prison officials intervened to stop Paul Bernardo from making public statement. *CBC News*. https://www.cbc.ca/news/politics/bernarndo-messages-stopped-by-prison-officials-1.7007197

Thomas, B. (2012). Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England. https://www.crisis.org.uk/media/236798/crisis_homelessness_kills2012.pdf

Tierney, T. F. (2004). Foucault on the case: The pastoral and juridical foundation of medical power. *Journal of Medical Humanities, 25*(4), 271-290. doi: 10.1007/s10912-004-4833-z

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*(4), 388-396.

Torrisi, M., Cacciola, A., Marra, A., De Luca, R., Bramanti, P., & Calabro, R. S. (2016). Inappropriate behaviours and hypersexuality in individuals with dementia: An overview

of a neglected issue. *Geriatrics and Gerontology International*, *17*(6), 865-874. doi: 10.1111/ggi.12854

Trammell, R., Rundle, M., & Borrego, A. R. (2021). Anger, frustration, and snitching: Inmates describe structured isolation in a high-tech prison. *Deviant Behaviour, 42*(9), 1067-1085. doi: 10.1080/01639625.2020.1720936

Trumbull, R. (2015). Derrida and the death penalty: The question of cruelty. *Philosophy Today, 59*(2), 317-336. doi: 10.5840/philtoday201522667

Turner, M., Peacock, M., Payne, S., Fletcher, A., & Froggatt, K. (2018). Ageing and dying in the contemporary neoliberal prison system: Exploring the 'double burden' for older prisoners. *Social Science & Medicine, 212*, 161-167. doi: 10.1016/j.socscimed.2018.07.009

United Nations (2015, December 17). United Nations standard minimum rules for the treatment of prisoners (the Nelson Mandela rules). https://undocs.org/A/RES/70/175

Van den Berg, C., Beijersbergen, K., Nieuwbeerta, P., & Dirkzwage, A. (2018). Sex offenders in prison: Are they socially isolated? *Sexual Abuse, 30*(7), 828-845. doi: 10.1177/1079063217700884

Van Der Riet, P. (2006). A palliative care story: Negotiating the abject. *Contemporary Nurse, 22*(1), 81-83. doi: 10.5172/conu.2006.22.1.81

Von Hirsch, A., & Ashworth, A. (2005). *Proportionate sentencing: Exploring the principles.* Oxford University Press.

Waldram, J. B. (2007). Everybody has a story: Listening to imprisoned sexual offenders. *Qualitative Health Research, 17*(7), 963-970. doi: 10.1177/1049732307306014

Waldram, J. B. (2009). Challenges of prison ethnography. *Anthropology News, 50*(1), 4-5.

Waldram, J. B. (2012). *Hound pound narrative: Sexual offender habilitation and the anthropology of therapeutic intervention*. University of California Press.

Werth, R. (2023). More than monsters: Penal imaginaries and the specter of the dangerous sex offender. *Punishment & Society, 25*(4), 977-997. doi: 10.1177/14624745221118883

Williams, J. A. (2005). *Understanding poststructuralism*. Acumen.

Williams, B. A., Goodwin, J. S., Baillargeon, J., Ahalt, C, & Walter, L. C. (2012). Addressing the aging crisis in US criminal justice health care. *Journal of the American Geriatrics Society, 60*(6), 1150-1156.

Wodak, R. & Meyer, M. (2001). *Methods of critical discourse analysis*. Sage.

Wong, S. C. P., & Gordon, A. (2006). The validity and reliability of the violence risk scale: A treatment-friendly violence risk assessment tool. *Psychology, Public Policy, and Law, 12*(3), 279-309. doi: 10.1037/1076-8971.12.3.279

Appendix A: Recruitment Poster

School of Nursing

University of Ottawa

PARTICIPANTS NEEDED FOR RESEARCH IN FEDERAL CORRECTIONS

We are looking for volunteers to take part in a study of compassionate release of aging offenders in federal correctional institutions, including those convicted of sexual offences.

As a participant in this study, you would be asked to participate in an individual interview, either in person, over the telephone, or via Zoom.

Your participation would involve a single interview session, which will take approximately 30-60 minutes, with the potential for a follow-up interview, which will take up to 30 minutes.

For more information about this study, or to volunteer to participate, please contact:

Jim Johansson
School of Nursing
At
N/A
Email: N/A

This study has been approved by the University of Ottawa Office of Research Ethics and Integrity

Appendix B: Informed Consent Form

Title of the study: Compassionate Release: Aging Sex Offenders in Federal Corrections

Name of Principal Investigator: Jim Johansson

University of Ottawa School of Nursing

N/A

N/A

Name of Supervisor: Dave Holmes

University of Ottawa School of Nursing

N/A

N/A

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Jim Johansson (Doctoral Thesis) under the supervision of Professor Dave Holmes.

Purpose of the Study: The purpose of the study is to explore the challenges faced by professionals working with aging incarcerated persons in Canadian federal correctional facilities, including those convicted of sexual offences, and obstacles faced in being granted compassionate release. The objectives are to understand the potential risks this incarcerated population may face if granted release, a specific focus on persons convicted of sexual offences, and to better understand the process for accessing compassionate release

Participation: My participation will consist of one to two interviews. I have the option to conduct this interview in person at a time and location of my choosing, or by either telephone or online platform, such as Zoom. Interviews will be approximately 60 minutes in length. Follow up interviews, if they occur, will be up to 30 minutes in length. If I choose to use an online platform for interview, I can choose to have my camera on or off. During interviews, I will be asked about my experience working with aging incarcerated persons, including those convicted of sexual offences. I will be asked about any challenges I have faced when working with this population, as well as questions related to compassionate release. Interviews will be guided by a set of general questions, and will be audio recorded (if in person or by telephone), or video recorded if done online. I have the right to have the audio or video recorder stopped at any time without giving a reason. If follow-up questions are required, I will be contacted by the researcher for a second interview, in the format of my choosing.

*If online interview is used, I choose to have my video turned on:

Yes ___ No ___

Risks: My participation in this study will entail that I discuss my experiences working with aging incarcerated persons, including those convicted of sexual and this may cause me to feel emotional discomfort. I have received assurance from the researchers that every effort will be made to minimize these risks. I have no obligation to discuss any experiences or situations I am not comfortable with. I can choose to not answer any of the questions asked, and I can withdraw from the study at any time for any reason. I have been assured that my confidentiality will be maintained, and that the identities of any persons discussed in my interview will not be revealed.

Benefits: My participation in this study will help to better understand the challenges faced in working with aging incarcerated persons in federal institutions. It will also help to better understand the process of compassionate release for aging offenders, the appropriateness

of this, and any obstacles faced. It may help to improve or expand the services available for this population.

Confidentiality and Privacy: I have received assurance from the researchers that the information I will share will remain strictly confidential. I understand that the contents will be used only for the doctoral research of the principal investigator and that my identity will be protected. My confidentiality will be maintained. My interview will be conducted in private and only the researcher and supervisor will have access to the recordings or transcripts. I will be assigned a random number pseudonym for the publication of any information. Any identifying information about me or any other persons discussed in my interview will be removed or modified in a way that ensures confidentiality is maintained. This includes my location of work. Only my profession will be attached to my pseudonym (ex. 'Nurse 3') and my place of work will not be revealed. I understand that this research is being conducted independently from CSC and the agency through which participation recruitment may have occurred.

Conservation of Data: The data collected will be kept in a secure manner. Audio and/or video files will be coded according to pseudonym and stored on a secure, password protected computer. All notes, transcripts and signed consent forms will be stored in a locked cabinet in a secure setting. If I choose to withdraw from this study, all data and information regarding my participation will be destroyed. My data will only be available to the researcher and supervisor. All data will be retained for five years after project completion, after which it will be destroyed.

Voluntary Participation: I am under no obligation to participate 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, all data gathered until the time of withdrawal will be removed from the dataset and not used in the study.

If I have any questions about the study, I may contact the researcher or their supervisor. If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity via email (ethics@uottawa.ca) or telephone (613-562-5387).

It is recommended that I keep a copy of this consent form for my records.

Acceptance: By signing my name below, I agree to participate in this research study.

Participant's name: _____

Date: _____

Participant's signature: _____

Date: _____

Researcher's signature: _____

Date: _____

Appendix C: Semi-Structured Interview Guide

Semi-structured interview guiding questions for initial interviews (questions may change or expand as interviews and data analysis progress)

- Can you tell me about the setting you work in
- Can you tell me about the patients/inmates you work with
- Can you tell me about the aging or older patients/inmates you work with
- What are some of the challenges these aging or older patients/inmates face in the setting?
- What are some of the challenges you face when working with these aging or older patients/inmates?
- Do you work with patients/inmates who have been convicted of sexual offenses? If so, can you tell me about working with them?
- Do you find there are differences between working with patients/inmates convicted of sexual offenses and those convicted of other offenses? If so, what are they?
- Have you worked with patients/inmates who had significant medical issues? Those who were near end-of-life, or perhaps those who died in prison? If so, what can you tell me about working with these individuals? What were some challenges you faced when working with them? What were some challenges they faced?
- What can you tell me about compassionate release?
- Have you ever been involved in the application for compassionate release? If so, can you tell me about it? Who is involved? Was it successful?
- Do you feel as though compassionate release is something that should happen more often for aging patients/inmates? Why do you feel this way?

- How might you go about deciding who would be most appropriate for compassionate release? Would the nature of their offence influence this decision? If so, how?

Appendix D: Ethics Approval

01/05/2022

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

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-03-22-7624
Titre du projet / Project Title	Compassionate Release: Aging Sex Offenders in Federal Corrections
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	01/05/2022
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	30/04/2023

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
James JOHANSSON	École des sciences infirmières / School of Nursing	Chercheur Principal / Principal Investigator
Dave HOLMES	École des sciences infirmières / School of Nursing	Superviseur / Supervisor
Etienne PARADIS-GAGNÉ	Université de Montréal	Co-superviseur / Co-supervisor

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Appendix E: Ethics Approval Renewal

03/05/2023

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

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-03-22-7624
Titre du projet / Project Title	Compassionate Release: Aging Sex Offenders in Federal Corrections
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Renouvelé / Renewed
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	01/05/2022
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	30/04/2024

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
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Dave HOLMES	École des sciences infirmières / School of Nursing	Superviseur / Supervisor
Etienne PARADIS-GAGNÉ	Université de Montréal	Co-superviseur / Co-supervisor

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