ARTICLE

The Challenges of an Aging Population in Ontario Correctional Facilities

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Reporting on a growing proportion of older inmates in correctional facilities in Ontario, the authors highlight a number of ensuing health- and accommodation-related challenges (terminal illness and dementia) for Corrections. Noting innovations such as Alzheimer-related programs and early-release strategies developed in the US and a peer-support inmate service in British Columbia, co-authors Murphy, Monteiro and Sapers here call on Canadian Corrections to develop a comprehensive older/elderly inmate strategy that includes a geriatric-release component.

INTRODUCTION

Approximately 40,000 adults were in custody in correctional facilities in Canada on an average day in 2016/17 (Malakieh, 2018). As the custodial population tends to be relatively young, the growing proportion of older inmates is often neglected, despite significant and unique physical and mental health needs. In addition, it is generally accepted that the aging process is accelerated in a custodial setting (Wilson & Barboza, 2010). Stresses of life behind bars – separation from social supports including family and friends, limited opportunities for mental and physical stimulation, the threat of victimization – coupled with years of difficult and/or unhealthy living before arriving in prison – can add years to the physiological age of an inmate (John Howard Society of Ontario, 2016). The present article seeks to explain the health-related and accommodation challenges associated with aging and, in particular, coping with dementia while incarcerated in a provincial correctional facility in Ontario, Canada.

Why Aging Inmate Populations are Growing

The proportion of the federal inmate population that is aged 50 or older – the benchmark typically used by the Correctional Service of Canada to refer to 'older' inmates – grew from 12% in 2000 to about 25% in 2016 (Sapers, 2015; Zinger, 2017). Approximately 13% of inmates in Ontario provincial custody between October 2017 and March 2018 were aged 50 or older (Ministry of Community

Safety and Correctional Services, 2018). Further, older inmates comprise an increasing proportion of admissions to custody in Canada. Older inmates constituted 16% of admissions to federal custody in 2015/16, an increase of 22% from five years earlier (Reitano, 2017). Of admissions to Ontario provincial custody, some 12% in 2016/17 were for individuals aged 50 or over, compared to about 8% in 2007/08 (Ministry of Community Safety and Correctional Services, 2018).

It is important to note that the growth of the older inmate population is not just attributable to demographics or shifting incarceration rates and patterns. The cumulative impact of numerous sentencing and parole reforms in recent years – for example, the introduction of new mandatory minimum penalties and restrictions to parole eligibility criteria – means that an increasing number of individuals are serving a longer sentence, and more of that sentence is being served behind bars before first release (Sapers, 2011). Consistent with broader aging trends in Canada, more individuals are being sentenced later in life, which is compounding the issue of older inmates behind bars. For example, 28% of older federal inmates in Canada in 2013 were first-time offenders convicted and sentenced for an offence at age 50 or older (Gobeil, Allenby, & Greiner, 2014).

Correctional Healthcare Systems vs. Government Health Services

The *Canada Health Act*, which identifies the objective of health care policy to protect and promote physical and mental health of all residents in Canada, explicitly dictates that federal correctional inmates are under the jurisdiction of Correctional Service Canada. The *Ministry of Correctional Services Act*, which guides the practices within provincial correctional institutions in Ontario, and the new *Correctional Services and Reintegration Act*, 2018 (yet to be proclaimed) also identify health care services as the responsibility of the correctional institution and not the Ministry of Health and Long-Term Care that provides health services to the public.

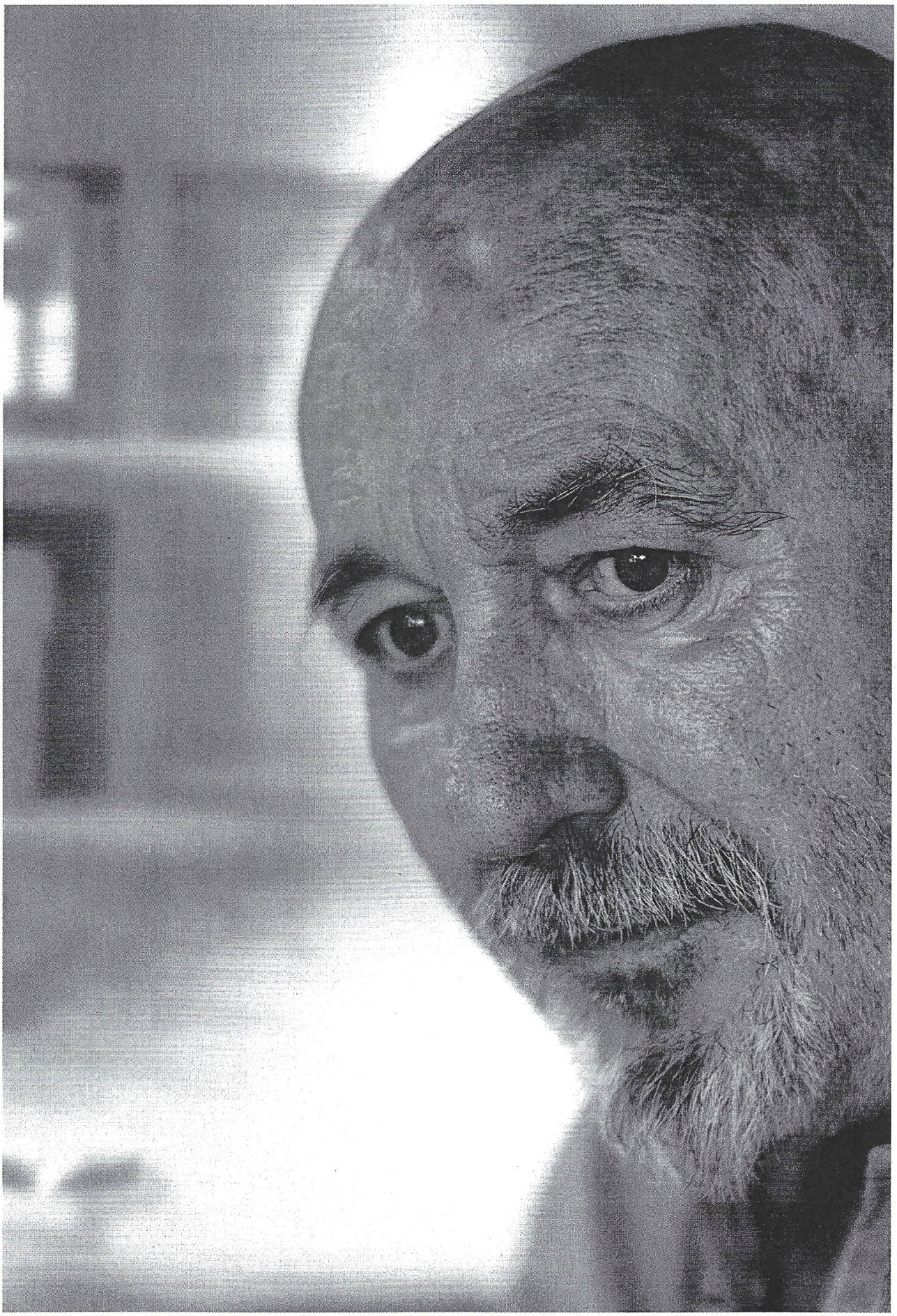
Obtaining the baseline data of the overall health conditions of the inmate population both federally and in Ontario is thus not easy. Further, these correctional health systems do not presently have electronic medical records, thereby making it extremely difficult to extract information from individual case records to identify trends and make informed estimates of the prevalence of various health conditions among the inmate population.

Heightened Prevalence of Chronic Illnesses Among Inmates

Despite data collection and analysis challenges, it is accepted that correctional facilities house a number of compromised and vulnerable individuals who have lived on the margins of society. Studies have shown correctional populations to have heightened prevalence of chronic illnesses, including hypertension, asthma, hepatitis, diabetes, HIV, arthritis, mental illnesses, and substance use disorders (Binswanger, Krueger, & Steiner, 2009; Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016; Kouyoumdjian, Schuler, Matheson, & Hwang, 2016; Stewart, Sapers, Nolan, & Power, 2014). Deficits in social determinants of health – such as education, housing, employment, and social support networks – are further associated with increased morbidity and mortality (Mikkonen & Raphael, 2010).

Physical Design and Infrastructure of Correctional Facilities Can't Meet the Needs of Infirmity

Assessing and addressing the particular health care needs of the older inmate population is complicated by the physical structure of the typical correctional institution having been designed for a young population. For example, the physical design and infrastructure of a typical institution does not take into account the mobility- or sight-impaired accessibility needs of aging and elderly offenders (Sapers, 2011). The most recent message of the Office of the Correctional Investigator of Canada noted that "many of Canada's prisons [...] are outmoded or have long since outlived their original purpose" (Zinger, 2018). Further, the health care services are largely reactive in nature, focused mainly on addressing the most acute and urgent medical conditions of inmates. Many aging-related cognitive impairments may not present with acute symptoms - such as noticeably problematic behaviour - in a correctional setting, thus hindering early treatment interventions. Additionally, the majority of prison health care departments are largely unfamiliar with the risks and needs associated with this age group. This often results in many health issues, including dementia, going unnoticed unless/until accompanied by symptomatic behaviour.



DEMENTIA IN CORRECTIONAL POPULATIONS

Essential features of dementia include disorientation of time and place, impairment of memory, and deterioration of other intellectual functions such as spelling, the ability to follow instructions, and naming common objects (Motiuk & Porporino, 1992). These conditions worsen gradually over time and interfere with a person's ability to carry out daily activities and to live independently (Ministry of Health and Long-Term Care, 2016). However, the structure of day-to-day life in a correctional institution greatly limits any opportunity to act independently or make decisions and this may lead an inmate's dementia to go unnoticed for an extended period of time (Vogel, 2016). Symptoms of dementia therefore may not be observed until the individual is unable to cope with the demands of the correctional environment, including appropriate interactions with staff or other inmates, or following rules (Vogel, 2016). If not properly diagnosed, an inmate may thus be at an increased risk of victimization or be subject to disciplinary sanctions resulting from behaviour that is merely symptomatic of dementia.

Prevalence of Dementia Among Inmates Expected to Rise

A 2016 report by the Ontario Ministry of Health and Long-Term Care (MOHLTC) estimated that close to 228,000 Ontarians are currently living with dementia; this number is expected to rise to 255,000 in 2020 and 430,000 in 2038 as the population ages (Ministry of Health and Long-Term Care, 2016). Although dementia is most common in people over 65 years old, nearly 7 percent of dementia diagnoses in Ontario are for people aged 40-65 years (Ministry of Health and Long-Term Care, 2016).

Though at present it is difficult to determine how many inmates currently in custody in Ontario have dementia, the heightened prevalence of mental illness in corrections is well documented; and, as dementia has been associated with mental illness (Barnes et al., 2012; Feczko, 2014), it is expected that the prevalence of dementia in corrections is similarly elevated at rates potentially multiple times greater than in the community (Wilson & Barboza, 2010). The figure is expected to rise over the coming decades in accordance with projected increases in life expectancy and older inmates (Moll, 2013). This will have major operational implications for correctional facilities that were not designed and built to house an aging population with complex mental health needs.

Dementia Care in Corrections: A Daunting Proposal

Approximately 90% of individuals with dementia will require full-time nursing care in an institution at some time between diagnosis and death (Wilson & Barboza, 2010). The psychiatric and behavioural problems – such as aggression, impulsivity, and delusions – that accompany the cognitive problems of dementia pose complications for institutional staff. Retrofitting institutions with special assistive devices and equipment to meet everyday housing, ambulatory, toileting, bathing, and feeding needs is an expensive enterprise, especially considering that several of Ontario's provincial facilities have already outlived their expected service life (Independent Review of Ontario Corrections, 2017). Further, correctional staff require appropriate training and skills to interact with those who have complex care needs in institutions (Moll, 2013; Vogel, 2016).

Traditional Diagnostic Tools for Dementia Fall Short in the Carceral Setting

To identify and tailor care for inmates with dementia, carceral institutions must adapt available diagnosis methods for dementia. A basic cognitive screening coupled with routine mental health checks for older inmates would improve diagnosing (Moll, 2013), but many of the traditional screening methods may not be appropriate for the correctional setting. For example, assessment criteria that includes impairments to basic activities of daily living – such as preparing meals, performing math calculations, orientation to time – may be irrelevant since such capacities are normally impaired by daily prison life (Vogel, 2016). Early warning signs that would initiate interventions in the community are thus likely to go unnoticed in the correctional setting. Future research should focus on assessing the reliability and validity of current dementia screening tools and developing new, corrections-specific assessment tools for use in correctional settings.

Once dementia is diagnosed, the inmate must be informed in a sensitive manner, with treatment planning and supports ready to prolong functioning as long as possible (Wilson & Barboza, 2010). Staff should have realistic expectations of the inmate's capabilities and needs, and treatment and care will need to be tailored for the inmate's experience and

quality of life. This will involve alterations to the physical environment of the correctional facility to support the inmate's functioning, including well-lit and quiet areas, contrasting colours and simple signs to delineate spaces as well as the provision of individual aids such as eyeglasses or hearing aids and clothing that is easy to get on and off (Wilson & Barboza, 2010).

'Peer Care Assistants' (British Columbia) and Gold Coats Early-Release Project (USA)

There are a number of examples of institutional care programs aimed at supporting older inmates. For example, the Project for Older People in the United States helps non-violent, non-terminally ill older inmates obtain early release (Iftene, 2016). At the California Men's Colony prison, inmates trained by the Alzheimer's Association – called 'Gold Coats' – are paid $50 a month to support fellow inmates with dementia (Belluck, 2012). Gold Coats report changes in impaired inmates' conditions at weekly support group meetings with the institutional doctor, and quite often have better knowledge of impaired inmates' conditions than do many correctional officers. Similarly, the Pacific Institution/Regional Treatment Centre in British Columbia, Canada, utilizes inmates as 'Peer Care Assistants' who are paid to take care of other inmates in need (Martin, 2011).

ALTERNATIVES TO INCARCERATION

The growing number of older inmates, rising costs of medical care and incarceration, and possibility of longer life expectancies resulting from improved prevention and treatment is straining correctional budgets. A number of jurisdictions in the United States are now looking at geriatric release alternatives as potential cost-saving mechanisms at relatively low risk to public safety. Though some correctional services would like to transfer older inmates with dementia to long-term care facilities, community facilities are often unwilling to take them, at times due to concerns regarding convictions, other residents, or the concerns of victims and their families (Brown, 2014). Although Canada is far from replicating incarceration rates in the United States, we nevertheless face many of the same challenges.

Calling for a Geriatric-Release-Component Strategy in Canada

Inmates who are over a certain age and in need of constant specialized nursing care should be considered for release on compassionate grounds and transferred to an appropriate institution in the community rather than adding the cost of incarceration to the expensive and growing costs of treatment and care. While elderly inmates should be equally deserving of rehabilitation and reintegration programs and supports, the rehabilitative benefit of corrections is brought into question for inmates with dementia who may not understand why they are in prison, or even that they are in prison.

CONCLUDING REMARKS

Today's reality is that a number of very ill inmates suffering from life-threatening, non-curable illnesses are dying in correctional institutions across Canada, sometimes in very tragic and less-than-dignified conditions. Without release on compassionate grounds, many older inmates die without the opportunity to spend palliative time with the support of family and friends, and to bring emotional closure to what have often been difficult relationships. Managing a terminally ill inmate consumes the financial and human resources of a correctional facility. It is an expensive and often exhausting endeavour.

The health-related and accommodation challenges of older inmates in Ontario's provincial correctional facilities also increasingly include dementia, which can easily go undetected in the carceral setting and even lead to punishment for associated behaviour. There needs to be change if our older generation of inmates are to age and die with some degree of dignity behind bars. There is nothing 'natural' about ending your days confined to an infirmary bed in a maximum-security correctional facility. An older/elderly inmate strategy is needed within corrections and it must include a geriatric release component. ■

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RÉSUMÉ

The Challenges of an Aging Population in Ontario Correctional Facilities

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Les auteurs rendent compte d'une proportion croissante de détenus âgés dans les établissements correctionnels de l'Ontario et font ressortir les enjeux qui en découlent, notamment sur les plans de l'aménagement de l'environnement physique et des problèmes de santé graves (maladie terminale et démence) dans le système correctionnel. Ils soulignent des innovations telles que des programmes axés sur la maladie d'Alzheimer et des stratégies de libération anticipée élaborés aux États-Unis, de même qu'un service d'entraide entre détenus en Colombie-Britannique. Les auteurs demandent à Service correctionnel Canada de mettre en place une stratégie globale à l'intention des détenus âgés, laquelle comporterait un volet sur la libération des détenus âgés.