

Community Reintegration of Aging Offenders (CRAO): Gaps in Knowledge Report



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Canada

Service correctionnel
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Preface

Letter from the symposium co-chairs

The *No Place to Call Home: The Challenges of Reintegrating Senior Parolees into the Community and Long-term Care* Symposium was used to gather organizations, such as Correctional Service Canada, Peterborough Reintegration Services, Citizens Advisory Committee, Elder Abuse Ontario as well as Trent University programs including School of Nursing, Social Work, Sociology and Forensics, together to discuss the silent issue of community reintegration of aging offenders.

Locally, the Citizens Advisory Committee (CAC) was formed in 1998 to observe, liaise and advise due to high profile and high needs parolees that were re-integrating into our community. With Peterborough having a high proportion of seniors and a high number of senior parolees residing here, community safety is a priority. As a committee, and as a community, we must take responsibility to ensure all of our seniors have a safe environment to live in and to ensure their health-related issues are cared for.

The *No Place to Call Home* symposium, and ultimately this report, started from the goal of the local CAC, which is to work with the community to increase education on the rising number of aging parolees and to understand our responsibility as a community. These individuals have served their sentences for the crimes they committed and by law can return to our communities to reside. This overarching goal of education stemmed into the goals of the *No Place to Call Home* symposium to find solutions on how to address the issue of the community reintegration of aging offenders.

The *No Place to Call Home* Symposium was a great success, but only one step to address this growing issue. The collaboration between the Trent Centre for Aging & Society and other organizations, such as CAC, allows us to bring different perspectives together to shed light on this issue and to bring it to the forefront so that governments and community stakeholders alike can make sure we are supporting aging offenders and the initiatives and solutions that are needed.

Symposium Co-Chairs

Ted Boynton
Peterborough CAC

Dr. Mark Skinner
Trent University

Letter from Correctional Service Canada – Parole

Canada, like many countries, is experiencing population aging. This demographic shift, along with an increase in late life sentencing and longer sentences have resulted in a growing number of older persons in federal custody, although overall the Correctional Service Canada's (CSC) population remains relatively young.

In 2018, in response to the growing number of older persons in custody, Correctional Service Canada developed a policy framework entitled, Promoting Wellness and Independence, Older Persons in Custody ('the Framework').

The Framework was informed by domestic and international research and in consultation with expert stakeholders in the fields of geriatrics, gerontology, law, culture, Indigenous health and correctional health. It is holistic and emphasises a person-centred, age, gender and culturally appropriate and multi-dimensional approach that supports health and wellbeing, programming, appropriate living accommodations, community engagement and partnerships. In practical terms, the Framework is a hybrid of a framework and a strategy that allows implementation to be concurrent with the refinement of the approach as new information and research become available. A hallmark of CSC's approach is the inclusion, through personal interviews, of the voice of over 500 older persons on their experience, worries and concerns about being an older person in custody.

One of the areas noted by older persons in custody is concern about transition/ reintegration into community. For many older individuals, returning to the community can be a challenge. The work undertaken by Trent University through its' No Place to Call Home Symposium sheds light on the complexity of these challenges, barriers and potential solutions. CSC is committed to developing partnerships with outside agencies with the goal of strengthening collaboration and promoting wellness and independence of older individuals. Ensuring older individuals' successful reintegration into the community will help facilitate healthy aging and promote overall quality of life. CSC welcomes Trent University's contribution in this area.



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1. Introduction

Overview

While strategies are in place to support aging offenders within Correctional Service Canada (CSC) institutions, relatively little attention has been directed towards understanding their community reintegration. Due to a combination of unique and complex health needs, as well as the stigma of incarceration, aging offenders face a plethora of barriers and challenges when transitioning from a correctional institution to community (Williams & Abraldes, 2007; Higgins & Severson, 2009; Maschi, Morrissey & Leigey, 2013). In order to help overcome the challenges, solutions are being implemented at various scales to ease the reintegration process; however, there is a need for additional support from both government and community stakeholders alike.

No Place to Call Home Symposium

To discuss these barriers and challenges, as well as to highlight solutions, Trent University, in collaboration with the Trent Centre for Aging & Society (TCAS), CSC, the Citizens Advisory Committee (CAC), and Peterborough Reintegration Services (PRS), held Canada's first symposium on the community reintegration of aging offenders. *No Place to Call Home: The Challenges of Reintegrating Senior Parolees into the Community and Long-term Care* was held on February 22, 2018 with more than 160 administrators, staff, officers, volunteers, researchers and students from CSC, CACs, chaplaincies, community reintegration services, community support, long-term care, palliative care, universities and other stakeholders in attendance.

Featuring three keynote speakers from CSC (Director General, Clinical Services and Public Health), Dalhousie University (Health Law Institute) and PRS (Haley House), and a panel of key stakeholder's perspectives from police, parole, health care and human rights law, the symposium was designed to initiate critical conversation about gaps in knowledge (see Figure 1.1 and 1.2 below for conference program). Additionally, a model for community reintegration, Haley House, was a featured discussion.

Figure 1.1: Symposium Program

Networking Village

- Central East Local Health Integration Network
- Citizen Advisory Committee
- Correctional Service of Canada
 - Mental Health
 - Recruitment
 - Victim Services
 - Volunteer Services
- Elder Abuse Ontario
- John Howard Society
- Kagita Mikam Aboriginal Employment and Training
- Trent University
 - Forensics
 - Social Work
 - Sociology
 - Trent Centre for Aging & Society
 - Trent/Fleming School of Nursing

Symposium Partners

Co-sponsored by the Trent/Fleming School of Nursing, Trent Forensic Science Program, and the Departments of Social Work and Sociology

No Place to Call Home

9:30am-10:00am	Registration
10:00am-10:15am	Welcome & Opening Remarks Dr. Kirsten Woodend , Dean, Trent Fleming School of Nursing; Dr. Mark Skinner , Director, Trent Centre for Aging & Society; Ted Boynton , Retired Inspector, Peterborough Lakefield Police, Current volunteer with the Citizens Advisory Committee for Peterborough Parole.
10:15am-11:00am	Opening Speaker – Henry de Souza Director General, Clinical Services and Public Health, Correctional Service of Canada <i>Correctional Service Canada's strategy for promoting wellness and independence of older persons within CSC</i>
Break 11:00 - 11:15am	
11:15am-12:00pm	Keynote Speaker – Dr. Crystal Dieleman Assistant Professor, School of Occupational Therapy Affiliate Member, Dalhousie Health Law Institute <i>"I'm too old for this sh***": Experiences of age and imprisonment</i>
12:00pm-1:00pm	Lunch & Networking Village Sponsored by Peterborough Community Chaplaincy

1:00pm-1:45pm	Feature Speaker – David Byrne Executive Director, Peterborough Reintegration Services <i>A Place Like This: Haley House as a Model of Supporting Aging Federal Offenders in their Transition to the Community</i>
Refreshment Break 1:45 - 2:00pm	
2:00pm - 3:00pm	Panel Discussion – moderated by Dr. Gillian Balfour , Chair, Sociology and Associate Dean, Teaching and Learning at Trent University. Larry Charnley , Inspector, Peterborough Police Service Kate Kincaid , past Director of Patient Care, South Bruce Grey Health Centre - Kincardine Kim Lawson – Parole Officer, Correctional Service of Canada Lisa Mizzi , Director, Home & Community Care, Patient Services, Central East LHIN Judith Wahl , Lawyer and past Executive Director of Advocacy Centre for the Elderly <i>Key perspectives on the challenges of community reintegration.</i>
3:00pm - 3:15pm	Closing Remarks Ted Boynton and Dr. Mark Skinner, Symposium Co-chairs
3:15pm - 4:00pm	Networking Village Please join us in the atrium to meet with community partners.

Report

Due to the fact that there is little attention directed towards understanding the community reintegration of aging offenders, the goal of this Report is to establish a base of knowledge about key gaps and how to move forward that will enhance the work of CSC, CACs and community reintegration services. The objectives of the Report are, 1) to provide a background on the community reintegration of aging offender literature, 2) to showcase expert perspectives on community reintegration of aging offenders, and 3) to outline the frontline knowledge of the barriers, issues and solutions to the community reintegration of aging offenders.

The report is organized in a manner that showcases varying perspectives on the barriers, issues and solutions to the community reintegration of aging offenders. Section 2 provides a background, which presents findings from international literature that explores aging inmates as well as their needs and their challenges of community reintegration. Section 3 features write-ups from each of the three keynote speakers and the expert panel of the *No Place to Call Home* symposium. These sub-components provide perspectives from CSC, the Dalhousie Health Law Institute and Peterborough Reintegration Services (PRS)/Centennial College. Topics include the CSC framework on promoting wellness and independence of Older Persons in Custody (OPiC), the experiences of age and imprisonment, and Haley House and the model in which they support aging federal offenders as they transition to the community.

Section 4 examines the state of frontline knowledge of the community reintegration of aging offenders by reporting on the findings from a follow-up survey with *No Place to Call Home* symposium attendees. These findings discuss the barriers, issues and solutions of community reintegration of aging offenders from the varying perspectives of symposium attendees to uncover what is already known, and present gaps in knowledge.

The report concludes with next steps in terms of directions forward from the literature and highlights the Community Reintegration of Aging Offenders (CRAO) Pilot Project being conducted at Trent University in Peterborough, Ontario that addresses the gaps. It also provides concluding comments about the importance of understanding the challenges of community reintegration for aging offenders and the necessity of bringing it to the light in order for governments and community stakeholders to continue their support.

2. Background: What we know from the literature

Correctional Service Canada (CSC) is seeing an increasing number of older persons in custody (Correctional Investigator Canada and Canadian Human Rights Commission, 2019) however, the population within CSC is young in contrast to the aging Canadian population which sees 16.1% of the population over the age of 65 (Statistics Canada, 2016). Within CSC, 5% of individuals in custody are over the age of 65. Of that group, 1% are women and 3% are of Indigenous ancestry (Correctional Service Canada, 2018). An older person is often identified as someone over the age of 65, however, an 'older offenders' can be identified as an offender over the age of 50 due to accelerated aging within prison (Maschi et al., 2013). In 2018, 20% of federal offenders in CSC custody were between the ages of 50 and 64. Numerically, this results to 2,833 of individuals in custody aged 50 and older, with 2,736 of those men and 97 women. Within that group, 707 are aged 65 and older, with 693 men and 14 women (Correctional Service Canada, 2018).

Some older offenders present complex and special challenges and needs within the prison environment. Aging offenders face social challenges within prison such as mobility and getting around, bullying and loss of freedom (Hayes, Burns, Turnbull & Shaw, 2013). In addition, health challenges such as arthritis, respiratory ailments, cardiovascular disease, diabetes and cancer can be present along with cognitive and emotional disorders such as depression, anxiety and dementia (Higgins & Severson, 2009; Hayes, Burns, Turnbull & Shaw, 2012). While the needs and challenges of older inmates in prison has previously been a focus of research, there has been limited attention paid to older offenders as they reintegrate into the community upon release. Research presented here showcases the challenges of community re-entry and the factors that contribute to those challenges, as well as strategies to help ease the community reintegration process.

Paired with the challenges of incarceration, aging offenders face challenges upon release when re-entering the community (Williams & Abraldes, 2007; Higgins & Severson, 2009; Maschi et al., 2013). Due to their frail physical condition, older offenders face the challenge of being placed back into an unsafe neighbourhood, they frequently suffer multiple medical conditions with limited to no health care plan upon release, they face unemployment and commonly suffer from mental illnesses (Williams & Abraldes, 2007). In addition to personal challenges, Williams and Abraldes (2007) discuss that the programming offered within prison that is geared towards re-entry does not have the capacity to provide geriatric specialized services to meet their complex health and medical needs discussed earlier.

Williams and Abraldes (2007) discuss social, medical and psychological factors that influence the ease of re-entry into the community for aging offenders. A major social factor felt by this population is the loss of contact with friends and family while serving their sentence. This loss of contact results in loss of financial, physical and emotional supports. As previously mentioned, many older offenders find it difficult to find employment due to the stigma

around incarceration as well as their age and ability to work. Additionally, older offenders commonly lack independent living skills needed to live within the community and often have a difficult time finding housing due to landlords and housing programs reluctant to take them on as tenants (Maschi et al., 2013). These social factors commonly affect 'life course older adults' – those who first entered the prison system as juveniles and served a sentence of 20 or more years. Medical and psychological factors that pose challenges for community re-entry are a lack of a medical plan upon release, the challenge of accessing long-term care and the high risk of adverse psychological reactions to release such as anxiety and post-release suicide (Williams & Abraldes, 2007). These challenges are commonly seen within 'acute and chronic recidivists', who have cycled in and out of prison with two or more sentences, and 'late onset offenders' who have committed crimes later in life, as they generally find community re-entry to be challenged due to age-related physical and mental health conditions (Maschi et al, 2013).

Speaking to the three pathways of offenders (life course, acute and chronic recidivists and late onset), Maschi et al. (2013) argue that the reintegration needs of older offenders are dependent upon their pathway. They state, "differing pathways can be traced for each of these groups and have implications for how their prison and community reintegration needs might be addressed" (p.201). In order to help explain the heterogeneity of older adults before, during and after prison, Maschi and colleagues present a framework which involves an integration of perspectives in order to develop promising practices for community reintegration of aging offenders. They state that by integrating the following, they are able to cater best practices for community reintegration to the specific individual and their unique needs:

- A life course perspective (how individual life circumstances impact the life course development while in prison or the community);
- An ecological systems perspectives (the impact of the personal environment);
- Critical theory (examination of power differentials across societal groups); and an
- Action and recovery theory (human agency towards change).

In addition to the integrative framework presented by Maschi et al (2013), scholars discuss solutions to ease the community reintegration process of aging offenders. One strategy discussed by Higgins and Severson (2009) found that social workers can offer support during this process. In this capacity, social workers can act as direct service providers, advocates, administrators, supervision agents and research and program evaluators for aging offenders leaving prison and re-entering into the community (Higgins & Severson, 2009). The use of social workers can also provide interventions that have promise to ease the reintegration process of older offenders. One such intervention is the use of geriatric

assessments. These assessments help to understand the unique challenges and needs of the older individual, as it evaluates their cognitive functioning, psychiatric status and family caregiving status. A second intervention method involves case management. Case management interventions are used as a way to address the complex challenges and needs of aging offenders. They provide screening, assessments, development of a service/care plan, coordination of needed services, follow-up/monitoring and reassessment before and during the reintegration process. Lastly, social work interventions support planning for older offenders' end of life care. Here, social workers can act as advocates for quality end of life care for the offender, can become a liaison between prison and community health care and aid in care planning (Higgins & Severson, 2009).



Over the last several years, there has been a growing focus within CSC on older persons in custody. In the 2010-2011 Annual Report of the Office of the Correctional Investigator, there was a special focus on this population, which probed into their condition of confinement, programming, physical and mental and palliative care and needs (Sapers, 2011). Following that, in the 2015-2016 Annual Report, the Correctional Investigator recommended CSC develop a national strategy aimed at older offenders to address their care and custody needs with a focus on programming, reintegration, public safety and health care costs (Sapers, 2016). In the 2016-2017 report, stated CSC would be developing a national strategy to be complete in 2017-2018 (Zinger, 2017, Zinger, 2018). In 2019, the Correctional Investigator of Canada and the Canadian Human Rights Commission published the *Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody*. This report examines the experiences, challenges and vulnerabilities of older individuals in federal custody as well as the ways the system could be improved for them (Correctional Investigator of Canada and Canadian Human Rights Commission, 2019).

In response to the need to address older persons in custody as a specific population, CSC developed a policy framework titled *Promoting Wellness and Independence of Older Persons in CSC custody* (Correctional Service Canada, 2018). This framework highlights how CSC is moving forward to implement a person-centred comprehensive approach to supporting wellness and independence of the older person population in federal custody. For more, detailed information regarding this framework, see section 3, which features a contribution authored by Henry de Souza, Director General Clinical Services and Public Health at CSC.

With literature aimed at highlighting the needs and challenges of older adults in custody, there is limited research on the challenges, barriers and experiences of the community reintegration of this population. Although the research is minimal, there is a push to develop strategies within Canada to address their complex needs and to help ease aging offenders back into their communities.

With this state of literature in mind, the *No Place to Call Home* Symposium addressed the gaps and critically discussed the challenges, barriers and experiences of the community reintegration process. To mobilize knowledge from the symposium, the following sections present expert and frontline perspectives from speakers and participants at the symposium. .

3. Expert Perspectives on the Community Reintegration of Aging Offenders

This section provides an overview on the perspectives from the keynote speakers and the panel of experts from the *No Place to Call Home* symposium.

The first contribution is by Henry de Souza, Director General, Clinical Services and Public Health at Correctional Service Canada (CSC). Mr. de Souza provides an overview of CSC, discusses the challenges of defining an older person in custody (OPiC) and presents how CSC is developing a strategy to promote wellness and independence of the OPiC population.

The second contribution is by Dr. Crystal Dieleman, Assistant Professor in the School of Occupational Therapy at Dalhousie University in Halifax, Nova Scotia and member of the Dalhousie Health Law Institute. Dr. Dieleman speaks to the experiences of age and imprisonment looking specifically at aging offenders' experiences with correctional programs within prison.

The third contribution is by David Byrne, past Executive Director of Peterborough Reintegration Services and Professor, Community and Justice Service, School of Community and Health Studies at Centennial College in Toronto, Ontario that outlines the model of Haley House, a community-based residential facility in Peterborough, Ontario that provides specialized support for aging offenders facing serious chronic physical and mental health issues, or impending end of life.

The final contribution presents the perspectives from key stakeholders in the community reintegration process, including Larry Charmley (Peterborough Police Service), Kate Kincaid (South Bruce Grey Health Centre), Kim Lawson (Parole), Lisa Mizzi (Central East LHIN) and Judith Wahl, Advocacy Centre for the Elderly). Written by the panel moderator, Dr. Gillian Balfour, Associate Professor, Sociology and Associate Dean, Teaching and Learning at Trent University in Peterborough, Ontario, it discusses the challenges, barriers and solutions to the community reintegration of aging offenders from the perspectives of parole, health care, police and human rights law.

Promoting Wellness and Independence of Older Persons in Custody

Henry de Souza

Director General Clinical Services and Public Health
Correctional Service Canada

Overview of CSC

Correctional Service Canada (CSC) is mandated, under the Corrections and Conditional Release Act (CCRA), to provide every inmate with essential health care that conforms to professionally accepted practices, and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community (Corrections and Conditional Release Act, 1992) Within CSC, the provision of health services is governed by the Health Sector and guided by Commissioner's Directives 800 "Health Services" and its associated guidelines and documents. Consistent with health services in the wider Canadian community, CSC's health services are accredited by Accreditation Canada.

Underpinned by the values of respect, fairness, professionalism, inclusiveness and accountability, CSC's Health Services vision is to improve offender health that contributes to the safety of Canadians and its mission is to provide offenders with efficient, effective health services that encourage individual responsibility and promotes health and wellness.

CSC manages and maintains 43 institutions across five regions of Canada (Atlantic, Quebec, Ontario, Prairies and Pacific), 91 parole offices, 15 Community Correctional Centres, and 200+ Community Residential Facilities.

Organization of Health Services

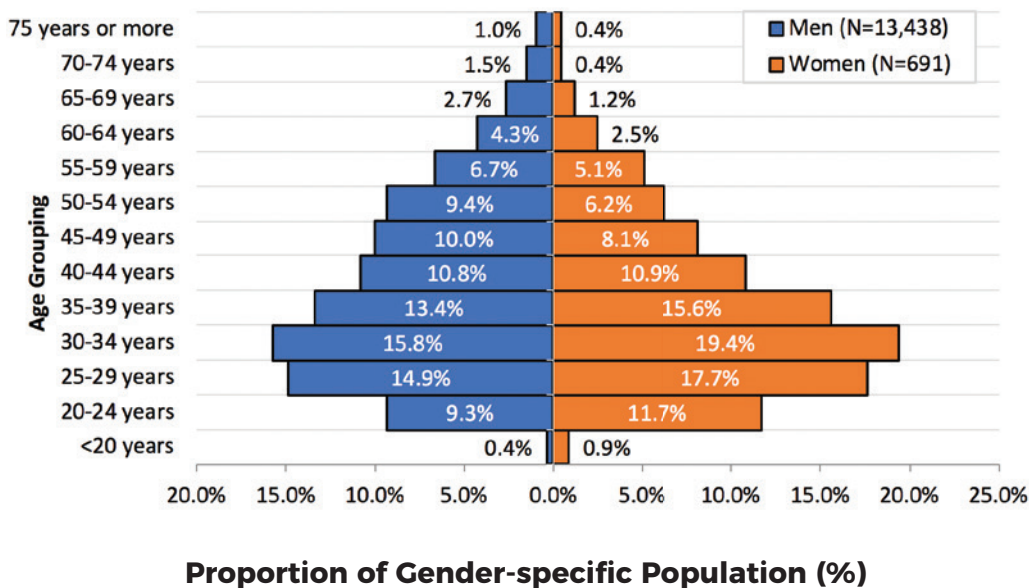
Health Services within CSC are provided by a wide range of regulated and non-regulated health professionals in Primary Health Care Centres located within correctional institutions, intermediate mental health programs, regional hospitals and regional treatment centres (psychiatric care). CSC relies on community health care for services and specialist consultations that are not available within CSC or can not be managed within CSC such as paramedic and hospital emergency services, hospitalization, advanced diagnostics (MRI, CT Scan).

Older Persons in Custody

For context, CSC's population is relatively young (Figure 3.1). In contrast to the Canadian population where 16.1% are over the age of 65 (Statistics Canada, 2016), only 5% of those in CSC custody are 65+. Of the 65+ population within CSC, less than 1% are women

and approximately 3% are individuals of Indigenous ancestry. The larger group of older individuals in CSC, age 50-64, make up 20% of those in custody. Similar to the 65+, the proportion of women and Indigenous persons remain relatively small, less than 1% and 3.7% respectively.

Figure 3.1 In Custody Offenders by Age Group and Gender



Source: Data Warehouse. Data current up to the Mid-Year of FY 2017-2018

In 2018, there were 2833 individuals in custody age 50+ and within that group, 707 were age 65+. The 65+ age group is disproportionately distributed across Canada with 29% residing in institutions in Ontario, 28% in Quebec, 19% in Pacific, 14% in the Prairies and 10% in the Atlantic.

Figure 3.2 shows that over the past five years the increases in both the overall 50+ (inclusive of 65+) and the 65+ are constant. Moreover, a closer inspection of changes within 5-year increments (Figure 3.3) shows no particular spikes in rates. Numerically, in 2018, there are 2833 individuals in custody age 50+ (2,736 men and 97 women) and within that group, 707 are age 65+ (693 men and 14 women). The age group 65+ is also disproportionately distributed across Canada with 29% residing in institutions in Ontario, 28% in Quebec, 19% in Pacific, 14% in the Prairies and 10% in the Atlantic.

Figure 3.2 Increases 2013-2017 of proportion of older adults in CSC Custody

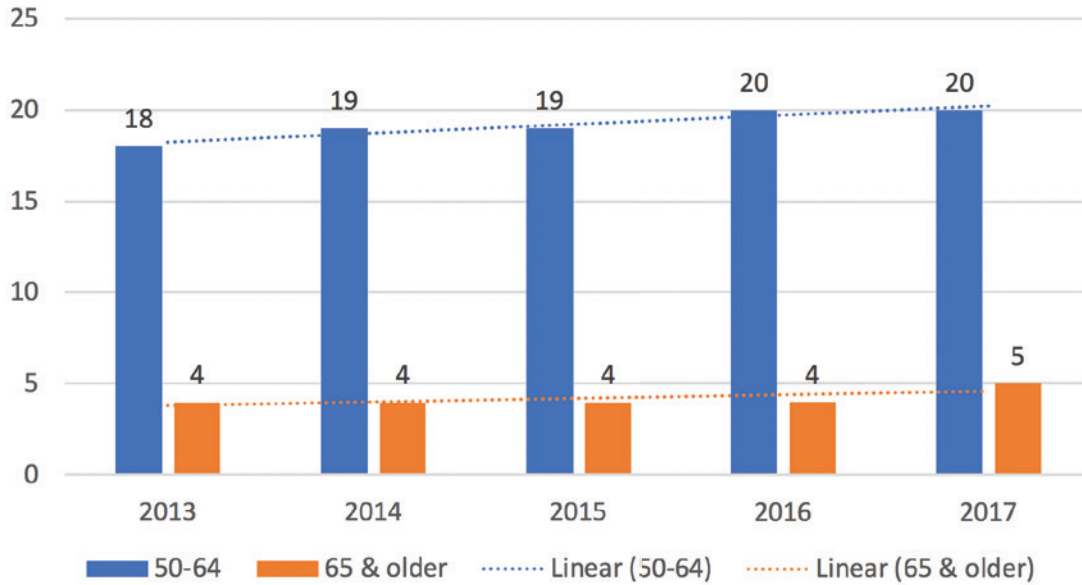
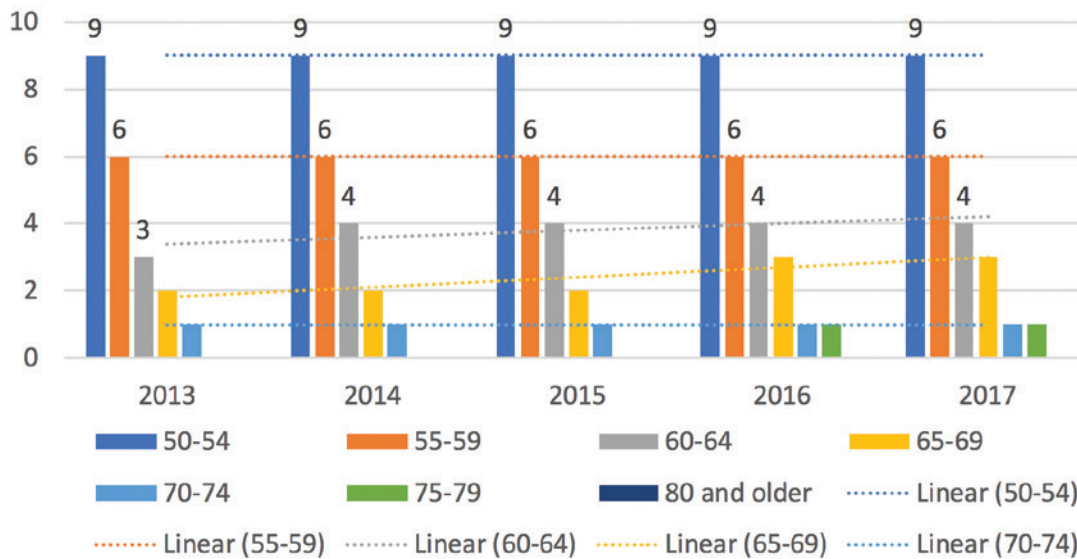


Figure 3.3 Annual Growth Rate 2013-2017 of older adults age 50+ in five-year age increments.

Age Groups over 5 years



Defining Older Person in Custody (OPiC)

Although the correctional literature suggests that offenders are 10 to 15 years physiologically older than their chronological age (Aday and Krabill, 2013) there is no consensus on what age constitutes an 'older' person in custody. As stated by Williams, Goodwin, Baillargeon, Ahalt and Walter (2012), definitions of older vary from 45 years and older to 65 years and older (Stojkovic, 2007; Yorston & Taylor, 2006) For example, "... the definition of an older prisoner in the United States varies by state, with starting ages ranging from 50 to 70 years". It is noteworthy that according to Williams et al. (2012), the "empirical evidence for accelerated aging of prisoners is lacking." (p.1151). Others have gone further to state, that "caution should be used when using chronological age exclusively to define the onset of old age." (Aday and Krabill, 2013). According to Aday (2003) and Williams et al. (2012), 'older' is best defined as a combination of chronological age and functional/cognitive abilities.

Given the lack of empirical evidence on what factors constitute 'older,' in a federal correctional system, CSC is adopting an evidenced based approach to understanding and addressing the needs of OPiC, rather than relying on speculation and/or anecdotal evidence reported in the correctional literature. As no single indicator or data source can provide all the information needed to build an evidence-based approach, CSC is conducting a comprehensive multidimensional needs assessment to gather information and test assumptions about what constitutes an older, Federally incarcerated population in Canada.

In order to manage the scope of this approach, CSC will proceed in two phases beginning with studying persons 65+ (**Phase I**) and subsequently studying the 50-64 age group (**Phase II**). The comprehensive needs assessment includes the following activities:

- Giving OPiC a voice by listening to the lived experience of OPiC through one-to-one personal interviews with a CSC nurse;
- reviewing the prevalence of chronic diseases among OPiC;
- assessing the functional, cognitive, and social wellbeing of OPiC (using the InterRAI Contact Assessment tool);
- considering the perspective of health care providers and operational staff within the context of care and custody of OPiC; and,
- conducting an environmental scan and a review of physical infrastructure requirements.

Participation on the part of the OPiC is voluntary. Based on the results of the comprehensive assessment, CSC will be better placed to determine the definition of 'older offender.'

OPiC Subgroups

OPiC are not a homogeneous group and therefore the needs assessment will include a number of sub-categories of OPiC population including:

Gender;

- Self-declared ethnicity: Indigenous Peoples, Blacks;¹
- OPiC receiving 24-hour inpatient care (Treatment Centres);
- OPiC receiving specific programming (Psychogeriatric Unit; Bowden Assisted Living Unit);
- History of incarceration. Quite apart from gender, ethnicity and culture, older persons may have different health care, psychological, spiritual and psychosocial needs depending on their history of incarceration. The correctional literature generally describes three groups of older persons based on incarceration patterns (Public Health England, 2017). The first group consists of those who have grown old in custody as a result of lengthy sentences imposed when they were younger. The second group consists of recidivists who have aged while going in and out of incarceration over a long period of time, and the third group consists of those who were incarcerated for the first time in their 50s or 60s. Stojkovic (2007) includes a fourth group, namely individuals sentenced to shorter incarceration late in life. Separating these groups is challenging, therefore the need assessment will focus on two broad categories, namely a) those who were incarcerated later in life for the first time; and b) all others.

Specific to Indigenous peoples, CSC has acknowledged that assisting Indigenous persons is an area that requires improvement. Within CSC, there is an awareness of culture and colonialism with respect to Indigenous peoples and their wellness-related needs. However, more is needed in the area of incorporating Indigenous worldview(s) and Western worldview(s) into the practice of health care. In order to address this gap, CSC will establish a framework to be implemented as a pilot program in the Prairie region to incorporate Indigenous and Western worldview(s) in the practice of health care that promotes equitable value of traditional medicine in the healing process.

Along with Indigenous populations, women are also a population that requires attention within CSC. The proportion of older women in custody is small, however, women face unique health and wellness issues related to advanced age. Older women typically sustain more injuries related to falls, have higher rates of fall-related hospitalization and have a greater risk for breaking a bone as a result of falling. This is in part due to lower bone density after menopause and higher rates of osteoporosis among women.

¹ The Correctional Investigator, in his annual report of 2012-13, noted that recent inmate population growth is almost exclusively driven by increases in the composition of ethnically and culturally diverse offenders. According to the report, over the past 10 years, the Aboriginal incarcerated population increased by 46.4% while visible minority groups (e.g. Black, Asian, Hispanic) increased by almost 75%. In 2012-13, 9.5% of federal inmates were Black (an increase of 80% since 2003/04), yet Black Canadians accounted for less than 3% of the total Canadian population. Aboriginal people represented 23% of federal inmates yet comprised 4.3% of the total Canadian population. One-in-three women under federal sentence were Aboriginal.

Developing a Strategy to Promote Wellness and Independence of Older Persons in Custody

In developing the strategy, CSC created a Health Care Advisory Committee (HCAC), a multidisciplinary group representing national professional associations (Canadian Association of Indigenous Physicians, Canadian Indigenous Nurses Association, Canadian Nurses Association, Canadian Psychological Association, Canadian Geriatrics Association, Canadian Association of Gerontology), specialties from Occupational Therapy and Medicine and representatives from CSC administration. Recently, an Indigenous Elder and a representative from the NGO, Dementia Justice Society of Canada, joined the HCAC.

In keeping with the advice from the HCAC, a 'person-centred' integrated approach to responding to the needs of OPiC was adopted (Figure 3.4). This holistic approach will be informed by culture and gender at various stages and transition points. It addresses the needs of OPiC in various domains of health; physical, emotional, spiritual, mental health and well-being.

In keeping with this approach, emphasis will be on supporting OPiC as they move from independence to dependence (Figure 3.5) with the goal of supporting individuals to remain independent and age in place² as long as possible through early identification, diagnosis, and management of chronic disease. Attention will also focus on issues often associated with aging such as but not limited to; falls, depression, dementia, nutrition, incontinence, oral health and social isolation.

CSC provides extensive health care services to persons of all ages in custody including older persons. Currently, when an older person presents with complex health conditions, care is managed on a case by case basis. Until now however, there has not been a comprehensive strategic approach specifically aimed at responding to the multidimensional care and custody needs of older persons from a population health perspective.

² Within the context of CSC, the concept of 'aging in place' is understood as the promotion of health and wellness within the context of an adapted physical environment that facilitates healthy aging, optimal wellness and quality of life during incarceration.

Figure 3.4 Older Person in Custody Person Centred Integrated Approach

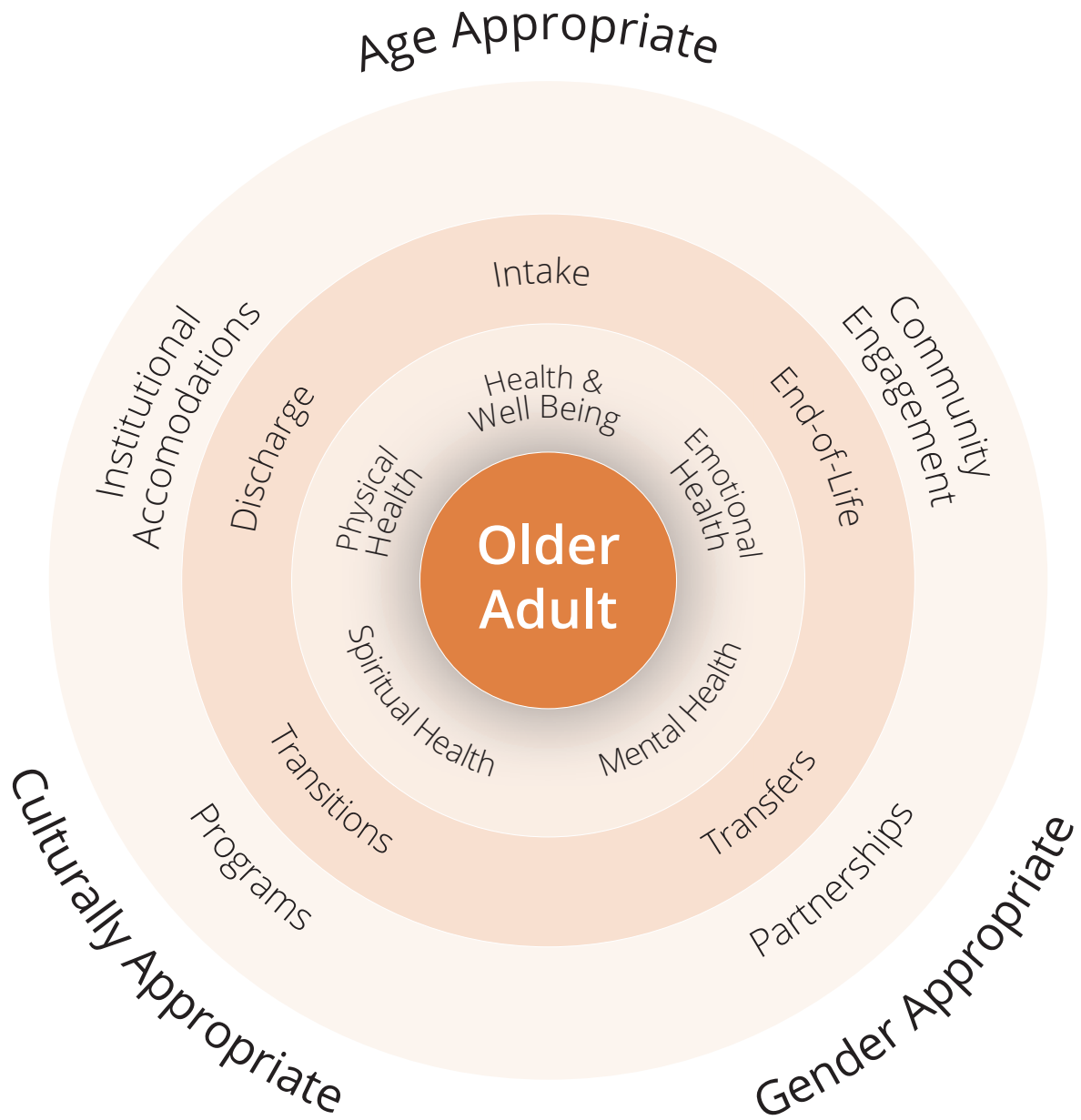
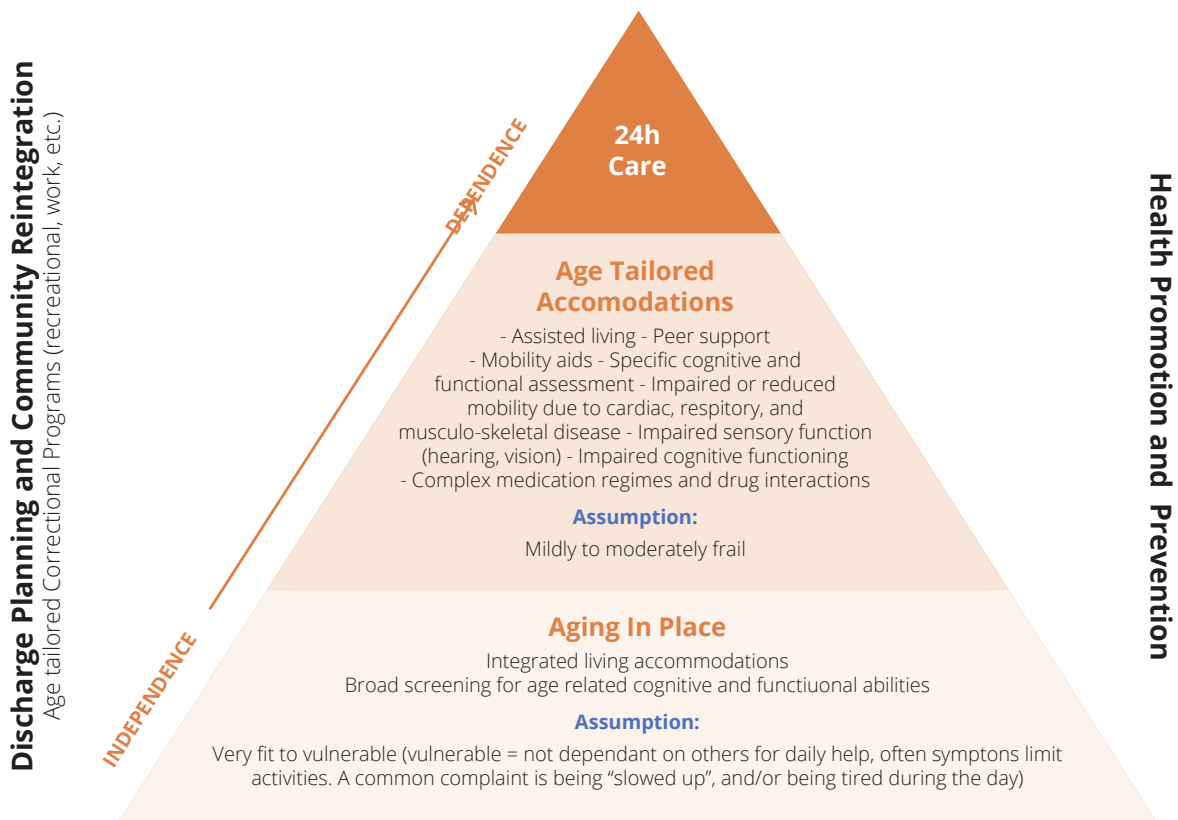


Figure 3.5 Integrated Culturally Appropriate, Gender Appropriate Coordinated Person-Centred Care



Accommodations, Transfers and Transitions

The strategy, guided by the integrated approach, includes accommodations, transfers and transitions; how to accommodate the OPiC, in discharge and in release planning. There is debate about whether or not OPiC should be living in age specific units or remain in an integrated setting (Handtke, Bretschneider, Wangmo & Elger, 2012; Inglis and Tully, 2016). The one-to-one discussions with OPiC along with the results of the interRAI assessments, environmental scan and a review of physical infrastructure requirements will help to inform CSC's planning process within the context of addressing the needs of OPiC.

To support the seamless transition in care of OPiC with on-going health care needs, it is important that discharge needs are identified in a timely manner and arrangements for medical follow up are made prior to release (CSC Discharge Planning and Transfer Guidelines, 2014). To enhance discharge planning and ensure a continuity of care, CSC can look to strengthen its existing discharge planning process by proactively engaging outside agencies to ensure all required assessment and planning is completed in advance to facilitate a smooth transition.

Community Engagement and Partnerships

Emphasis will be placed on engaging community organizations and the development of partnerships to help respond to the needs of OPiC. Building on existing partnerships, including the engagement of volunteers, can help address the stigma that many OPiC experience upon release. Establishing dialogue and communication early with long-term care facilities and other residential housing options can help to ensure effective transition and continuity of care. Working with and engaging Indigenous expertise to ensure cultural interpretation as it relates to communication, language, assessment and community-based services will be critical.

Promoting Health and Wellbeing

In addition to accommodation is the concept of health and well-being. This includes chronic disease management, exercise, polypharmacy, work related issues, retirement, immunizations, nutrition, continuity of services at transition points and various screening checkpoints, all of which are important issues to address. In addition to biophysical issues, additional challenges that OPiC may face as they age include spiritual needs, guilt, isolation and loneliness, which need to be addressed within the institutions as well.

Programs

Providing programming is an area not within the health care mandate but is a large part of CSC's mandate. Tailored Correctional Programming is offered to provide meaningful recreational and social programs that support healthy aging and encourage older persons to stay active, engaged and informed. Activities include walking, gardening, woodworking, low impact exercises, support groups and other relevant recreational activities. Community engagement is integral in relation to reintegrating rehabilitated and in reasonably good health parolees into the community. Collaborating with community partners is important to facilitate achieving standards and access to required expertise, such as in-reach and follow up, engaging volunteers, reducing stigma and engagement with Indigenous expertise to achieve Indigenous cultural interpretation and facilitate culturally appropriate services.

Staff Training

In addition to programming, staff training is important in addressing the needs of older persons. CSC is working with Queen's University in Kingston, Ontario who have developed training modules for professionals, as well as orientation and education for administrative and correctional staff. These modules are being piloted in Kingston with Ontario professional, administrative and correctional staff, with the hope that it will be piloted more broadly within CSC.

Conclusion

CSC's OPIc strategy will be updated and revised as relevant data and information becomes available. The process of consultation with experts in areas of older persons in custody, geriatrics, correctional health care, ethics, end of life care, and community stakeholder engagement is ongoing. One of the primary drivers on designing and developing care and supports will be the results of the comprehensive needs assessment.

“I’m too old for this sh**”: Experiences of age and imprisonment

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Being actively engaged in the tasks and activities of everyday life is a key element to the well-being and quality of life of older adults. Active engagement is associated with longer life, psychological well-being, physical and cognitive health and increased social supports (Hao, 2008; Park, 2009; Thomas, 2011; Parkinson, Warburton, Sibbritt, & Byles, 2010; Jung, Gruenewald, Seeman, & Sarkisian, 2010). Being visibly active in the community counters the stigma of growing older and being useless or a burden to society (Roth, Keimig, Rubinstein, Morgan, Eckert, Goldman, & Peeples, 2012). However, the benefits of active engagement should be measured by the quality of engagement rather than the number of activities in which a person engages (Liang & Luo, 2012; Preston, Shapiro, & Keene, 2007).

Most older adults in prison are not severely disabled or at their end of life. However, the number of activities older adults can do in prison is small, and they are generally less inclined to participate in the formally structured activities (Santos, 2003). Opportunities for quality engagement in various activities are impeded by highly structured monotonous routines (Farnworth & Muñoz, 2009), long periods of isolation, limited activity choice, lack of meaningful programs (Haney, 2003), limited facilities, loss of freedom, and lack of privacy (Whiteford, 2009). Most programs and services implemented within prisons are done so because they are considered valuable in other contexts, however, they have not been adapted to the uniqueness of the prison setting where daily life is regimented and confined with an inflexible timeline (Filinson, 2016). As a result, older adults in prison are inactive across a range of activities and are less active than their peers in the community. They tend to derive little value from prison programs designed for the needs of younger prisoners, such as employment and educational training (Filinson, 2016).

Imprisonment Trajectories

There are three primary imprisonment trajectories experienced by older adults: long term, revolving door, and late entry.

Long Term

The long-term trajectory, making up 24% of federally incarcerated older adults, includes those who are convicted and enter prison before the age of 50 for a life or indeterminate sentence and grow old in prison. Having this early and long-term incarceration results in the loss of

developmental milestones typical of adulthood such as emotional maturity, financial security, becoming active community members, building social relationships and intimate partnerships, pursuing educational and vocational goals, and forming a personal identity. By the time they are older adults, these people are highly institutionalized as they have reconciled themselves to prison life and have had little opportunity to make choices and decisions about the direction of their own lives. Additionally, the older adults experiencing this long-term trajectory often have less and less connection with people outside of prison as the years passed by, resulting in a significant disconnect with the broader community and the progress of society. These older adults often express fear or reservation about returning to the community. Retirement, common to most older adults in western societies, is not considered when parole conditions and expectations are set. Older adults living under parole supervision in the community are still expected to find employment, participate in correctional programs, and find independent housing.

*Bob is in his mid 50's, has served 14 years of a life sentence, with a minimum of 25 years before he comes eligible for parole. Bob has done all the programs on his correctional plan and, for the past few years, he has worked on the prison's grounds-keeping crew but aches and pains in his hips and knees are making work challenging. He has decided to retire from correctional programs and prison work, something that is not uncommon for older adults who have been imprisoned for many years, stating, "I've had enough, Crystal. I'm too old to keep doing this sh*t over and over again."*

Revolving Door

The revolving door trajectory, experienced by approximately 45% of federally incarcerated older adults, typically includes a series of shorter sentences interspersed with short periods of time in the community over the course of their adult life. These people are in a constant state of transition and change throughout adulthood, living with constant high levels of stress. They experience repeated loss of tenuous gains with each revolution. Each time they are released from prison, they need to secure housing, employment, social supports, and medical care. Each time they return to prison, they lose the supports and services they have secured as well as their place on any waitlists. They are not able to settle into a way of life either prison or community, since there is no guarantee that they will be placed in the same prison within each incarceration, and they do not necessarily return to the same community each time they are released from prison. They are in a constant state of starting over, as they truly have no place to call home.

*Stan is 60 years old, starting a four-year sentence – his sixth federal sentence for robbery-related offences. Each time he has returned to prison, he has started the same, or similar, correctional plan because his criminogenic risk factors remain the same. He states that he's done with robbing banks and with doing correctional programs. "I'm getting too old for that sh*t. It's a young man's game, Crystal, a young man's game." Instead, he wants to write his memoirs. However, as he begins to recount some of his life stories, he repeatedly stumbles over the details and mixes up the order of events. It becomes clear that he is showing early signs of dementia.*

Late Entry

Lastly is the late entry trajectory, which includes older adults who experience their first conviction after the age of 50 and make up approximately 28% of federally incarcerated older adults. They have lived a typical adult life, often including marriage, family, education, employment, and social and community involvement. Incarceration results in a significant loss of almost everything they have built for themselves over the course of their lives. They experience significant mental health and 'adjustment' concerns upon admission to prison, as they grapple with this new reality. This was not what they had planned for their retirement years.

Joe is in his late 60s and is two years into a 20-year sentence for sexual offences that all occurred during his 20s and early 30s, with no indication of any offending behaviour in the last 30 years. He lived a typical middle-class life as a junior high teacher and now receives a pension from the teacher's union since his retirement. He is married with adult children and young grandchildren. Joe has a history of severe depression for which he has received treatment on and off throughout his life but expresses enormous relief at no longer carrying the secrets from his past and now feels that he is "cured". Regarding the programs offered in the prison, he stated, "I'm too old for the jobs and things they have in here, but I feel like I could do something to help the other guys."

What these examples have in common is that they all identified something they would like to do other than the standard correctional programs and prison work to help them move their lives forward. It is common that it is not considered how receptive older adults are to the programs within prison, the degree to which they perceive their participation to be voluntary and older adults' own evaluation of the programs that are offered to them.

Perspectives of older adults in prison

There is very little research examining the subject experience of older adults in prison. Filinson (2016) questions how receptive older adults are to correctional programs, the degree to which older adults in prison perceive their participation to be voluntary, and older adults' own evaluation of the programs offered to them. Although the findings represent just a preliminary look at older adults' own perspectives, this study provides important insights into the daily activities of incarcerated older adults. Conducted in a medium security prison in the northeastern United States, 67 out of 100 men over the age of 55 participated in interviews about daily life in prison. Three general categories of activity were discussed by the participants: 31% of participants discussed getting exercise such as walking around the unit or yard, running the track, lifting weights and participating in team sports, all with differences between how social or competitive they were; 36% discussed employment within prison, with the majority doing unskilled manual labour and a small minority in trades or tutoring; 52% discussed their participation in programs; 22% did not participate in any exercise, employment or program; and 10% participated in all three (Filinson, 2016).

While the prison where the research took place provided a list of 250 programs, only 29 programs were available at the time of the study. Many participants reported completing the offered programs more than once (Filinson, 2016). Higher levels of activity were not associated with people's health, perceived health or greater social interactions, however self-improvement was affirmed from participation in programs. Activities such as tutoring and mentoring enabled empowerment and leadership roles with the younger men (Filinson, 2016).

The participants, themselves, perceived that barriers to their participation in various activities were based on their own individual traits or inadequacies as well as the lack of personal choice in pursuing activities (Filinson, 2016). One of the most common perspectives of participants was that "institutional confinement intrinsically denigrates the worth of activities that would be fulfilling in a community setting" (Filinson, 2016 p.139). For example, employment in the community provides people with a source of income, personal satisfaction, a sense of achievement, and/or a means of contributing to the broader community. However, in prison, employment often consists of unskilled labour that contributes primarily to the function and upkeep of the prison.

One of the most critical findings from Filinson (2016) is that prisons restrict peoples' choices for engagement, rendering them powerless to organize a meaningful day of activities. The older adults who participated in the study were dismissive of social ties and activities unique to prison, rejecting full immersion in prison life to remain focused on preparing for life after prison. The participants did not recommend expanding program options for employment or exercise, rather, they suggested programs that would improve their post-prison lives, such as programs related to discharge planning, work release and halfway house arrangements. They preferred options that would equip them to survive in the community as they did not anticipate retirement or being dependent on others (Filinson, 2016).

Filinson's research clearly reveals that older adults in prison want opportunities for self-determination – to be able to make choices and take independent action in their own lives and make decisions about their own futures. They want to serve others and feel useful, and to be part of a larger community.

There is a significant relationship between self-determination and intrinsic motivation (Ryan & Deci, 2000). Prisons rely heavily on external motivators to elicit preferred behaviours, however everyone will not respond the same way to the same motivator. Motivators such as threats, deadlines and evaluations diminish intrinsic motivation because they help to bring out an external perceived locus of control: "...people are moved to act by very different types of factors, with highly varied experiences and consequences. People can be motivated because they value an activity or because there is a strong external coercion. They can be urged into action by an abiding interest or by a bribe. They can behave from a sense of personal commitment to excel or from fear of being surveilled." (Ryan & Deci, 2000 p.69).

Recommendations

There needs to be a degree of autonomy, competence and relatedness in order for there to be an ongoing sense of well-being and integrity (Ryan & Deci, 2000). Recommendations for moving forward include: 1) strengths-based case management approaches that support and enable client centred interventions, 2) exercise options that are more accessible to older adults, 3) work opportunities that offers more than monotonous, manual, dead-end labour, and 4) programs that are inherently valued and freely pursued and that allow for the recovery of lost agency, personal empowerment, autonomous decision making, well-being and full membership in their chosen community (Filinson, 2016; Maschi et al., 2013).

A Place Like This: Haley House as a Model for Supporting Aging Federal Offenders in their Transition

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In April of 2016, Peterborough Reintegration Services (PRS) opened Haley House in Peterborough, Ontario to meet the needs of aging offenders transitioning from federal correctional facilities to the community. The fruit of the long-term efforts of Community Chaplain Dan Haley, Haley House has been recognized recently as a best practice in the field. The following section of this report will identify the central problem that Haley House was designed to address, outline the Haley House model and list the challenges that PRS still faces in developing the Haley House model. The goal of this section is to provide the reader with a broad sense of what Haley House is and why it is successful in order to ensure that this model can be repeated in other communities.

Defining the Problem

A recognition of the need to find community-based health care solutions for offenders living in institutions is related to a number of factors, three of which will be identified here. First, for aging offenders, a central challenge to living in institutions is accommodation. Offenders approaching end of life or who suffer chronic health issues need services and supports implemented inside institutions that are challenging to realize given the limits imposed by security regulations and facilities that were not designed with healthcare in mind (Sapers, 2015). These limitations impact an offender's ability to participate in the daily routine of an institution, a second factor. In institutions many aspects of an offender's routine are determined by the institutional schedule and the activities and work the offender elects to participate in. This is complicated for offenders who, due to the results of aging, may be slower to move from one place to another or unable to access certain areas in the institution (Forster, 2009). This presents the third factor, moral stress. As Raines (2000) notes, moral stress refers to situations in which the professional knows the right thing to do but is prevented from doing it for various reasons, often because competing values are at play. In correctional settings, efforts to meet the needs of aging inmates often conflicts with security requirements and limitations within the facility, diminishing the opportunity to provide adequate care.

Despite these three competing factors, up until recently, transitioning offenders from institutions to community-care settings remained a challenge. This is firstly due to the problem of risk. Many long-term care facilities feel that they cannot manage the risk that ex-offenders pose to reoffend. While aging offenders may pose some risk to reoffend, this perception is compounded by the stigma that is attached to all those found guilty of criminal offenses, especially those whose offenses result in federal correctional time. The second challenge is that of fit. While there are many community residential facilities nationally who are able to accept aging offenders, few of them are built to accommodate the needs that these individuals present, especially with respect to mobility.

Haley House, Aging Offenders and the Community

Recognizing the need to provide community health care solutions for offenders that resolve the challenges of risk and fit, staff at Peterborough Reintegration Services began to develop a plan that led to the building of Haley House in Peterborough, Ontario. Haley House is a community-based residential facility contracted by Correctional Service Canada (CSC) to provide specialized support for men facing serious chronic physical and mental health issues, or impending end of life. The current Haley House facility opened in April 2016. It is fully wheelchair accessible, has wide doorways, wheelchair accessible showers, lifts between floors and other additions to accommodate the population it seeks to serve (see Figure 3.6). Additionally, Haley House has two rooms that are geared towards offering support to those facing imminent end of life or severe disability (see Figure 3.7).

Figure 3.6 Ramp into Haley House



Figure 3.7 Client Room



The Haley House model was designed to provide the safe and equitable supervision of those on conditional release and to recognize and build up the dignity of individuals facing serious – and often terminal – health prognoses. As a facility, Haley House was built to provide its residents a safe, home-like environment which includes, three meals each day, access to health care professionals such as physicians, personal support workers (PSW) and community support, medication management and distribution, transport and accompaniment to appointments, development and maintenance of Resident Actions Plans, collaboration with parole offices, 24/7 security and palliative care. All this work is accomplished with a focus on recognizing the inviolable dignity of its residents, and that the best outcomes in a residential environment can be achieved by ensuring that the social determinants of health are prioritized (Gibson et al., 2012).

This commitment of the originators of the Haley House model to upholding the dignity of its residents is the result of a faith-based, principled approach to offender management. This approach is best understood as a process that begins with two basic questions. The first question is; what can the encounter with aging offenders reveal to us about their needs as human persons? (Vanier, 2008) The second question is; how do we meet their needs in a setting that also addresses the needs of the community with regards to safety? These questions, from which the Haley House model emerged, insists that in encounter with offenders the lives of both the offender and the service provider are enriched, while ensuring that the safety of the community is prioritized as well.

Admissions into Haley House come from referrals from the local community assessment team (CAT). The CAT consists of staff from Peterborough Reintegration Services, Peterborough Parole Office, Peterborough Police Services and the Central East Local Health Integration Network. The criteria for admissions into Haley House start with prioritizing people who are difficult to place due to health care concerns. As a result, the CAT prioritizes individuals who pose a challenge to other community support services or CRFs. Additional criteria include the compatibility due to their staffing model and what they can accommodate, as some prospective clients have health care needs that are too great for Haley House to address.

The staffing model at Haley House consists of a case work manager, program manager who does operations and outreach, assistant case workers, PSWs and a food services coordinator to prepare the client's meals. In addition to the staff, Haley House is supported by numerous partners such as CSC, the Central East LHIN, the Peterborough Police Services, family physicians, nurses, PSWs, the Canadian Mental Health Association (CMHA), Home Grown Homes, Kawartha Food Share, City of Peterborough and United Way Peterborough.

Challenges, Outcomes and the Way Forward

Despite the overwhelming success of the Haley House model in its first years of operation, staff have faced some challenges. First, in facilitating end of life care to ex-offenders, Haley House has faced challenges in supporting clients to the end of life in the residence, with many clients transitioning to hospitals. Second, as Haley House clients transition out of the facility and into other settings, PRS has identified the need to improve outreach with past clients, creating a continuum of support. Finally, and most significantly, PRS has struggled to build bridges to long-term care facilities. This is integral, as these relationships will ensure the transition of Haley House residents is optimal.

In seeking to overcome these challenges, PRS has identified a number of key outcomes for the Haley House model. The first outcome is to have fewer people facing health care concerns, including end of life, in prison. A second outcome is to work in partnership with CSC to relieve institutional staff of the significant burden of caring for inmates with serious chronic health conditions. Lastly, Haley House is working on acting as a conduit to facilitate the safe and timely release of individuals from federal institutions into community-based long-term care facilities. The local parole officers and the Central LHIN have begun to work on transitioning Haley House clients into long-term care facilities and they hope to systematize the process, so that it is as successful as possible.

Key Perspectives on the Challenges of Community Reintegration

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For over a decade, criminologists have documented the rise in aging prisoner populations, and the challenges correctional authorities will face in the near future with regards to providing personal safety, health care, meaningful and suitable work, and simple mobility for these prisoners. Correctional institutional design and programming has yet to respond to the needs of an aging offender population and remains deeply entrenched in the offender archetype of someone who is young, male, and able-bodied. Canadian research shows that an increasing number of first-time federal offenders are over the age of 50 convicted of their first offence (Hotton-Mahony et al 2018). As stated here by the Correctional Investigator, Ivan Zinger:

My Office has raised concerns regarding the challenges facing the aging and elderly in federal custody for more than a decade. Over this time period, the aging inmate population has continued to grow and now comprises 25% of the total inmate population” said Ivan Zinger, Correctional Investigator of Canada. “Aging offenders use a disproportionate share of prison health care services, are vulnerable to victimization and often reside in prisons that are inaccessible and ill-equipped to manage their health care needs” (Canadian Human Rights Commission & the Office of the Correctional Investigator, 2018).

The rise of an aging prison population is the reflection of the natural aging cohort evident in all of our communities but is also driven by the effects of two decades of ‘tough on crime’ sentencing law reforms and fiscal austerity policies that clawed back programming and staffing across provincial and federal prisons. At the level of sentencing courts and parole board decision making, rehabilitative ideals of treatment and community reintegration have given way to objectives of denunciation and deterrence through incapacitation. Thus, our prisons have slowly filled with non-violent offenders with complex mental health and physical health needs with few community resources. These offender populations are now aging out of the correctional system into communities in need of housing and health care.

Peterborough, Ontario and the surrounding county is located less than an hour from several federal penitentiaries for men serving sentences of at least two years, some of whom have been convicted of serious personal injury offences. As a result, our communities are confronting a need to respond to the well-being of aging male offenders released on parole oftentimes with complex health care needs and little to no social support after years in custody. On one hand, concerns lie with the well-being of seniors in custody and the need to address conditions of confinement. On the other hand, concern also lies with the human rights implications of delayed conditional release of elderly offenders due to their complex health needs and lack of access to

housing. Outlined here are the key challenges of navigating the needs and rights of criminalized elderly people released into communities from the perspective of police, parole, and health care professionals, as well as legal and social justice advocates who participated as panelists at the *No Place to Call Home* Symposium.

Police services in this community have worked cooperatively with the local parole office and works closely with transition houses such as Haley House (for more information on Haley House, see contribution written by David Byrne). From the perspective of police officers, aging parolees face significant stigma from service providers and community residents. As with most criminalized groups, public perception of a parolee is that they will re-offend and cannot be trusted, nor do they deserve to be treated the same as other seniors. Fear and mistrust, as well as notions of deserving or undeserving are real barriers to community reintegration. Larry Charmley, police inspector with a long career in the Peterborough area, recognizes the difficulty of educating the public with regards to the high likelihood of successful reintegration of older offenders on parole. For example, of 200 reports of violence in long-term care facilities, Charmley noted that a very small percentage of those reports involve residents with past criminal records. Community supports including stable housing and access to health care are what enable effective reintegration of aging offenders.

From the perspective of how elderly persons living on parole would access long-term care, Anjelika Vedenin spoke of the role of the Central East Local Health Integration Network (LHIN) in the community reintegration of aging offenders through the Long-term Care Act. The LHIN is responsible for determining the eligibility for long-term care and authorizing admission. To be eligible, applicants must be 18 years or older, have a health card and have care needs that can be met by the long-term care facility. In order to determine eligibility, Angelika described that care needs are determined through a home assessment which include house assessment, physical ability, social supports, cognitive ability and behaviours that may suggest long-term care may not be suitable. It is during house assessments that information about previous offences is commonly revealed. During the counseling conversations, the applicant is informed about the environment of long-term care and that parole conditions cannot always be met. An application can be rejected for two reasons: there is no availability in a suitable facility or not enough nursing expertise to meet the needs of the applicant. One concern in smaller communities is implicit bias that arises in the application process when a parolee's name is recognized by the LHIN counsellor. This bias may influence the assessment of the parolee's application for long-term care. In the event of an unsuccessful application, the LHIN is expected to advocate for the applicant by working with the long-term care facilities to determine if there is any further information that is required in their decision making.

Legal advocacy of seniors in need of long-term care brings together the Advocacy Centre for the Elderly and the LHIN. Judith Wahl, a lawyer who works with seniors who have been denied

access to long-term care, noted that denial of housing is rare due to the LHIN's assessment and advocacy method. However, there are times when long-term care facilities refuse applications for reasons other than what is legislatively permitted (lack of appropriate facility and nursing care). Wahl explained that although legislation does allow long-term care to refuse applicants, she has found in her advocacy work that long-term care facilities will also refuse to accept applicants with dementia. When inquiring about the grounds for refusal, Wahl found that the facilities would not provide enough detail and when formally requested to provide details by the advocacy group, the long-term care home would comply and accept the applicant.

Another area of concern is the violation of privacy law with regards to inappropriate disclosure of person information and if that is why long-term care was issuing the rejection in the case of a person living on parole seeking housing. As Wahl explains "long-term care homes are not entitled to know whether the applicant has a criminal record. The application process is based on health. In a small community, their records will likely be known or assumed if they are coming from a place like Haley House. This is an extremely challenging system and they are not dealing with such a degree of acuity of a huge range. This was never the intent of long-term care homes. We need to work collectively to get refusals away from the perceived risk to the actual risk because that is the fair criteria".

Once a parolee reaches their warrant expiry and they are no longer under supervision, they must have housing in place. When confronted with waiting lists or lack of eligibility for housing, the parolee is at greater risk of harm due to unstable housing. Judith Wahl explains that although no person can be denied access to long-term care due to income, as it is a part of the health system, there are waitlists. Anjelika Vedenin reminds us, "waitlists are long. If you are a regular applicant, it is sometimes seven years, however, the legislation allows priorities. If you are at risk, the LHIN can facilitate that admission. There are no long-term care homes with empty beds". With regards to the housing needs of those with particular behavioural problems, not exclusively those on parole but also those with dementia or other cognitive impairments, there are limited resources: "Presently, there are 68 long-term care homes within the Central East LHIN district and 44 have staff available to try and manage behaviours. There are nurse practitioner staff that go to the homes and manage the behaviours short term or try to facilitate getting some additional treatment. There are no places for those residents with those behaviours to go" (Anjelika Vedenin).

Kim Lawson spoke on behalf of the Peterborough Parole Office. She discussed their role as facilitating the effective and safe reintegration of offenders. Their primary role is to keep society safe and to monitor the conditions parolees are released on by assessing, monitoring and intervening with an offender's risk. As parole officers, Kim described that they operate in a supportive role and are primarily involved in risk management. She described the importance of educating the public and long-term care administrators of how risk is managed through

parole supervision and conditions of release. For example, a parolee's static risk is based on past events or experiences, whereas dynamic risk that changes over time due to intervention, programming and age. As an offender ages, they pose far less risk to re-offend or act out. Risk of parolee is constantly monitored in communities and in long term-care facilities, more so than the potential risk of non-criminalized residents.

In efforts to address some of these challenges of stigma, lack of access to long-term care due to perceived risk, Angelika Vedenin explained that LHIN has a close working relationship with parole officers and together they will intervene on behalf of a parolee in need of long-term care. For example, parole conditions could prevent an offender from applying to a long-term care facility such as history of assaultive behaviour. Yet, the offender may also be in critical need of supportive housing due to his age and deteriorating physical condition. In that instance, parole officers would advocate for him to have some conditions lifted so he could enter a long-term care home. Kim Lawson from the local parole office agrees that communication and education with regards to actual risk are key to community reintegration. Another organization involved in advocacy for aging offenders in the community is the Community Care Access Centre (CCAC). Kate Kincaid, past Director of Patient Care at South Bruce Grey Health Centre, spent time with case managers and regional directors of CCAC to assist in the housing eligibility and assessment process. Kincaid suggests that the CCAC has a real opportunity to be present in penitentiaries as part of the release and discharge planning of aging offenders. Judith Wahl agreed with the need to educate health care professionals on the life course of offending behavior: aging offenders may have histories of violence but are no longer a risk to others.

With regards to the role of communities in changing attitudes towards housing and health care are a universal right, Larry Charmley points to the need for leadership within long-term care to become knowledgeable on the subject risk and rights to housing, and to educate their staff. In the end, organizations will be more receptive to accepting parolees. Part of this leadership approach requires working closely with parole officers so as to establish protocols for risk management and supervision. Bigger obstacles exist however with regards to the legal right to access long-term care. According to Judith Wahl, refusal for long-term care must be challenged and formally justified with documented reasons, because currently parolees have nowhere else to go for supportive housing, moreover they are legally entitled to receive health care. Sometimes the long-term care homes need supports and require special funding to provide supports and services to their residents rather than turning them away. As Kate Kincaid reminds us as well, there is a continuum of housing services such as retirement homes, short-term stay units, interim care beds and respite care each with their own eligibility and assessment practices. Kim Lawson also describes how in-home support, such as personal support workers coming into a rooming house to provide care to an aging parolee's in poor health is another area of service provision that requires education and progressive leadership.

A key aim of the *No Place to Call Home* Symposium was how to replicate the Haley House model in other communities across Canada. Yet, this will require effective partnerships and leadership. Financial support and sustained investment are always identified as a barrier, however, recognition of the need for long-term care for aging offenders, and education to counter stigma of risk requires making “good use of leaders in your community who have the knowledge” (Kate Kincaid). This is echoed by Larry Charmley, “if the challenge is funding, do not just throw up your hands. You need to develop the partnerships and things will start happening” but more importantly “dispelling stigma is crucial. It is important to identify who the organizations are so that you can start to build something. Identify who can make something happen, then you figure out your communication message to the community. No one is going to like a parole house being set up in their community”. Community advocacy for investment in a service such as Haley House can evolve from key community stakeholders such as universities and colleges, as well as regional health centres. As a community with one of the largest senior population per capita in Canada, Peterborough has ample opportunities to become a leader in innovative developments such as Haley House, but also public education about the realities of being an elderly person living on parole and their very low risk to re-offend. Kim Lawson suggests that parole officers too can do a better job of educating the public on the way offenders are supervised and public safety: “for many people in the community, the work of parole officers is mysterious and scary. They think it is secretive, when it is very open and transparent. Unfortunately, a lot of people do not see that. Opportunities for education is crucial. If we have more opportunities to share the role of parole officers, it can only benefit everyone”.

4. Frontline Knowledge Regarding the Community Reintegration of Aging Offenders

Following the *No Place to Call Home* Symposium held at Trent University in February 2018, attendees were sent a follow-up survey in order to gain an understanding of what is already known about the community reintegration of aging offenders. Specifically, the survey asked respondents to list 1) barriers facing aging offenders when reintegrating into the community, 2) issues surrounding the community reintegration of aging offenders, and 3) what are possible solutions to consider in addressing the barriers and issues. Table 4.1 provides a summary of the survey results.

Table 4.1 Summary of survey results

Barriers facing aging offenders when reintegrating into the community	Issues surrounding the community reintegration of aging offenders	Solutions to address the issues and barriers
Stigma	Access to long-term care	Aging offender specific community residential facility (CRF)
Access to housing	Availability of housing	Increased release planning
Lack of supports and skills	Community resources and services	Public education

A total of 39 responses (of 164 attendees) were received from symposium attendees representing a variety of sectors and organizations, including religious groups, policing services, parole, the non-profit sector, legal services, health care, education, corrections and community support agencies. The answers were compiled and analyzed to provide insights on the varying and diverse perspectives of the symposium attendees and to determine the pre-existing knowledge surrounding the challenges and opportunities of the community reintegration of aging offenders. Through examining what is known, we are able to present gaps in knowledge which can inform future research opportunities.

Barriers facing aging offenders when reintegrating into the community

Due to a variety of factors previously mentioned in this report, aging offenders are facing barriers when reintegrating back into the community. Based off survey responses, the largest barrier discussed by symposium attendees was the stigmatization of offenders by the community. Survey answers mention the NIMBY-ism displayed by community members when thinking about offenders, older or not, living within their communities. These sentiments were described as being based on the assumptions and stereotypes of offenders and people with criminal records. Specific to aging offenders however, many survey respondents described

that this special population also has to deal with ageism on top of the stigma of having been incarcerated. These feelings and actions of stigmatization were described as stemming from a lack of public education regarding the risks and recidivism rates of offenders on parole, especially those that are older and have chronic illness.

Not only are aging offenders stigmatized by community members, stigmatization was also described as being seen within long-term care facilities, causing discrimination in the acceptance process due to their perceived risks and behaviours. Whether it is within long-term care or the larger community, echoing arguments made in previous sections, the surveys show that there is a lack of acceptance of aging offenders due to the stigma regarding criminal records and history of incarceration.

A second barrier described by the survey respondents was accessing housing within the community upon release. Many described this to be a challenge due to the general lack of suitable housing options for aging offenders, such as community-based residential facilities (CRF). Survey respondents described suitable housing as a place that is safe, affordable, has availability and can meet their complex needs (physical and mental health needs, as previously described in this report). Additionally, as described in the survey, more prominent in aging offenders is the barrier of accessing long-term care housing. Paired with the long wait times felt by many older adults, aging offenders applying for long-term care face other challenges regarding eligibility and acceptance due to their perceived risks and behaviours, brought on by the stigma of incarceration.

The final barrier discussed by the survey respondents was a lack of supports and skills. Caused by spending any great length of time in prison, many aging offenders were described as finding themselves with missing support systems. These supports, whether they are social, financial or medical, can help to ease the community reintegration process. Along with supports, many survey respondents described that aging offenders were also lacking general life skills that can help them integrate. The lack of skills such as technology and general employable skills create barriers for this population to provide for themselves financially and to successfully reintegrate into the community.

Issues surrounding the community reintegration of aging offenders

Independent of aging offenders, there are issues within communities and the society at large that pose issues and challenges surrounding the process of community reintegration for aging offenders. One of the biggest issues, as described by the *No Place to Call Home* Symposium attendees was long-term care. Respondents in sectors such as parole, corrections, and community support agencies described this issue, and stated that many aging offenders

applying for space in long-term care facilities are denied due to their perceived risks and behaviours. This issue was explained as being caused by a lack of education of long-term care staff on how to appropriately meet the unique care needs and behaviours of aging offenders, the lack of funding for long-term care to support this population, the general issue of bed space availability and the stigma of having a criminal record.

Similar to barriers, housing was something that posed challenges surrounding the community reintegration of aging offenders. While the barrier presented itself as the access to safe, affordable and supportive housing, the issue is the availability of housing that caters specifically to the multifaceted needs of aging offenders. As noted in the literature and within the report, aging offenders have unique and complex care needs such as mental health, chronic illness and physical disabilities which require support and accessibility. The survey respondents stated that housing to meet these needs are lacking, however, mentioned Haley House in Peterborough, Ontario (Section 3) as a model of a house that does support this population.

A third issue addressed by the survey respondents was the resources and services that are lacking within the community that meet the needs of aging offenders. In addition to housing, aging offenders require resources such as health care and social support and services to help with housing retention in order to successfully reintegrate. Survey respondents discussed how there is not enough of these services within communities to help with the population's high level of care needs of older people in general, let alone older offenders.

Solutions to address the issues and barriers of community reintegration of aging offenders

After examining the barriers and issues of community reintegration of aging offenders, using experience from their varying perspectives, survey respondents offered suggestions for solutions on how to address the issues and barriers of community reintegration of aging offenders. In order to address the housing issue, respondents urged for an increase in housing capacity. Specifically, respondents indicated a need for an aging offender specific long-term care and/or CRF. To fulfil the housing needs, respondents eluded to the need for an increase in funding. Housing specific funding was mentioned to be used for a variety of things, such as more bed space in pre-existing long-term care facilities and for accessibility renovations and upgrades in already established CRFs.

Another solution mentioned in the survey responses was the need for an increase of release planning. Beginning the planning process within prison ensures appropriate discharge plans are in place to help the aging offenders coming into the community access community supports like housing and physicians. Additionally, survey respondents indicated how using in-prison programming can also help mentally prepare inmates for their release.

Lastly, survey respondents discussed the importance of education in order to address the issues and barriers of community reintegration of aging offenders. Respondents described needing education in both the health care and community side of the reintegration process. In health care, education was described as being necessary, especially for long-term care staff and the LHIN, on the needs and the realities of aging offenders. On the community side, there is a mention of the need for education on the realities and risks of aging offenders. Educating and providing an understanding of aging offenders will help to dispel the stigma and to encourage a supportive reintegration process.

Gaps in knowledge

Through distributing surveys to *No Place to Call Home* Symposium participants, barriers, issues and solutions to the community reintegration of aging offenders were highlighted and discussed. The surveys revealed some interesting barriers such as stigma, access to housing and lack of supports and skills, as well as issues regarding long-term care, housing and lack of community resources. The surveys also revealed some possible solutions on how to address these barriers and issues such as increasing housing capacity, improving pre-release planning and increasing public education on the risks and realities of aging offenders.

The survey reveals that sectors such as corrections, parole, health care, policing, non-profit and community support are thinking about this issue of the community reintegration of aging offenders. It shows that these sectors are aware of the challenges and barriers and are thinking about possible ways to overcome them. What is missing, however, is the voice of the aging offenders. In order to fully understand the barriers and issues or community reintegration and to being able to think about possible solutions, it is imperative to hear from the aging offenders themselves. Having the voice of the aging offender in research on community reintegration allows us to understand all the barriers they have, the issues they deal with and any opportunities they have experienced across the continuum of reintegration (while within prison, to within a housing facility).

This call for the voice of aging offenders within community reintegration research is addressed in the Community Reintegration of Aging Offenders (CRAO) pilot project. The CRAO Pilot Project is a research project being conducted at Trent University in collaboration with Correctional Service Canada, Citizens Advisory Committee, Peterborough Parole Office – Ontario Region, and Peterborough Reintegration Services. The basis of the project is to give voice to the aging offenders to examine their experiences as they transition from institutions into the community.

5. Moving Forward

Drawing from the literature and the knowledge from the *No Place to Call Home* symposium attendees, there are opportunities to use the gaps presented and to move forward towards shedding light on the issue of the community reintegration of aging offenders. Table 5.1 presents a summary of the gaps from the literature and the frontline knowledge and shows the next steps, which are further described in the proceeding sections.

Table 5.1 Summary of gaps and next steps

Literature	Frontline Knowledge	Next Steps
Challenges of the community reintegration of aging offenders	Experiences of the aging offenders	Need for research on the community reintegration of aging offenders
Canadian specific literature on community reintegration of aging offenders	Public education regarding the community reintegration of aging offenders	Community Reintegration of Aging Offenders (CRAO) Pilot Project
National examples of solutions to the challenges of community reintegration of aging offenders		

Directions forward from the literature

The literature presented in Section 2 outlined the growing number of aging offenders within the custody of Correctional Service Canada (CSC). It also outlined the complex needs of this population and some of the challenges they face while upon release when reintegrating into the community. Additionally, it presented a framework and potential solution to help meet the needs of aging offenders and to meet their needs as they transition from institution to community.

The presentation of literature also highlights gaps in which further research and analysis is needed. One gap is that there is limited research on the challenges of aging offenders as the reintegrate into the community. Although some literature exists (Maschi et al., 2013; Williams & Abralde, 2007), it is limited. More research is needed to fully understand and encompass the challenges and solutions to the community reintegration of aging offenders.

A second gap is the lack of Canadian literature and examples on the community reintegration of aging offenders. Although a policy framework was developed by CSC addressing older persons in custody (see Section 3), there is missing literature of Canadian specific examples of solutions to the community reintegration issue. Having these national examples could help in developing additional strategies to address the issues of the community reintegration of aging offenders.

Community Reintegration of Aging Offenders (CRAO) Pilot Project

To address the gaps in knowledge about the community reintegration of aging offenders, researchers at Trent University, in collaboration with CSC, the Citizens Advisory Committee, the Peterborough Parole Office – Ontario Region and Peterborough Reintegration Services have launched the Community Reintegration of Aging Offenders (CRAO) Pilot Project in July 2018. The goal of the one year pilot project is to examine the experiences of aging male offenders as they transition from correctional institutions into the community, and to better understand the organizational structure and approach of Haley House. The objectives are 1) to document the issues, challenges and opportunities of community reintegration of aging offenders, and 2) to establish the conceptual and methodological foundations for a multi-jurisdictional CRAO research project across Canada.

The research is focused on Haley House, a community-based residential facility governed by Peterborough Reintegration Services (PRS) and funded by CSC located in Peterborough, Ontario (see Section 3). The CRAO Pilot Project conducted interviews with Haley House residents, staff and stakeholders to gain an understanding of the experiences of community reintegration for the aging offenders including barriers and challenges and their experience obtaining supports, including their experience accessing and residing at Haley House, and insights into the development of Haley House, its connection with local partners and its role within the local community.

Upon completion of the CRAO Pilot Project in June 2019, the Trent researchers produced a project report to be made publicly available as a companion to this State of Knowledge Report. This report includes summary of the community-based approach and pilot study findings.

Concluding Comments

Although there is a lack of understanding of the community reintegration of aging offenders, there are actions being implemented to bring this silent issue to the light. As demonstrated in this report, symposiums like the *No Place to Call Home: The Challenges of Reintegrating Senior Parolees into the Community and Long-term Care* help bring key stakeholders together to discuss the issue and to highlight solutions.

Through the symposium, report and Community Reintegration of Aging Offenders (CRAO) Pilot Project, they highlight places like Haley House, which allows such models to be shared and hopefully implemented elsewhere across Canada in the hopes that the needs of aging offenders can be met within the community.

To conclude, the essence of this report is encapsulated best in Gillian Balfour's earlier observation that, "our communities are confronting a need to respond to the well-being of aging male offenders released on parole oftentimes with complex health care needs and little to no social support after years in custody."(p.27) In speaking to mobilize knowledge from the *No Place to Call Home* Symposium, this report and the accompanying CRAO Pilot Project highlight the ways forward that researchers, policy makers and community leaders can ensure that these care needs, supports and services are developed, implemented and evaluated to meet the future needs of aging offenders as they reintegrate into the community.

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