

**Written Evidence Submitted for the Standing Committee on Human Rights
March 2018**

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II. Summary of Main Points

For the last 7 years I have been conducting research and writing about issues in the federal correctional system. This research has focused on vulnerable prison groups, especially people aging in prisons [defined as 50 years of age or older] and/or suffering from terminal illnesses. Most of my expertise builds on 197 interviews that I conducted with men over 50 in 7 penitentiaries in Canada between 2013-2015] as well as on my legal and socio-legal theoretical research [For details on the methodology, please see Annex 1]. After Aboriginal women, people aging in prisons is the fastest growing group of incarcerated individuals. Currently, this group makes up 25% of the incarcerated population, and this number is on the rise. In the last decade, the percent of people aging in prisons has doubled. There is an overlap between people aging in prisons and those presenting other markers of vulnerability such as: physical chronic illnesses, terminal conditions, mental health issues, physical disabilities, and being a visible minority (especially Aboriginal). In my research, I identified a number of issues regarding prisons and conditions of confinement, which are summarized below. These issues may raise moral, ethical, and legal problems, and should be prioritized moving forward.

- a. The federal correctional health care system is at times inadequately responding to prisoners needs in terms of:
 - pain management,
 - availability of medical staff on prison grounds,
 - wait times to see a specialist,
 - difficulties in obtaining escorted and unescorted temporary absences to see a health practitioner in the community,
 - access to psychiatrists and psychologists.

- b. More than half (54%) of people over the age of 50 suffer from a disability that impairs their daily activities. However, accommodation and assistance for incarcerated individuals suffering from a physical disability or other chronic illness is often inadequate:
 - Infrastructure is old and not all institutions are disability-friendly (i.e. stairs and lack of elevators, long distances to walk in a short time, double-bunking);
 - Lack of peer caregivers or appropriate caregivers;
 - Safe accommodation is lacking, and older individual are at high risk of abuse both by peers and staff members;

- Inconsistent availability of devices to help with disabilities (i.e. braces, walkers, canes, etc.);
 - Programs are not age-specific, are of little relevance to older individuals, and are largely inaccessible to older individuals, whom tend to serve longer sentences. Instead, younger prisoners and prisoners with shorter sentences are prioritized to participate in programs. This means, that often, by the first parole eligibility dates, older individuals would not have completed mandatory programming, and this disqualifies them from receiving parole.
- c. Security measures and disciplinary tools are often used to manage people suffering from physical and mental diseases. These include:
- Disciplinary tools, including segregation,
 - Administrative segregation,
 - Protective custody or “segregated units”,
 - Observation cells.
- d. At least 11 individuals were suffering from terminal illnesses in federal prisons:
- Without palliative care available to them. This means that they were not supported by multidisciplinary teams, had no family contact or pain management, and access to medication and medical services was not readily available.
- e. Medical assistance in dying (MAiD) is now available to prisoners, while other end of life treatment options are not:
- While the actual MAiD procedure takes place outside prison, the request, consent for, and assessment are predominantly being made and conducted in prison. This calls into question, at the very least, the validity of the consent being given.
 - Evidence suggests that palliative care is inconsistently available in prisons; both palliative care and MAiD should be options for end of life treatment; at the moment, due to the poor quality of palliative care, there is a risk that MAiD may become the only option of many prisoners.
 - End of life care decisions should be made outside prison, but at the moment, release is not readily available for sick, even terminally ill, individuals.
- f. There are a number of issues surrounding release, including:
- With increasing periods of parole ineligibility coupled with vague and inconsistent criteria, parole is difficult to access. As a result, many aging and sick individuals are spending significant periods of time in prisons, despite evidence that the risk they present to society is low or non-existent.
 - Compassionate release (formally called parole by exception) is virtually non-existent; It is granted under s 121 of the Corrections and Conditional Release Act (CCRA), but this rarely happens. Procedural issues make it difficult for prisoners’ applications to succeed.
 - The Royal Prerogative of Mercy is virtually never used, even for very sick individuals who are ineligible for parole.

- Preparation for release that reflects the needs of older and sick individuals is non-existent. Consequently, these individuals face difficulties and are unable to successfully reintegrate into society.
- Correctional Service Canada's (CSC) approaches to community reintegration and liaisons with community institutions are inconsistent. Released individuals must rely on local non-governmental organizations (NGOs) and their resources, and these vary widely across the country.

III. Factual Evidence

The sections below describe the experiences of the 197 men I interviewed from 5 penitentiaries in Canada.

a. Health care for vulnerable individuals

Of these men, 37% suffered from at least 4 to 7 different medical conditions. 28% suffered from between 8 and 16 illnesses.

Table 1: Distribution of physical illnesses

Physical Illness	Frequency	Percentage (%)
Severe sight problems	162	82.2
Arthritis	100	50.8
Other	94	47.7
Hypertension	83	42.1
Back problems	63	32.0
Severe heart problems	54	27.4
Diabetes	53	26.9
Skin problems	53	26.9
Severe hearing problems	52	26.4
Digestive problems	48	24.4
High Cholesterol	48	24.4
Severe oral problems	48	24.4
Circulation	39	19.8
Physical disability	37	18.8
Foot problems	33	16.8
Hepatitis	28	14.2
Asthma	24	12.2
Wounds	24	12.2
Cerebral–vascular problems/Epilepsy	19	9.6
Sleep apnea	16	8.1
Severe prostate problems	15	7.6
Cancer	14	7.1
Hernia	13	6.6
Bladder	11	5.6
Sciatic nerve	11	5.6
Thyroid	10	5.1
Constipation	9	4.6
Pinched nerve	6	3

Overall, 39% of the individuals interviewed reported suffering from at least one chronic mental health condition. 21% reported suicidal ideation.

Table 2: Distribution of mental health conditions (not mutually exclusive in an individual)

Mental Health Conditions	Frequency	Percentage (%)
Depression	48	24.4
Anxiety Disorder	34	17.3
Other	22	11.2
Dementia	9	4.6
PTSD	8	4.1
Bipolar Disorder	7	3.6
Schizophrenia	6	3.0

For people with chronic illnesses, a major challenge was access to appropriate medical services. Overall, 54% of the men mentioned that, in their institution, nurses were not available 24/7. In most institution, the wait time to see a nurse was between 3 days and 1 week, regardless of the problem.

Access to specialized treatment differed from institution to institution. Dentists were by the far the most sought after with 45% of participants making a request to see one. All institutions had a dentist come in at regular intervals, and the wait time to see a dentist was usually a couple months. However, in some institutions, like Milhaven Institution, a maximum security prison, this wait time also applied to emergencies. Optometrists and psychiatrists were also in high demand, with 31% and 9% of men making requests respectively. These professionals would also come on-site to provide services. Optometrists were generally available within 3 months. In contrast, the wait time to see a psychiatrist could be years, especially if the individual was not suicidal. For example, at Warkworth Institution, 1 psychiatrist and 1 physician served 600 people. Participants reported that if they indicated that they wanted to see a psychiatrist, they were asked whether or not they were suicidal. If they were not, then they would not be seen. Participants access to psychologists was not much better; some reported having access to 3 sessions with a psychologist for the duration of their stay at Warkworth (which in some cases, was upwards of 10 years).

Prisoners accessed other specialists, including oncologists, cardiologists, surgeons, and urologists, at community hospitals. Generally, wait times were over one year. In some of the most crowded institutions, people would sometimes be denied appointments. People were denied appointments with psychologists (14%), optometrists (5%), and cardiologists (14% while 43% were still waiting to see a cardiologist). At Pittsburgh Institution, the biggest problem hindering

access to specialists was the lack of escorts to the community. There were only two officer escorts available daily for a population of 270 people, 70% of whom were old and sick. If, on the day of the community appointment, the prison did not have an escort available, the individual would simply lose the appointment and would have to be rescheduled on the next date available, perhaps months down the road.

Overall, 62% of the participants reported suffering from severe pain on a regular basis. Pain was linked to a range of health problems such as arthritis, cancer, physical disabilities, long term severe back problems, digestive issues, outstanding wounds, diabetes, hypertension, severe oral problems, hernia, sciatic nerve, high cholesterol, and foot problems.

For pain, Tylenol was generally available at the canteen for prisoners to purchase and use at will. Nonetheless, all the individuals that I counted as reporting severe pain for the purpose of this study maintained that Tylenol did not ease their pain. Thus, my question regarding pain treatment, as well as their answers to it, referred to medication prescribed by the prison physician. The medication the prison physician generally prescribed in cases of chronic or acute pain was Tylenol 3, as this is the only compound available. The *CSC National Drug Formulary* is the official list of medications available in penitentiaries. This document confirms that the only prescription painkillers available in penitentiaries are Tylenol 3 and, in special cases, methadone or morphine. It also mentions that all community prescriptions for painkillers will be changed to Tylenol 3, since it is the cheapest compound. 43% of those who received pain treatment reported it as ineffective in alleviating their suffering.

Surgeries take place in community hospitals, and not penitentiaries. They require that escorts be available, and are most common among people aging in prisons. In my study, 24% of the participants underwent surgery while in prison after the age of 50. It is protocol that people are shackled during surgery. However, the participants complained less about the shackles and more about the post-surgery recovery space. For example, 12% were brought back to prison immediately after surgery, especially after hernia surgeries. Spending a night in hospital, even if highly recommended, was avoided as much as possible, because security escorts would also have to spend the night and that was an added cost. Most individuals spent about a day or two in hospital after surgery, and 8% spent some time in a prison hospital, after serious surgeries, like heart or

brain surgery. Most of the 25% who underwent surgery complained about being given little slack when it came to prison routines (NB: For more on this, see Annex 1 and Annex 2).

b. Accommodation and support for people with disabilities

54% of the participants reported having mobility problems that interfered with their daily activities. Walking (37%) was most commonly interfered with, followed by getting on and off bed (17%), and climbing stairs (37%). 19% of all participants were paraplegic, and hence, unable to move without a wheelchair. I was not able to speak to a number of individuals, despite their desire to be interviewed, because they were bedridden and I was not allowed on their units. Thus, the most disabled individuals did not partake in this study.

Overall, just over 6% of participants received regular help with their mobility issues, and this help was always from a peer assigned as a caregiver. This was also the case at Frontenac Minimum Security (where more than 50% were over 50 and suffered from various disabilities), as well as at Collins Bay Medium Security, Joyceville Medium Security, and Milhaven Maximum Security. Peer caregivers were available in Pittsburgh Minimum Security Institution as well as Warkworth and Bath, both medium security institutions. Where available, peer caregivers were supposed to help individuals transfer between places, help them with cleaning their cells, and sometimes with eating, washing, and dressing. However, there were many reports of caregivers stealing food and medication from their charges, as well as failing to show up on time to take them to appointments or being careless about wheeling them around and helping them clean themselves.

The two biggest challenges for people living with physical disabilities were the lack of access to medical supplies and devices, as well as environmental challenges. For instance, the more conditions an individual suffered from, and the more disabled the individual was, the more demands for health care items he raised. For example, over 30% of those with over 8 conditions had requested health items and were refused; over 27% had asked for items and were granted those items; over 18% had asked for items and the request had been partially granted; while over 23% had never asked for anything else in addition to what they were given by the institution. In contrast, 60% of people who had up to 4 conditions had never asked for anything. However, as a rule, all categories were more likely to be refused items they asked for than to be granted them. The most

in demand items were extra pillows or blankets to deal with poor circulation or hypothermia, a better mattress for back problems, vitamins, and walking aids.

The accessibility afforded by the infrastructure depended on the institution. Aside from Milhaven Maximum Security Institution, all other penitentiaries were double-bunked to varying degrees. The rule was generally that the new comer went on the top bunk. Nobody wanted the top bunk, so a younger roommate was unlikely to make a concession for an elderly cellmate. Where beds were side by side, like at Pittsburgh Minimum, the space was too small to wheel in a wheelchair, for example. Thus, a couple individuals reported having to leave the wheelchair at the door and crawl themselves to the bed.

35% of those interviewed reported having fallen in prison within the prior year, and 19% fell more than twice during the same period of time. This study confirmed that the likelihood of falling was directly related to the number of chronic conditions and mobility problems an individual presented. The majority of those who had fallen within the last 12 months fell in icy conditions. Institutions like Warkworth, Pittsburgh, and Collins Bay are very large, and going outside is mandatory in order to get from one's cell to the pill distribution center, the infirmary, the cafeteria, the canteen, or the programming building. For many, every step taken outside, in winter, is a hazard. Other common falling spots were from the top bunk, on the stairs, and in the shower. For example, Frontenac Minimum Security Institution had all the cells upstairs, while programs and food distribution took place downstairs. Showers and toilets had no accessibility handrails.

It is also worth noting that in all institutions, aside from maximum security institutions, individuals had to pick up their medication in person, often by standing in line for one hour or more. In at least 4 of the 7 institutions the line formed outside, regardless of the weather. I have seen this practice outside the study in many other federal institutions (for instance at Nova Prison for Women in Nova Scotia).

Poor physical health was connected to increased vulnerability. The more physical conditions one was suffering from, the more likely that individual was to be abused by peers (33% of those suffering from 1 to 4 conditions, 57% of those suffering from 5 to 7 conditions, 70% of those suffering from 8 to 16 conditions). The same relation can be noted between physical conditions and staff abuse (40% of those suffering from 1 to 4 conditions have been abused by staff, 50% of those suffering from 5 to 7 conditions, and 64% of those suffering 8 to 16 conditions).

c. Security measures and disciplinary tools

The number of physical conditions seemed to influence or be influenced by the time individuals spent in segregation. The more conditions an individual had, the more likely he was to have spent time in segregation for disciplinary or administrative reasons (21% of those suffering from 1 to 4 conditions, 32% of those suffering from 5 to 7 conditions, and 50% of those suffering from 8 to 16 conditions; in contrast, 24% of those not suffering from 8 to 16 conditions had spent time in segregation).

Instances of mental illness among inmates seemed to be commonly met with disciplinary charges and solitary confinement. The rate of disciplinary incidents was relatively small. About 31% of participants had been charged with disciplinary offences, and most were non-violent. Those who had been punished inside the institution, especially for violent behaviour, tended to report that they suffered from some sort of mental illness; 51% of those reporting mental illnesses reported disciplinary charges versus 34% of those not reporting mental illness.

23% of participants had spent time in segregation since turning 50. It appeared that the mentally ill were more often sent to segregation than their healthier counterparts (36% as opposed to 15%). Those with a mental illness diagnosis were more likely to have been sent to segregation for disciplinary reasons than their healthier counterparts (60% as opposed to 40%). Similarly, of the people who requested segregation for their own safety, the majority reported suffering from a psychiatric condition (73%). It is unclear from the study if segregation was used in response to mental illness or if segregation led to or exacerbated mental illness. It is likely both.

In addition, 70% of participants over 50 in maximum security were held in protective custody. Individuals diagnosed with dementia tended to be housed in higher forms of security. Due to the possibility of being housed in a high security unit, only 5% of people reporting suicidal ideation asked for help. Those who did report it, ended up in observation cells for different periods of time. The issue with isolating individuals in protective custody, mental health units, observation cells etc., is that, even though they have similar consequences as solitary confinement (23h locked in, little programming, limited visits) there is no cap on how long these individuals can be held there (and, indeed, they are held in such spaces for years). For more on this topic, please see Annex 2.

d. Terminal illness in prison

At the time of the interviews, Pittsburgh was housing upwards of 10 terminally or close to terminally ill individuals. I was also informed that one such individual was housed at Milhaven Maximum Security Institution.

While there may have been attempts to provide palliative care in prison on an individual basis, this was seriously restricted by the prisons' security policies. Without a palliative care unit, the prisons faced difficulties administering the kinds of medication available in the outside community to people in similar situations. The lack of a proper palliative care unit also meant that medical staff were not available at all times, there was no special housing for people who were terminally ill or in severe pain, and there was no adjusted infrastructure. None of the institutions I visited had a palliative care unit. In Peterborough, there was a hospice where dying prisoners from Ontario were sometimes sent. Indeed, a number of the participants from Pittsburgh mentioned that prisoners were sometimes sent there to die, though the space was limited, and transfers required a significant amount of paperwork.

For Pittsburgh, the lack of a proper palliative care unit meant that appropriate painkillers were not available, approval was required for any kind of therapeutic intervention including trips to the community (in the CSC steel van) to the hospital for chemotherapy, and limited time with their family. Prisoners would generally be visited at their bedside by spiritual counselors, but their family would not be allowed on the units. Hence, a prisoner's limited mobility made family reunions very difficult.

For Milhaven Maximum Security Institution, palliative care meant day after day spent in a cell in protective custody. One might wonder why a dying prisoner would be subjected to the highest security rules possible. When a prisoner is incarcerated, his risk is assessed based on personal traits and the offence committed. Regardless of anything else, murder scores so high on the risk assessment scale that an individual convicted of murder generally has to spend a number of years in maximum security. Such was the case with the individual terminally ill at Milhaven. While a transfer to a lower level due to illness was in sight, such transfer required paperwork that was not expeditiously completed. In the meantime, the prisoner was confined to a protective custody cell without any kind of end-of-life care.

It is my understanding that since 2015 when the interviews ended, CSC has attempted to improve the lives of terminally ill prisoners by housing many of them in Regional Treatment Centres (RTC) or some Community Correctional Centre (CCC) facility. While this is an improvement, I note that CCCs are not medical facilities, and RTCs are psychiatric facilities. Both are correctional facilities where security continues to trump health care. Further, depending on the region, RTCs or CCCs spots may not be available, and thus, very sick individuals remain in regular prisons.

e. Medical assistance in dying is now available to prisoners

I am separately entering into evidence the proceedings from the End of Life in Prison Satellite Meeting (September 2017, Halifax) (Annex 4), where experts from across the country raised concerns regarding having prisoners decide upon receiving assisted dying while in prison, especially since meaningful palliative care options are not available. Most people agreed that individuals should make decisions regarding their end of life care in the community, where they have access to both palliative care and MAiD. The subsequent CSC policy regarding the implementation of MAiD was not consistent with these discussions. Currently, the whole MAiD process is designed to take place in prison, except the second assessment and the actual medical procedure. Despite CSC's recommendation that compassionate release considered as part of this process, as the current system stands, there is no meaningful option for either release or access to palliative care in the community.

f. Options for release

Half of the study's participants were sentenced to life in prison; about 10% had an indeterminate sentence, and the rest were serving determinate sentences. The majority of people serving life, indeterminate or long sentences were convicted prior to turning 50. Almost half of the participants had already served over 10 years of their current sentence at the time I talked to them, with over 11% having spent between 20 and 29 years in prison, and another 11% having spent over 30 years in prison. Slightly over 33% had not reached their parole date at the time of the interview. Half of this latter percentage, however, had a hearing scheduled within the following year. Only 3% had to wait another 10 years for their first parole eligibility date.

Most of the participants were either eligible for parole at the time of the interview or had already passed their first parole eligibility date. In addition, 19% had their first parole eligibility date over 10 years ago. 24% of the participants had applied for parole in the past (sometimes repeatedly), but were denied. The reasons they reported for being denied were very similar to the reasons people gave for not applying. For example, their ability to fulfill the requirements of their correctional plans was a very big problem. More than half of the people serving life sentences (who made up 50% of the sample) mentioned that they had not completed their correctional plan by their first parole eligibility date, generally because there were no spots available in the mandated programs.

The success of parole applications seemed to be random and unpredictable, and this affects all prison groups. However, circumstances that actually make individuals low risk (disease, age, etc.) do not appear to be systematically taken into account. This disproportionately affects older people, who are less likely to find jobs or to still have support in the community given that half of them have served very long sentences. The reasons why parole applications are rejected point out key institutional shortcomings as release plans (e.g. supporting individuals in finding housing and employment in the community), as well as availability of required programs, are the responsibility of CSC. These matters do not reflect the individual's risk or rehabilitation potential, but the failures of the system. Among other things, such failures lead to low-risk senior prisoners potentially spending longer periods in prison than their younger counterparts.

Despite the fact that 15% of the individuals had been previously paroled and that 18% were less than a year from their statutory release, only 3 people out of the entire sample attended a preparation for release program. When such a program was offered, space was limited and younger people, who were more likely to become productive members of society, were prioritized. Many people also did not think that the programs offered would be of any use. A number of prisoners thought that they should be taught how to use computers, and that upon release they should have already been set up with a bank account, a social insurance number, a health card, and an identification card.

Under the CCRA, there is an option for parole-by exception, meant to ensure that people a) who are terminally ill, b) whose health is incompatible with incarceration, c) whose health is threatened by continued incarceration, or d) who are under an extradition order, are released.

Despite the fact that many of my study's prisoners were very sick, none of the participants had ever heard of parole-by-exception, let alone been encouraged to apply for it by their case managers or other counsellors. On one hand, 60% of the sample (i.e. those serving life or indeterminate sentences) would not be eligible to apply for parole by exception at all. On the other hand, even the 40% of elderly prisoners who could theoretically apply for parole-by-exception would appear to have extreme difficulty in succeeding on a s 121 application. For example, in his 2010-11 Annual Report, the Correctional Investigator addressed the issue of compassionate release in a chapter related to death and dying in prison. He noted that there were 22 requests for parole under s 121 between 2005 and 2010, and that 12 were granted. In addition, there were 21 applications for release by royal prerogative and none was granted. In his 2012-13 report, the Correctional Investigator again examined compassionate release and criticized the fact that "few inmates [are allowed] to die in some semblance of dignity in the community." Additional evidence as to the scarcity of parole-by-exception is the fact that the Federal Court has only heard two judicial reviews of related negative decisions by parole boards. Neither of them were based on a request for release due to medical issues. They were instead grounded in s 121(d), which pertains to release while awaiting deportation.

There are a number of problems with the current provision, which renders it of very little practical use. The provision is poorly regulated; it does not provide for a coherent and expeditious process; and it is unduly restrictive. Those sentenced to life in prison are not eligible to apply, "unless they are terminally ill." Thus, the offence committed – perhaps decades earlier – determines eligibility, not a prisoner's actual health and low-risk status. The Commissioner Directive has indicated that people sentenced to life in prison who are not terminally ill can apply for a Royal Prerogative of Mercy instead. However, according to the Office of the Correctional Investigator, such a release has not been granted to anyone in over 10 years. Individuals not serving life sentences were no more successful in accessing parole by exception. In fact, none of the 197 individuals I interviewed had ever heard of it.

IV. Recommendations for the Committee's Consideration

1. Improve release options for vulnerable individuals

In light of the high needs of vulnerable groups (aging, mentally ill, terminally ill, disabled individuals), the fact that they tend to be at low risk of re-offending, and that their needs are not appropriately met in prisons (and arguably, in some cases, they could never be properly met, as prisons are not, nor should they be, nursing homes), **a substantial reform of the parole system needs to be undertaken**. The criteria taken into account for regular parole needs updating, to reflect the fact that in some cases, program completion and securing a job post release aren't relevant indicators of risk. Rather, health status and age should become significant criteria. Equally, **parole board members should receive training** regarding the realities of old and sick individuals applying for parole and how to apply parole criteria in a flexible manner that accounts for these realities.

Second, **s 121 of the CCRA, parole by exception, needs to become a key avenue for release** in light of the fact that people are being incarcerated for longer time, face long periods of regular parole ineligibility, and are becoming significantly ill during these periods. Regarding how the compassionate release system should be improved, please see my attached article on Compassionate Release (Annex 3). Compassionate release must at the very least become available to everyone, including individuals serving life sentences. Equally, **the Royal Prerogative of Mercy should become substantively available** to individuals whose health is not compatible with the rigors of incarceration.

Finally, considering that people are spending decades removed from communities, they need **significant preparation for release** to ensure successful reintegration. Such preparation will include programming that must be relevant for people who may be old or very sick, and who have entered prison in a different technological era. Equally, these people need to be connected and supported by community organizations. To achieve this, the government must play a more significant role in ensuring that there is space for released individuals in community facilities and that, once released, these individuals receive the health care they need. A joint effort from the federal government and provincial government may be needed for this to be realized.

2. A different approach for the implementation of MAiD is needed

The current approach raises concerns regarding whether, without equal development of release options and palliative care, the availability of MAiD alone transforms a long prison sentence into a death sentence. For recommendations on how MAiD should be implemented to offer a meaningful choice to individuals, I would like to direct you towards the attached recommendations that I wrote based on the discussions carried on at the End of Life Satellite meeting in September 2017. At the very least, **individuals who qualify for MAiD should be released into the community, and be presented with meaningful alternatives regarding their end of life care.** A joint federal-provincial effort should be put in place to ensure that this is feasible.

3. Reform the prison infrastructure and health care system with the aging population in mind

Decarceration of the old and sick should be the main goal of governmental policies. However, people will still get sick in prison, and while they are there they need more appropriate health care. For a compact set of recommendations on how a systemic reform may be achieved, please see my attached article on Chronic Issues in Prison (Annex 1). To summarize, these recommendations focus on the fact that the **number of medical personnel must be increased** to reduce wait times and increase quality of care, **a wider range of medication is needed, staff training must be updated to reflect knowledge in geriatric issues, as well as mental health, terminal and chronic health problems** etc. In addition, **programs relevant for older individuals must be introduced, and these programs must have enough space available for everyone who needs them.** Finally, **old and/or sick individuals should never be double bunked, and should never serve time in institutions where the infrastructure is inadequate** (i.e. stairs, large spaces that need to be crossed in a limited time, prisons where individuals have to wait outside to receive their medication).

4. Segregation of any type must be prohibited for sick individuals

There is significant evidence that isolation increases health problems. There is also evidence that the higher the form of security and accompanying isolation, the less likely individuals are to receive needed health care, appropriate programming, and to have substantial access to release.

Appropriately meeting health needs and fostering rehabilitation is the opposite of holding people in solitary confinement, protective custody, or observation cells. There is evidence that people suffering from dementia or mental illness, and Aboriginal people, are frequently housed in such facilities. All of these characteristics overlap with aging individuals. Other ways of ensuring the safety of these individuals, while promoting their social and health needs, must be developed. Specific attention should be focused on release and community options for these individuals.