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Health impacts of the Safe Streets and Communities Act (Bill C-10)

Responding to Mandatory Minimum Sentencing

Joshua Lau, MPH, Dr. Ruth Elwood Martin
Collaborating Centre for Prison Health and Education
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Acronyms

MMS - Mandatory minimum sentencing

SDH - Social determinants of health

CCPHE - Collaborating Centre for Prison Health and Education

CBR - Community based research

YCJA - Youth Criminal Justice Act

IDU - Injection drug use

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THE VIEWS EXPRESSED IN THIS PAPER ARE THOSE OF THE AUTHORS AND DO NOT NECESSARILY REPRESENT THE VIEWS OF THE COLLABORATING CENTRE FOR PRISON HEALTH AND EDUCATION.

SECTION I: INTRODUCTION

Purpose

The purpose of this report is:

- To emphasize a social determinants of health (SDH) perspective when attempting to achieve meaningful crime reduction for individuals with incarceration experience. Evidence suggests that unmet health and social needs can result in perpetual crime.
- To understand how mandatory minimum sentencing (MMS) in former Bill C-10 (now enacted into the Criminal Code) will negatively impact the SDH for the most vulnerable groups of the Canadian prison population, which may result in increased criminal activity and recidivism.

Goal

This section will be tailored to the audience for which the report is made:

1. Government: To persuade officials that MMS does not benefit public interest or the incarcerated individual, who will most likely return back to the community after serving their sentence.
2. Journal: To discuss how MMS negatively impacts health
3. Partners and community organization: To discuss the evidence of negative health impacts associated with MMS to lobby for policy changes.
4. CCPHE: To use this report to initiative discussion on other prison health policies requiring reform.

Definitions

This report is based two definitions of health, borrowed from the World Health Organization and the 1986 Ottawa Charter for Health Promotion. The former defines health as "…a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity"(1) while the latter states that health is "…a resource for everyday life, not the objective of living" (2). The recognition that health is multifaceted, and not just physical, is paramount in prison health.

This can be seen in Table 1 which lists the SDH, all of which influence health but are not directly related. These factors should be examined when implementing changes to the criminal code. For instance, a lack of education makes employment more difficult. This leads to changes in financial income which can affect the ability to purchase food and housing. Furthermore, many inmates experienced adverse childhood events such as physical and/or sexual abuse, poverty and addiction, all of which can alter the trajectory of good health. By examining crime through this lens we are better able to address the roots of deviant behaviour and create solutions that rehabilitate offenders, not punish them.

Table 1: The Social Determinants of Health (3)

1. Stress, Bodies, and Illness
2. Income and Income Distribution
3. Education
4. Unemployment and Job Security
5. Employment and Working Conditions
6. Early Childhood Development
7. Food Insecurity
8. Housing
9. Social Exclusion
10. Social Safety Net
11. Health Services
12. Aboriginal Status
13. Gender
14. Race
15. Disability

Principles and values of The Collaborating Centre for Prison Health and Education
The values that guide this report are:

"Respect, trust, inclusion, compassion, empowerment, voice and agency, collaboration, integration, community development, ethical and caring relationships, research with meaningful outcomes, multi-disciplinary, recognition of varied experiences and differing modes of inquiry, reciprocal learning, (w)holistic and ethical ways of engagement" (4).

Methodology

Evidence cited in this report was gathered from a variety of sources: academic and grey literature, policy briefs, government websites, advocacy groups and the news. All documents are accessible through online databases or websites. Key word searches include "incarceration", "health", "crime" and "mandatory minimum sentence". Analysis was conducted by examining relevant interest groups and making recommendations based on the findings in the literature.

SECTION II: BACKGROUND

What is Bill C-10?

On June 3rd 2011, the Conservative government's Speech from the Throne promised to alter crime laws within 100 sittings days of Parliament to ensure harsher sentencing for those involved in criminal activity (5). This "tough on crime" approach was actualized when Minster of Justice, Rob Nicholson, proposed Bill C-10 to the House of Commons. As a compilation of nine other pieces of legislation, this omnibus bill was aptly named *the Safe Streets and Communities Act.*

However, Bill C-10 has garnered controversial attention from political (6), health (7) and legal communities (8). In short, increased MMS aims to reduce sentencing disparities so prison terms can be uniformly applied to all law breakers. It automatically applies the minimum sentence and disregards the unique circumstance in which the offence took place.

All of the bills listed in Table 1 were proposed in previous Parliamentary sessions, but failed to pass due to the minority government (9). Despite research evidence showing the adverse impact of MMS on the American justice system, *the Safe Streets and Communities Act* was given royal assent on March 13, 2012.

Table 1: Adapted from the Ministry of Justice website (10)

Title:	**Previously proposed as:**
1. The Protecting Children from Sexual Predators Act	Bill C-54
2. The Penalties for Organized Drug Crime Act	Bill S-10
3. The Protecting the Public from Violent Young Offenders	Bill C-4
4. The Ending House Arrest for Property and Other	Bill C-16
5. The Increasing Offender Accountability Act	Bill C-39
6. The Eliminating Pardons for Serious Crimes Act	Bill C-23B
7. The Keeping Canadians Safe (International Transfer of Offenders) Act	Bill C-5
8. The Justice for Victims of Terrorism Act	Bill S-7
9. The Preventing the Trafficking, Abuse and Exploitation of Vulnerable Immigrants Act	Bill C-56

What are the main policy problems in Bill C-10?

Careful examination reveals that the logic behind MMS is flawed. Proponents suggest that if individuals know the penalties beforehand they will be deterred from committing crime. The problem with this rationale is that it assumes all crimes are premeditated and that individuals have the capacity to weight the associated costs and benefits (11,12). This is not the case, as many individuals suffer from mental health or addiction problems that compromise their decision making abilities. For example, studies have also shown that offenders do not discriminate between sentences of three years and five years when considering the punitive consequences of their actions (12). This demonstrates that severity is not always appropriately weighed. Lastly, MMS ignores the fact that there are numerous individuals who are willing to replace front line drug dealers when they are arrested (11).

Additionally, American states such as Michigan, New York and California have already shown that MMS is ineffective. Incarceration rates increased six to ten fold when these policies were implemented and there is little evidence to show it actually reduced crime (11). We could expect to observe similar trends in Canada if this approach is employed. Stripping the judicial system of its discretion may also be met with resistance, as illustrated by the recent refusal of a superior court judge, Anne Molloy, to apply the MMS for a case involving the negligent possession of firearms (13).

The Conservative government has also not been transparent about the fiscal impact of Bill C-10. It currently costs $65,000 to $130,000 a year to incarcerate an individual, and this number is expected to grow (14). Projections the Parliamentary Budget Office predict that the federal government would be paying an additional $8 million and the provincial and territorial governments paying and extra $137 million after Bill C-10 is passed (15). Moreover, a recent study the Quebec Institute for Socio-economic Research and Information has shown that the increased cost for prison expansion associated with C-10 was $14 billion (16). Therefore, it would be a far better use of public resources if funds were directed towards addressing the determinants of crime and health, in order to prevent offending in the first place, rather than focussing on increased incarceration.

Bill C-10 also has other legal complications. It could conflict with the Canadian Charter of Rights and Freedoms because unreasonable MMS may not be proportional to the weight of the offence. Therefore it would be subjecting the accused to "cruel and unusual treatment or punishment" (17). For instance, producing just six marijuana plants is enough for a judge to apply the MMS. Furthermore, the increase in the number of arrests could overwhelm the court system leading to longer wait times for sentencing (18). This could result in more people having their rights infringed because they were not "tried within a reasonable amount of time" (17). This is legally known as the Askov Ruling, in which court hearings are delayed due to institutional problems.

Why is it important to address the issues raised in Bill C-10?

Passing Bill C-10 has both health and social impacts. Research has shown that prisoners, compared with the general population, have poorer physical and mental health which only further contributes to their criminal activity when they are released from prison (19,20). (20)While the vision of the Health Services Sector of Correctional Service Canada is "improved offender health that contributes to the safety of Canadians" (21), passing a bill that increases mandatory minimum sentences will do just the opposite and will not improve public safety. Currently, Canadian prisons do not deliver continuity of health care or continuity of social services such as counselling, mother-baby programs and harm reduction strategies. All of these services would enable inmates to successfully transition back into the community. Therefore, harsher sentencing coupled with a lack of prison reform fails to address the relationship between poor physical/mental health and criminal behaviour.

Vulnerable subgroups such as women and their children, youth, the elderly and Aboriginals will suffer under MMS. For instance, incarcerating women adversely impacts health because of infrequent contact with family members and cohabitating with other drug using and mentally ill inmates (22). Overcrowding prisons will also contribute to the increased risk of communicable disease transmission through coerced sex and needle sharing (19). Therefore, increasing MMS will further exacerbate these health outcomes because of the prolonged exposure to the incarceration experience, which will perpetuate the cycle of recidivism.

However, this is not to say that the prison system should be done away with. There are many factors that need to be considered when determining the balance between punitive and rehabilitative measures. For example, imprisonment can deter crime, however, this tends to work best for first time offenders and is less effective for repeat offenders (12,23). It can also be effective at deterring certain types of criminal acts. One study showed that arrests were effective at preventing burglary, but not larceny (12,24). This underscores the need to allow the judicial system to exercise sentencing discretion as there is no "one size fits all" approach to the justice system, something that Bill C-10 fails to recognize.

SECTION III: IMPACT OF MANDATORY MINIMUM SENTENCING IN BILL-C10 FROM A HEALTH PERSPECTIVE

What are the health problems associated with incarceration?

KEY MESSAGE: Incarceration negatively impacts emotional, psychological and physical health.

Incarceration has been shown to increase an inmate's physical and mental distress (25). The literature has cited numerous reasons for this including overcrowding, risky sexual activity, inability to access sterile drug paraphernalia, and the traumatic nature of the prison experience itself (26). Of particular concern to public health is the psychological impact it has on inmates.

In his article "Incarceration as Exposure", Massoglia discusses the notion of primary and secondary stressors (25,27). Primary stressors are experiences which significantly disrupt daily life. In the context of crime, this would be the experience of arrest and imprisonment. As primary stress ripples outward it causes secondary stressors to precipitate, including the inability to provide for one's family, stigma associated with the criminal label and the lowering of social class. In the long term, exposure to chronic stress suppresses the body's immunological response resulting in greater susceptibility to disease.

This is not merely anecdotal evidence, as it is supported by the field of psychoneuroimmunology that examines the interplay between psychological stress and biological responses (28,29). For instance, a Japanese study demonstrated that mental stress was associated with coronary heart disease (30). These results were corroborated in a large cross cultural study that examined 11,119 patients who suffered a heart attack. These individuals experienced more work, home and life related stress compared to a matched control group (31). These findings are relevant to the incarcerated population given that inmates are four times as likely be diagnosed with hypertension and twice as likely to be diagnosed with heart problems (25). Therefore correctional facilities should offer incarcerated men and women training to cope with stress.

Susceptibility to infectious disease is also amplified in prisons. According to survey conducted by Correctional Service Canada in 2007 of federal inmates, approximately 5% of men and 8% of women reported positive HIV status; similarly, 31% of men and 37% of women reported positive hepatitis C status (32). This survey also questioned inmates about their risk taking behaviours, namely, sexual activity and injection drug use (IDU) while incarcerated. Reported IDU was 22% for men and 29% for women, with a vast majority of both genders engaging in sexual activity during imprisonment (>80%). These statistics are particularly worrisome because it illustrates that greater risk of acquiring a communicable disease in prison than in the community (33–35).

Prison leavers also face a myriad of health problems after their release. One crisis is the heightened risk of death. Data from the United States show that prison leavers are twelve times as likely to die in the first two weeks upon release (36). A main cause of death is drug overdose. When returned to the community, many former inmates will drug seek and overestimate their ability to tolerate substances. This results in an overdose death rate that is 129 times greater than the general population. Another problem is the lack of health care service continuity, known internationally as "throughcare" (37). For example, in the three year follow-up of a cancer screening project in a Canadian prison, only 50% of women received pap smears (38). This showed that many women did not continue regular screening. Data from Vancouver, Canada, also showed that HIV infected inmates had two times the odds of non-adherence to anti-retrovirals upon leaving prison (39).

As a result of these negative health implications, the World Health Organization issued the Moscow Declaration which states the importance of prison health in the public health system. Key elements in this declaration include the need for prison health services to be of comparable standards to those found in the community, focussing on preventing the spread of HIV/AIDS and tuberculosis, and the need for inter-sectoral collaboration in achieving these goals (40).

Who is affected by the policy implications of Bill C-10?

1. Women and their children

KEY MESSAGE: Women, specifically mothers, have gender specific needs that are different from men. Correctional policies need to be altered to reflect this.

In Canada, women represent a small percentage of the total prison population, namely 6% of provincial inmates and 4% of federal inmates (41). Women are usually arrested for non-violent theft, assault, property crime and fraud. Because of their relatively small percentage compared to the male population, correctional services often overlooks the gender specific needs of women. The World Health Organisation's KYIV Declaration outlines the unique challenges faced by women in prisons and seeks to establish international standards that correctional institutions can incorporate into their own policies (42). These include addressing the high prevalence of mental

illness, optimizing reproductive and maternal health, management of HIV/AIDS, and the need for correctional staff to undergo sensitivity training. Unfortunately, Bill C-10 fails to recognize the needs of women and does not incorporate gender specific amendments, which will have consequences for women's health.

Female inmates have needs that are different from the male population, and from women living in the community. For instance, they are more likely to be victims of physical and/or sexual abuse, to use injection drugs, and to engage in self harm (43,44). Upon arrival, they may experience the shock of being forced to live with other drug using or mentally ill inmates. Incarcerated woman are also geographically removed from their town of residence because they must travel large distances to female prisons that are few in number (45). This damages family relationships, especially with young children who are transferred to extended family or foster care. This is compounded by financial constraints which limit the number of opportunities that a mother can see her child.

As such, pregnant mothers and women with small children are particularly vulnerable to extended MMS. Incarcerating mothers has greater negative impacts than incarcerating fathers. This is because babies form immediate attachments to their mothers, who are usually the primary care giver (46). Studies have shown that early skin-to-skin contact promotes mother-baby interactions resulting in less crying and more consistent breastfeeding (47). According to the WHO, it is crucial that babies be breastfed for a minimum of six months to encourage immunological defenses and to obtain nutrients that are absent in infant formula (48). MMS severely disrupts this bonding process and can leave children developmentally disadvantaged causing greater susceptibility to other diseases later in life, such as type II diabetes, hypertension, high cholesterol and obesity (49). It can also cause them to adopt a disorganized attachment style (46). This is the inability to gain sustained attention from a caregiver to have basic needs fulfilled, and can manifest in emotional, psychological and social difficulties, all of which can lead to crime. Evidence suggests that intervening at the maternal level can prevent crime in children, which is why experts suggest taking a holistic family approach to crime reduction (45).

Furthermore, while prison may provide relief from homelessness or abuse, female inmates generally perceive their incarceration experience to be negative because of an inability to exercise agency in their own health (22). Recently, academics been exploring ways to engage women in developing health research that is relevant to their incarceration experience (50). Community based research (CBR) using participatory approaches seeks to involve women at each stage of investigation, and has been shown to be a useful process in developing pertinent research topics. Researchers should view this as a unique opportunity to employ CBR, which is highly effective in creating sustainable relationships and identifying health problems that incarceration tends to exacerbates. Doing so could prove effective at combating the adverse health impacts that will emerge through MMS.

2. Adolescents

KEY MESSAGE: Adverse social condition shape youth criminality.

In Canada, youth between the ages of 12-17 are prosecuted under the Youth Criminal Justice Act (YCJA), which previously took a rehabilitative approach to sentencing (51). As such, it was effective at reducing criminal cases by 30-50% in British Columbia, Ontario, Yukon, Northwest Territories and Newfoundland (52). Concurrent reductions were observed in other provinces. Moreover, the number of youth who were found guilty of crimes also decreased by 10% after its enactment (52). Therefore, this legislation was an effective at balancing punitive and rehabilitative measures before the Bill C-10 amendments.

By contrast, the new changes overemphasize punishment. This was motivated by the Conservative's desire to stress public protection from violent and repeat young offenders, which they feel the previous version of the YCJA lacked. For instance, a violent offence will no longer be restricted to "causing, attempting or threatening to cause bodily harm" (53), but would include any actions that increase the chance of bodily harm. Other notable amendments include placing youth in custody while in remand, sentencing youth as adults for certain criminal acts, publicly identifying youth when they are convicted, and keeping records of warnings and cautions so future penalties will be easier to enforce (53). While the conservatives are trying to keep communities safer, a SDH perspective suggests that this legislation will hinder the justice system's ability to deter crime.

Many young offenders have adverse social conditions that lead them into criminal activity in the first place (54). One study showed that boys residing in underprivileged neighbourhoods have an earlier onset of violent criminal behaviour than those living in privileged communities (55). In the B.C. context, youth in custody report greater incidences of bullying, violence, physical and sexual abuse than other adolescents (56). As a result of these unstable environments they are more likely to have poor chronic and mental health outcomes. This includes depression, anxiety, suicidal tendencies, intentional self injury such as cutting (56), tooth decay, obesity, hypertension and diabetes (57). Because of the barriers to accessing health services, these illnesses are often undiagnosed or are inconsistently treated.

As previously discussed, the social determinants of health and crime were not adequately addressed in this bill. Therefore, it is illogical to direct funds into policing and incarcerating youth. Intervention strategies that address determinants of health in our youth population should be targeted before criminal behaviours emerge, something that C-10 does not do. This will help to hinder future criminality when they enter adulthood and enable them to maximize their health potential so they can contribute to society in productive ways.

3. Seniors

KEY MESSAGE: Seniors require additional material and social resources to cope with the aging process in prison, and even more so when they are released into the community.

Another population that Bill C-10 will impact are the elderly, who are serving long-term or life sentences. In the U.S.A. elderly inmates make up a small proportion of the prison population, and are therefore a low priority for correctional services. This is similar to Canada, however, within the past decade the number of aging offenders has grown by 50% in the federal system (58). Taking into consideration the incoming wave of baby boomers, this figure is expected to increase. As such, there is a great risk of violating their basic human rights because they are treated similarly to younger inmates and are not granted the special healthcare provisions required at their age (59). This can be solved by implementing age specific policies to prevent neglect.

Elderly inmates should have the right to individual cells where they will not have to live with younger, perhaps more violent offenders (something that will naturally occur through overcrowding as a result of Bill C-10) (59). Aging inmates should also be given additional resources, such as blankets and clothing, to stay warm in the winter; and special accommodations should be made for those who are physically disabled, such as wheel chair assistance. Furthermore, older inmates who show aggression or disobedience should be disciplined under alternative rules that acknowledge their deteriorating cognitive faculties.

Furthermore, implementing Bill C-10 will require that prison policies reflect the difference between physiological and chronological age. A problem that is frequently encountered in working with this population is defining who "the aging" are. In other words, if policies for seniors are developed and implemented, at what age should they start to apply? A common threshold is 50 since health problems are considerably more complex at this age. Additionally, experts assert that the stress of incarceration accelerates the aging process compared to younger inmates and those living in the community (60,61). Thus, an inmate's health profile is comparable to someone 10-15 years older (59,62).

Common health problems of aging inmates include Alzheimer's disease, stroke, cancer, dementia, ulcers, heart problems, diabetes, hypertension and deteriorating eyesight and hearing (63). Declining health also requires life-style supports such as hearing aids, eye-glasses, walkers and canes. Because of their illnesses, older inmates require more medical attention from health human resources, which results in greater consumption of the health care budget in prisons. One prison physician in Connecticut stated that half of the aging inmates that he oversaw required an on-call nurse 16 hours a day in order to manage their health problems (59). Examination of a California based prison also showed that many older female prisoners were not able to carry out daily prison activities, such as walking to meals, climbing to top bunks or standing for count (64).

Many older inmates also suffer from mental illness. A study from the UK showed that aging male prisoners suffered from psychiatric problems such as psychosis, neurosis and personality disorder (65). Other evidence points to the fact that over 50% of older male prisoners have moderate depression (66). This could create "institutional dependency" in which prisoners demand more time and effort from staff to have their needs met (63). Some speculate this reflects a loss of social support structures that would enable them to live a healthy lifestyle outside the prison system.

Lastly, because older inmates are less likely to offend and accrue so many health problems while incarcerated (19,67), it raises the question of whether it is a good use of public tax dollars to incarcerate them. In the most extreme cases, offenders suffer from multiple disabilities that would render them physically and/or mentally incapable of harming society. As such, it is important to consider whether older inmates should be offered some form of conditional release (68). Therefore, implementing MMS requires the government to develop concurrent policies that speak to the complex needs of the aging inmate population.

4. Aboriginal peoples

KEY MESSAGE: A history of colonization has severely traumatized Aboriginal peoples, which is indicated by a growing crime rate and poor health.

Even before the proposal of Bill C-10, a progress report on federal corrections observed a growing Aboriginal prison population. From 1998 to 2008, the number of federally sentenced Aboriginals increased 20%, with female Aboriginal inmates increasing dramatically by 131% (69). It is predicted that by 2017 the 20-29 Aboriginal age bracket will increase by 40% in the Canadian population. This is worrisome because this group contains the greatest number of offenders from the Aboriginal community (69). Therefore, their representation in the justice system will be accentuated by Bill C-10.

This bill also fails to recognize the historical and socio-economic factors that underpin criminality in Aboriginal peoples, namely colonization, which has inarguably damaged the cultural fabric of indigenous society. Colonization has caused a "severe disturbance of cultural ways and values" (70), which wounded Aboriginal bodies, minds and spirits. This is exemplified in the breakdown of strong family and community ties, environmental relocation, implementation of residential schools, and devaluation of Aboriginal identity (71,72). As such, these factors have created social environments conducive to ill health. Suicide, drug-use, rape, early childhood abuse and neglect, and increased criminal behaviour are all symptoms of historical trauma (73).

This has implications for Aboriginal health today. For example, Aboriginal HIV infection rates through IDU in Vancouver are double the rate of non-Aboriginals (74), and a greater number of drug users are women who engage in sex work (75). Aboriginals are also at greater

risk of mental illness (76). Therefore, it is important to introduce correctional polices that are culturally and historically sensitive to the pains that indigenous peoples had to endure.

One result of colonization is "post traumatic stress disorder" (PTSD), which has also been reframed as "post traumatic stress response" (PTSR). This is to acknowledge the external effects of colonization, instead of blaming it on internal weakness as implied by the word "disorder" (73). PTSR is defined as a traumatic event that has the capability to induce fear and horror (77). In the Aboriginal context, PTSR is rooted in deculturation through residential schools (73). Its relevance cannot be understated given that 62% of B.C. residential school survivors in a sample of 127 suffer from PTSR (76). PTSR has been linked to other diseases including heart problems, immunological disorders and hormone dysfunction (73). Moreover, those with PTSR develop unhealthy coping mechanisms, such as alcoholism or violent behaviour, which can lead to crime. Conditions worsen when coupled with a lack of monetary and social resources to manage mental and physical illness.

Legal enforcement is ineffective when attempting to regulate crimes related to drug and substance use (78). In the United States MMS for drug crimes dramatically increased the incarceration rate for African-Americans (78,79). The War on Drugs intensified racial disparities in the prison population, often resulting in unequal representation between whites and blacks in the justice system. African-Americans often came from impoverished backgrounds and were frequently subject to greater police surveillance than their white counterparts (26). Racial disparities in Canada's prison population also exist. Aboriginals represent 18% of federally sentenced prisoners, even though they only comprise 4% of the general population. Historical evidence from the United States suggests that harsher sentencing laws would produce similar racial disparities in Canada.

Western biomedicine now recognizes that SDH predicts health outcomes. By contrast, Indigenous perceptions of well-being have always been steeped in the belief that healthy individuals stemmed from healthy communities. As such, it is important that SDH be emphasized when ameliorating the effects of Bill C-10. When Aboriginal men were asked what they needed to lead a crime free lifestyle, many of their answers overlapped with SDH. This included engaging in traditional experiences, maintaining fulfilling education and employment, freedom from prison and stigma, and professional support from doctors, therapists and parole officers (72,80). On a broader level, recent advances to address SDH in Aboriginal peoples include the Transformative Change Accord First Nations Health Plan, which outlines 29 action items to close the health gap between Aboriginals and non-Aboriginals; and the Tripartite First Nations Health Plan which aims to develop a new structure for health care administration (81,82). All of these measures are aimed to reduce the impact of historical trauma.

SECTION IV: KEY RECOMMENDATIONS

Correctional institutions in Canada should consider the following recommendations in their prison policies to alleviate the impact of Bill C-10. Ultimately, inmates should have access to services and knowledge that empower them to live healthy lives in prison and in the community after their release.

General recommendations

A. Canada should be proactive in fostering conditions that prevent crime, not reactive once the offence has already taken place.

- Reduce crime by allocating resources towards improving the SDH. This can be accomplished by address homelessness, unemployment and education disparities in vulnerable and hard-to-reach populations.
- Alternatives to incarceration should be considered for low level, non-violent offenders (83). These include drug treatment courts or community justice programs.

B. Make correctional institutions places of health promotion.

- This can be achieved by reforming prisons to reflect international best practice, such as those endorsed by the World Health Organisation, "Health in Prison Project" (44). Examples include promoting interpersonal/family relationships and healthy nutrition and exercise. Health assessments should be performed upon entry to identify promotional activities that will suit the context of each prison (84).
    - This requires buy-in from all stakeholders including correction services, public health and prison management teams. In addition, this requires specific training for prison managers and correctional officers to develop facilitation skills, in order to foster the inmates individual participation in health promotion processes.
- If health promotion funding is limited, correctional services should engage in innovative and collaborative processes that engage the voice of the participants to reallocate funding. For example, prisons could use a toolkit entitled "A Guide to the Use of Economics in Healthcare Decision Making." This book discusses a framework called Programme Budget and Marginal Analysis (PBMA), which is a collaborative, multi-level approach to resource redistribution (85).

C. "Through-care", which is continuity of healthcare from community to prison and back to the community, should be a well established process in correctional institutes. However, it should also be broadened to include obtaining stable housing, employment and/or education (45).

- Prisons should establish more partnerships between health and social programs in the community.

- Correctional staff should have access to the electronic health records of their inmates so medical histories can be used to properly diagnose illness. Similarly, any treatment obtained in prison should be relayed back health professional in the community upon release.

D. A therapeutic community model should be implemented in all prisons (86). The community is used as the therapeutic instrument and seeks to teach pro-social skills to inmates. This is accomplished by actively involving all prisoners in program development and delivery. The Nanaimo Correctional Centre in BC, Canada, was given the Premier's Innovation and Excellence Award for using this approach, which was able to reduce crime rates after prison release.

Specific recommendations

1. Women and their children

A. All correctional staff should undergo gender sensitivity training, includes a component on substance use and self harm, which is prevalent in the female prison population.

- Furthermore, male correctional staff should not be left alone with women since a high percentage of female inmates have suffered physical and/or sexual abuse from a partner or family member (42).

B. Female inmates should have access to services found in the community. These include pre-natal classes for pregnant women, and counseling for those who have mental illness or are diagnosed with a disease (e.g. cancer, HIV).

C. Incarcerated mothers should be allowed to keep their babies in prison. This is practiced in 22 countries such as England, Wales, Australia, Brazil and Denmark. Children should be allowed to stay up until the age of three (42,87).

- Mothers and babies should also be allowed to share the same room – a practice called "rooming-in". It promotes breastfeeding on demand, and healthy mother-baby interactions (88). Breastfeeding has also been shown to decrease risk of breast and ovarian cancer for the mother (89).

2. Adolescents

A. Treat and manage immediate health problems while youth are in custody. These include infectious disease such as HIV/AIDS and TB; hygienic issues such as scabies or lice; and mental illness and addictions that could stem from traumatic childhoods or poor living conditions (57). Youth should also be immunized to prevent future infection.

B. Provide youth with mentors who can guide them through difficult circumstances. This kind of social support is important in buttressing good mental health and can lead to smoother transitions

to adulthood. It also teaches pro-social skills they may not have learned from guardians at home (56).

C. Youth should be housed in developmentally suitable environments where staff receives training on issues unique to adolescent health, particularly substance use (57).

3. Seniors

A. The physical prison environment needs to be suitable for aging inmates. Allow seniors to occupy living units that are close to meal halls and recreation rooms. They should not be required to climb stairs or bunk beds. Special showering equipment such as rubber mats and handrails should be installed to prevent falls. Extra assistance with personal hygiene may be required (63).

B. Programs need to be tailored to meet the physical and cognitive needs of seniors. Special exercise routines will help prevent chronic diseases that stem from a sedentary lifestyle. Vocational or learning programs should be customized for those who have cognitive challenges (63).

C. Older inmates should be offered parole more often since they are less likely to reoffend and more likely to have adverse health outcomes in prison, compared to younger inmates (63). Those who have a terminal illness or are severely disabled should be considered for compassionate release. If this cannot be granted, prisons should provide hospice and palliative care (90).

D. More multi-method research should be performed on the elderly in Canadian prisons to explore their health experience. This can be achieved by holding focus groups and one-on-one interviews. Prisons may discover varying responses since aging first time offenders have different needs than those who have spent many years in jail (60).

4. Aboriginal peoples

A. Culturally sensitive rehabilitation for Aboriginal peoples is paramount. Any program geared towards this population should be developed in a collaborative and participatory manner. This includes input from Aboriginal inmates, liaison officers, and community members. Universal access to healing lodges should be standard, using a holistic approach with elders, children and nature (69).

B. Prisons can provide the structure necessary to living a healthy life in the community. Aboriginal inmates have identified nine areas that would help them. These include skills to develop healthy relationships, connections to cultural experiences, addictions counseling and establishing a daily routine (91).

C. Successful models of Aboriginal rehabilitation should be applied to inmates from other cultures who experience similar racial disparities in prison. Prisons should be aware of their demographics to ensure programs are culturally sensitive to the people they serve.

Conclusion

Bill C-10 aims to reduce sentencing disparities so that prison terms are uniformly applied to those who violate the law. However, empirical evidence is at odds with these goals. Incarcerating more people for longer periods of time will lead to adverse health impacts for the Canadian public. The recommendations should be used to alleviate its impact on women, youth, seniors and Aboriginal peoples. Future legislation should not ignore the relationship between health and crime, especially because it has the potential to meaningfully reduce criminal activity.

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