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Mixed Reviews: Perceptions of Prison Health Care Delivery in Western Canadian Prisons

William J. Schultz

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Abstract:

Prison health care is often described as sub-standard, and reduces the quality of life for those experiencing incarceration. However, examining incarcerated peoples' perceptions of prison health care reveals specific nuances on the topic. I draw on 587 interviews with incarcerated people and 131 correctional officer interviews, collected as part of the University of Alberta Prisons Project, to detail how incarcerated people perceive prison health care. First, a substantial minority of participants describe prison health care as a positive part of their experience, specifically detailing its impact on substance use and chronic health problems. Second, participants describe gaps in prison health care, with specific focus on medication provision and communication. Finally, participants describe prison health care as a form of capricious governance, which increases the pain of incarceration. Together, these three themes shed light on how prison health care shapes the experiences of incarcerated people.

Introduction

Research describes prison health care as sub-standard, and access is—at best—a significant issue that impacts quality of life for incarcerated people (Novisky et al., 2021). Despite Canada's international reputation for providing universal medical care, incarcerated Canadians suggest accessing health care in prison is still a stressful and negative experience (Iftene, 2019). However, little is known about the health care experiences of incarcerated Canadians, as most research is U.S.-based. While researchers have detailed the health challenges of older men in federal prisons (Iftene, 2019) and have described the challenges previously-incarcerated men experience in accessing health care post-release (Hu et al., 2020; Kouyoumdjian et al., 2018), data on how currently-incarcerated people experience health care is sparse (Novisky et al., 2021). Reflecting this, Canadian research on the topic is dominated by high-level quantitative analyses (Kouyoumdjian et al., 2018), secondary data analysis (Scallan et al., 2021), and small case studies (Iftene, 2019). While research on specific health-related topics exists (Bucerius et al., 2021; Griffin et al., 2023; Paynter et al., 2022), the complexities of negotiating research agreements with correctional officials mean that broader explorations of how prison health care shapes the experiences of incarcerated Canadians are not available. This gap makes it complex to address barriers to health care access in correctional institutions.

In this chapter, I draw on 587 interviews with incarcerated people and 131 interviews with correctional officers (COs), collected as part of the University of Alberta Prisons Project (UAPP), to detail how incarcerated people perceive prison health care. I triangulate these interviews with field notes, participant observation, and reflections from 15 months I spent working as a CO in a provincial prison medical ward. I draw on secondary data collected as part of this study to ask the following research questions: 1. How do incarcerated people describe the

quality of health care they receive? And 2. What impact does the provision of health care have on experiences of incarceration? I begin this chapter with a broad description of how health care is delivered in the broader Canadian context. I then draw on participant interviews to detail three unique themes that incarcerated people shared around prison health care. I conclude with discussion and policy recommendations.

Research context

Since the mid-1960s, Canada has provided subsidized health care for all permanent and temporary residents (Government of Alberta, 2023; Health Canada, 2019). Canadians consider universal health care to be a source of national pride, as well as something that differentiates Canada from the U.S. (Forget, 2002). Debates over health care typically relate to increased costs and the role played by different levels of government. Canada is governed by a federalist system, constitutionally dividing powers between different levels of government. For instance, while the federal government is responsible for making criminal laws and appointing judges, individual provincial governments are responsible for policing, law enforcement, and the operation of courts. One exception to this issue relates to health care, which is a split-jurisdiction issue (Health Canada, 2019). While provincial governments are responsible for managing and delivering health care, the federal government provides half of the funding required through a negotiated health care agreement with the provinces (Health Canada, 2019). In theory, the funding formulas that govern this arrangement ensure that Canadians have equal access to health care across the country. In practice, health care systems vary significantly across different parts of the country, as rich provinces are better able to manage inflation and can provide more infrastructure and higher staff wage, while poorer provinces and territories—which are also typically more remote—struggle to retain health care staff (CBC News, 2023).

Understanding the bifurcated delivery of health care provides important context to discussions around prison medical care. All individuals who serve more than two years in prison are the responsibility of the federal government, while everyone who is remanded[1] or sentenced to less than two years is the responsibility of the provincial governments (Pelvin, 2019). Consequently, Canada has fourteen different prison systems—one for each of the thirteen provinces and territories, and another for the Correctional Service of Canada (or CSC), the federal prison agency operating 43 institutions and 14 community correctional centers across the country (CSC, 2021).

In the most recent data available (2021-2022), Canada had an adult incarceration rate of 106.4/100,000 population, with approximately 40 people per 100,000 housed in the federal system, and the remainder in provincial systems. Comparatively, Canada had an incarceration rate of 127/100,000 in 2018-19, before the COVID-19 pandemic—itself a decrease from previous years (Malakieh, 2020). Overall, CSC prisons had 6,886 total custodial admissions and a daily in-count of 12,394 in 2021/2022, while provincial prisons had 149,921 total custodial admissions (87% of which were men) and an in-count of 20,438 (Statistics Canada, 2022). Over 71% of provincially held individuals were remanded, a status that averages 2-5 days in custody (Malakieh, 2020).

Each of these systems delivers health care to residents differently. Federal penitentiaries have full-time medical staff who are employees of the CSC, and who exclusively provide care to federally incarcerated people (Gisler et al., 2018). Health care is a contentious matter for the CSC, as new policy developments have led to conflicts and controversies. For instance, the CSC is dealing with an aging population of incarcerated residents (Iftene, 2019), as one in four

[1] Held in custody and awaiting trial.

individuals serving a life sentence is now over the age of 50 (Office of the Correctional Investigator & Canadian Human Rights Commission [OIC & CHRC], 2019). This has led to significant logistical challenges, and the CSC has implemented custodial assisted living units and psycho-geriatric units to deal with aging residents. However, there is limited political appetite for reform around this issue, and there does not appear to be a consistent policy on how best to deal with aging individuals serving life sentences (OIC & CHRC, 2019). Consequently, aging offenders represent one of the most significant issues facing the CSC, and the safety and health of older individuals is challenged by the significant levels of violence that occur in federal prisons (Iftene, 2019; Iftene & Manson, 2013).

In contrast, each province provides prison health care in a way that is unique to its setting. Provinces such as Ontario and Quebec—containing 23 million, or 58% of Canada's 40 million residents—deliver health care through dedicated medical systems operated and funded by the prison system. In contrast, provinces including Alberta, British Columbia, and Nova Scotia deliver health care to individuals through the same stand-alone government agencies that delivers health care in the community (Lee et al., 2021). This means that although health care staff work *in* prisons, they do not work *for* prisons. Instead, medical staff are employed by provincial health agencies, are overseen by provincial licensing colleges, and routinely work shifts in both prisons and local hospitals/medical clinics. This design is seen as having advantages in terms of training, efficiency, and access to resources.

Incarcerated Canadians need significant levels of medical care (Kouyoumdjian et al., 2018), and it is well-understood that prisons do not effectively deal with all these issues (Iftene & Manson, 2013). Research on how incarcerated Canadian women experience reproductive health care is scathing, suggesting that prison health care dramatically reduces the overall

wellbeing of incarcerated women (Paynter et al., 2022). Research on the health care experiences of older men is also highly critical, and points out the massive issues faced by incarcerated seniors (Iftene, 2019). However, critiques of prison health care are clouded by research suggesting that certain groups of incarcerated people view prison health care as a significant benefit helping them to address chronic health issues and drug use disorders (Bucerius et al., 2021; Griffin et al., 2023). Overall, these conflicting portraits mean that our picture of how incarcerated Canadians perceive and engage with health care is unclear, and we know little about how individuals' experiences with health care impact their time while incarcerated (Iftene, 2019). Furthermore, while agencies such as the Canadian Human Rights Commission and the Office of the Correctional Investigator routinely publish critical reports about health care in federal prisons, we have almost no insight into provincial institutions (Iftene & Manson, 2013). This is a significant gap, as provincial prisons hold the majority of incarcerated Canadians and are the first point of contact for newly-arrested people suffering health problems (Pelvin, 2019).

Our lack of insight into how health care is delivered in these settings means that recommending any sort of reform on the issue is difficult. Likewise, addressing the shortcomings of prison health care requires a better examination of how incarcerated people engage with and experience health care delivery every day. In the remainder of this chapter, I address these two gaps by drawing on the first-hand perspectives of prison staff and incarcerated people to detail how health care is delivered in one provincial prison system.

Method

I draw the data for this paper from 587 semi-structured interviews conducted with incarcerated people in four provincial prisons in Western Canada, as well as from 131 semi-structured interviews with COs working in the same facilities. These took place as part of the

University of Alberta Prisons Project, a large team-based study involving two principal investigators (PIs) and between four and six graduate research assistants (see Bucerius, Schultz et al., 2023; Schultz et al., 2023; Schultz, 2023 for study protocols).

Each of the four prisons had distinctive characteristics. Rocky View Remand Centre (RVRC)[2] held approximately 1,700 remanded individuals who were awaiting trial. Because of its size, RVRC served as a major hub for most of the prisons in the province where this research took place. It also meant that RVRC served as a crucial provider of health care for people who had recently been arrested and who were consequently withdrawing or needed care for chronic medical issues. Crestwood Remand Institution (CRI) was also a remand center, and although smaller than RVRC (approximately 700 individuals) it also experienced high levels of volatility, especially around in-custody fentanyl overdoses (Bucerius et al., 2023). These two institutions both possessed broad similarities to U.S. jails (Schultz et al., 2021).

The second two institutions were smaller, primarily sentenced facilities. Silverside Correctional Centre (SCC) was a medium-sized sentenced prison, housing approximately 500 remanded and sentenced men and women. SCC experienced less volatility than the remand centers, as individuals were transferred there after being stabilized at RVRC. Finally, Harbor Bay Correctional Centre (HBCC) housed approximately 350 sentenced men. HBCC was the oldest, and the most relaxed, of the four institutions. It had the most experienced group of prison staff in the sample, and officer/incarcerated person interactions were broadly characterized by peacekeeping tactics and the development of productive relationships (Liebling et al., 2011).

Crucially, RVRC and CRI were the only institutions offering 24-hour nursing care, as SCC and HBCC had no medical staff available between 2300 and 0700 hrs. COs dealt with

[2] As part of our research agreement, all location and participant names are pseudonyms.

medical issues that arose during these hours, usually by escorting the incarcerated person in question to hospital emergency rooms. Medical staff transferred individuals requiring close medical supervision to either CRI or RVRC. Consequently, individuals who required overnight medical observation were housed in the remand centers, meaning that minimum-security individuals with health problems could be held in maximum-security health wards until they were well enough to return to the smaller sentenced prisons.

Recruitment and demographics

The UAPP received access to each prison for between 10 and 14 days. Given these time limits, the study PIs assembled a team of themselves and four to six research assistants (one of whom was the author), allowing for more data collection in a shorter period. Typically, individual researchers took responsibility for specific units, building relationships with individuals who worked and lived in those spaces. We recruited participants by making announcements on the living units, explaining who we were, what we were doing, and requesting volunteers to sign up for interviews. Most incarcerated individuals were excited to participate, even though we provided no incentives to do so. Due to the breadth of our invitation, we interviewed 587 participants spread across all four prisons.

Interviews took place one-on-one in private spaces, such as interview rooms on prison units.[3] We gained informed consent and ensured that participants knew that interviews were anonymous. If participants consented (which all but one did), we digitally recorded our discussions. Interviews were one-on-one, and were shaped by an interview guide that asked questions including “What kind of resources do you have access to here?”, and “How are your relationships with prison staff?” The open-ended nature of these questions ensured that we

[3] University of Alberta Research Ethics Board approval Pro00061614.

collected a broad range of data on prison life. Reflecting the grounded theory design of the project (Charmaz, 2014), we also ensured that individuals were able to speak about topics that were relevant to them or that they had specific experience with. Incarcerated people frequently brought up their experiences with prison health care, meaning that this topic emerged as an unexpected finding within our broader study.

Many participants described coming from difficult and contested backgrounds. About 40% of the sample were indigenous and had dealt with extensive forms of historical trauma (Tetrault et al., 2020). Likewise, a disproportionate amount of the individuals who described histories of homelessness, abuse, and life-long system involvement were Indigenous, demonstrating the long-term systemic impact of Canada's colonial histories (Tetrault, 2023).

CO recruitment required a different approach. We initially sent out emails to all staff members, inviting them to participate, and made announcements at pre-shift "muster" briefings. However, few officers responded to these invitations, meaning that we primarily used chain referral, or "snowball sampling" (Biernacki & Waldorf, 1981) to recruit participants. My experience as a correctional officer assisted in this process. Having spent five years as a CO at SCC before entering graduate school, I was able to quickly build rapport with many officers, especially ones who I had worked with (See Schultz, 2022, 2023 for a more detailed discussion). Consequently, I spent most of my time observing COs while the remainder of the research team interviewed incarcerated people. I also collected field notes during this process, as I observed interactions between officers which provided insight into how COs approached their work. These notes included detailed reflections on prison health care, something aided by the 15 months I spent working as a medical officer in SCC's medical department. My fieldnotes helped flesh out concepts which COs and incarcerated people alluded to during interviews (Maxwell, 2013).

Importantly, the health agency who employed prison medical staff did not permit them to participate in interviews.

CO interviews averaged approximately 50 minutes, while incarcerated people's interviews averaged about an hour. Twenty-one officers identified as women, and the remaining 110 identified as men. Of the incarcerated participants, 495 identified as men while 92 identified as women. Forty-eight percent of incarcerated participants identified as White, 39% as Indigenous, and the remaining 13% as Black or other. For officers, ten participants came from visible minority groups, and the remainder of the participants identified as White. This sample is roughly representative of both officer and incarcerated populations in the prisons in question.

Analysis

Our research team transcribed each interview verbatim and assigned randomly generated pseudonyms to individuals and institutions. To ensure analytical rigor when coding and analyzing the data, we drew on the principles and heuristic devices of grounded theory (Charmaz, 2014). The study PIs and four research assistants used basic tabular data to identify themes and to verify the overall strength of patterns in the data. We used the themes emerging from this process to create separate coding schemes for incarcerated people and correctional officers. We tested the respective schemes against 6-10 randomly-chosen interview transcripts to see how closely the coding reflected participant data, and made adjustments to address inconsistencies. After several repetitions of this process, we reached a point where we consistently reached between 85 to 90% overlap on any randomly chosen interview transcript, thereby establishing interrater reliability. Themes relating to health care included "Health Care and Medical," with subthemes including "access" (n=92, with 132 references), "medical staff"

(n=77 with 97 references), “quality of treatment” (n=94, with 141 references), and “medications/prescriptions” (n=147 with 205 references).

Findings

Incarcerated people described positive and negative aspects of the health care they received. While a proportion of the incarcerated population described health care as a benefit, a larger group expressed distinctive complaints around wait times and the provision or non-provision of prescription medication. Overall, these comments led to a range of unique and sometimes contradictory themes, which in aggregate help us understand the broader role that health care plays in organizing modern Canadian prisons.

Positive perceptions of prison health care

A minority of participants (approximately 20%) discussed a positive aspect of incarceration. These individuals were disproportionately drawn from situations of extreme disadvantage, including housing insecurity and domestic violence (Bucerius et al., 2021). These individuals described prison as a “good” place, by which they meant a place where they were able to address the chaotic aspects of their lives (Crewe & Ievins, 2020; Schneider, 2023). Medical access and health care were key features of these narratives. As Margaret (CRI) phrased it, “health care is pretty right on the money. We have a clinic right next door. So, they usually answer your call and you’re there next day.” Arnold (HBCC) agreed: “You know here you got a bed. You get medical attention right and you even get benefits here. You have dental plan, you got healthcare right, access to John Grisham up the ying yang.” Prison staff confirmed these narratives, discussing how they routinely saw individuals get “healthy” and deal with chronic medical issues while incarcerated.

Participants who expressed positive perceptions of institutional health care commonly described short-term imprisonments as comparatively healthy experiences, and described prison as a key location for accessing social supports not always available in the community:

> *Zach (SCC):* Yeah, there's a couple people actually, my last roommate said that he's here [in SCC] because it's cold out, he's homeless and heat and water and all that stuff, and last year I met a guy who said he's just here to sober up.

> *Lisa (SCC):* A lot of these women come in are like 80 years old and the only reason why they're alive is because they come in [to prison] every couple of months. They come in, they get free health care. They get free dental.

Individuals who lacked secure housing routinely brought up health care as a positive aspect of incarceration, something that reflects recent work describing prisons as places of refuge for specific groups of vulnerable individuals (Bucerius et al., 2021; Schneider, 2023). Stories like Zach provides were common, as individuals commonly relied on short prison stays to get health care and escape Canada's notoriously cold winters. As Lisa implies here, such themes were particularly key for incarcerated women, especially those who were escaping abuse. Bucerius et al. (2021) employ the same data set to discuss these themes in detail.

Lisa's comments highlight the importance of in-prison dental care. Dental care and prescription drugs are two major exceptions to Canada's universal health care, and users either pay for such services out-of-pocket or through individual health insurance plans—something rarely available to incarcerated individuals:

> *Interviewer:* I hear that the [medical] services are generally better here?

> *Ethan (SCC)*: Within two weeks, I was in to see the dentist 'cuz I had a tooth that broke at [RVRC], I was waiting to see the dentist, and when I got here I put in a request form, and the next week I was in [to see] the dentist … It got infected and I had to take antibiotics for a week and then he came and pulled it. I showed up November 4th, by the end of November I had the tooth pulled.

While some clinics provide free dental care for indigent people in the community, none of our participants discussed these options, suggesting they did not know about them. Instead, as Ethan's words demonstrate, many incarcerated people tactically used short-term prison sentences to have serious dental health issues addressed for free. Importantly, stories like the one Ethan shares above suggested that "dental care" usually meant having the offending tooth extracted.

Perceptions of prison health care staff.

Such tactical approaches meant that incarcerated people viewed health care staff much differently than COs. Many individuals framed nurses and psychological support workers as sympathetic figures and helpful allies in addressing medical needs. Jayden (CRI), who was recovering from a serious injury, phrased it this way:

> That's one thing that really good down there [in the medical unit], the nurses are good, 'cause they're not guards obviously. You know what I mean, they're actually human beings, they care about their profession … Every day they [health care staff] come check up on me, every day they come see me. Once a day, and if you take meds they will come 3, 4 times a day right. That's one thing, I will give them that. The nurses here and the doctors are really good."

About half of all participants expressed positive perceptions of health care staff, even if they criticized how medical care was delivered generally. Most of these narratives described health

care staff as professional and caring individuals focused on their duties. Participants couched positive perceptions of medical staff in direct contrast to COs, who incarcerated people typically described as unprofessional, jaded, and cynical—something clear in Jayden's discussion here. Incarcerated people frequently drew contrasts between the humanistic approaches of medical staff and security-focused perspectives of COs, even to the extent of qualifying who they would possibly assault. Raphael (RVRC) described why some COs "deserved" to be "punched out," but made a specific exception for health care staff: "I'm not going to lie. I mean some these [CO] pricks deserve it. Not nurses. Some of them are kind of mean, but they're not like the guards though." While individuals like Jayden and Raphael were appreciative of the medical care that they received in prison, the distinctive forms of boundary work they employed to differentiate between themselves and correctional officers (Schultz et al., 2024) contributed to their positive impressions of prison health care.

Incarceration, health care, and drug withdrawal.

Crucially, participants who employed "getting healthy" narratives around incarceration typically connected such comments to substance-related health issues, as most participants had drug use disorders. Drugs were readily available at the remand centers, and we had to cancel multiple interviews at RVRC and CRI because our participants were high (Bucerius, Haggerty et al., 2023). Drugs were far less common at HBCC and SCC, meaning that most individuals we interviewed there had gone through withdrawal and were drug free. While individuals who admitted to drug seeking often spoke scathingly of medical staff, individuals who received medical assistance in dealing with withdrawal symptoms sometimes had a different perspective:

> *Eliza (SCC):* [New individuals on the unit] haven't been straight long enough to care because they're grabbin' dope in RVRC or grabbing dope in here. I think this center

> [SCC] is actually pretty good for not medicating people. Like prescription drugs, they got a list of stuff that is acceptable and a list of stuff that isn't. And if it isn't, you're just not getting it, it doesn't matter how dependent you are on it, they'll give you something to get off of it and you're done. That's it.
>
> *Interviewer*: Like methadone or something?
>
> *Eliza:* Yeah, methadone, there's a few options for that. There's some pills that they can give them for three days that take withdrawal away if they're not serious users. … I think this center's pretty reasonable not to [over-prescribe] you know. Like in RVRC, they're still a little happy [with some of the stuff they prescribe].

Eliza had spent time in many prisons. While she used cocaine and methamphetamine outside of prison, she described intentionally using her time in custody to "dry out" and let her body recover. Incarcerated people commonly shared such stories at HBCC and SCC (Bucerius et al., 2021), and participants suggested control of prescription medication by health care staff played a distinctive role in how "dry" prison units were. In Reid's (HBCC) words, "I needed to go to jail to clean myself up and clear my head … I've been here 13 months and I haven't done any drugs in 9 months." Health care staff who were (in Eliza's words) "a little happy" with prescriptions fed drug seeking behavior and thereby shifted unit dynamics in negative ways for individuals trying to "stay clean." Drug-seeking individuals were deeply hostile to prescription limits, but individuals like Eliza and Reid who perceived incarceration as a chance to "get right" often disagreed, pointing to the positive impacts of sobriety and negative impacts of drugs on unit subcultures (Bucerius et al., 2023).

Negative perceptions of prison health care

While the individuals quoted above shared broadly positive perceptions of prison health care, the large majority of participants (approximately 80%) expressed distinct complaints about their experiences. Complaints varied, but typically focused on quality of care, access and communication, and the management and accessibility of medications.

Quality of care.

First, participants who had experienced serious injuries described prison health care access as limited, sub-standard, and frustrating:

> *Interviewer:* So you broke your leg playing volleyball, and then they brought you to the hospital and the doctor gave you a treatment plan and they just didn't follow it?
>
> *Tristan (CRI):* Yeah, and they gave them like specific instructions of what to do with me. They didn't do that. They only did it once and then they left me alone. I wrote numerous complaints to the healthcare and I got nothing back.
>
> *Interviewer*: Right. So how's your leg now?
>
> *Tristan*: It's messed up, you know.

Individuals like Tristan who were recuperating from serious injuries sometimes suggested that prison medical staff did not do an effective job of caring for major problems. Tristan's complaints here center around the lack of physiotherapy he received after surgery for a broken leg, but many individuals expressed similar complaints for injuries sustained in fights with other incarcerated people or with prison staff, or for treatment of injuries sustained upon arrest. While most individuals stated that they received the minimum level of care required to address their injuries, few suggested that the health care they received was sufficient to fully address the long-term physical consequences of such injuries. For individuals who experienced chronic effects

from their injuries, the limited levels of care available were a source of physical and psychological pain (Crewe, 2011; Sykes, 1957).

Health care access and communication.

Second, most individuals we interviewed—including many with positive perceptions of health care staff—expressed complaints about the health care access system. Individuals described access as limited and managed by significant levels of gate-keeping bureaucracy:

> *Grayson (CRI):* You only get to see a psychiatrist once a month if you're lucky. … he comes in on Tuesdays, [and] I was in court on Tuesday. So if you have court on Tuesday, you never get to see him.
>
> *Interviewer:* Is that the only mental health option you guys have?
>
> *Grayson:* We have psychologists that come in here but they [just] come and talk to ya, which is nothing, I could talk to the wall. So you're on a month long waiting list to see a psychiatrist down there … so what happens if you get court that day, just happened to be your turn? Boom, you don't get seen for a month and you get kicked out on the street.

While SCC and HBCC provided 16-hour nursing care and 24-hour care was available at RVRC and CRI, none of the prisons employed full-time doctors. Instead, prescribing doctors and psychiatrists attended the prison once weekly. To access these services, individuals had to put in health care request forms, go through a screening interview with nurses, and be booked into a clinic date—a process that took weeks, did not consider scheduling, and removed control from incarcerated people. Such bureaucracy was "just annoying, it's a hassle, and it takes too long for them to see you. You put in a request to see the dentist, they won't see you for a couple months, and you have to be pretty much dying for them to see you (Bella, CRI)."

Particular complaints centered on how health care personnel managed requests, as individuals were frustrated by the long periods of time it took to access a doctor or nurse, and often complained that they were unable to have their medical concerns addressed prior to release:

> *Roy (CRI):* I have a really hard time sleeping. Probably get maybe three, four hours a night sleep. I asked the healthcare about it, and they're like, you have to write in a request to a psychiatrist. So I wrote a request for the psychiatrist. They sent me back a package of exercises, and told me I should be doing these exercises to relax and stuff. And I'm like, how am I supposed to do exercises in a cell with three people? And I can't do these exercises and stretches. I have two hernias and the double stomach operation ... It's not possible. Like, can you please see me, so you can assess me, so I can get something to help me sleep at night? And they just never answered me.

Responses to health care requests often depended on nurses' experience and discretion. On high alert for drug-seeking behavior, medical staff used the request system as a means of bureaucratically limiting medical access. Health care staff typically responded to complaints such as "I have a headache" or "I am having trouble sleeping" with written responses such as "drink more water," or provided a generic sleep hygiene package rather than the medical visit and prescription opportunity the writer often hoped to secure. Consequently, a system of informal medical advice emerged on units, as individuals taught each other the most effective ways to describe symptoms on medical request forms to secure in-person appointments. Others lobbied COs, hoping that officer intervention would help them secure appointments. Such actions became a self-reinforcing cycle: COs and health care staff pointed to these actions as evidence of drug seeking behavior, while incarcerated individuals expressed deep frustration about having to constantly prove the legitimacy of every request. Such processes maddened

individuals who did not know how to negotiate the request system, as they often found legitimate requests delayed and dismissed as drug-seeking behavior.

Medication access.

As these quotes imply, many individuals expressed frustrations with how COs and health care staff dealt with prescription medications. Participants suggested that prison and health care administrators viewed all medications through the lens of drug seeking behaviors. As Brent (SCC) phrased it, "No, the most they give me for this [broken arm] is Tylenol. They don't provide anything more, it's 'cause you're an inmate right." Consequently, even individuals with serious injuries were restricted to over-the-counter medications:

> *Flynn (SCC):* They won't give you what you want. I broke my back, I broke my neck. I can't sit [up straight]. I had four surgeries, and I still have to go for some more. Every time I try to tell them [medical staff] something, it's just "put in a request, put in a request." Well, I put in like twenty thousand already and I just put in some more today. … [the]) painkillers they are giving are shit. And they got my prescription and property. All my Tylenols, my Percocets—give me those, they're mine.

As Flynn's comments here show, incarcerated people took issue with how medical treated prescriptions for their physical injuries, especially when such issues were long term and chronic. Drugs that were susceptible to misuse, such as the Tylenol-3 and Percocet Flynn identifies here, were restricted and individuals were instead provided generic painkillers such as ibuprofen.

Such restrictions had consequences, especially for individuals prescribed antidepressants. Many individuals had their prescriptions suddenly changed upon prison admission:

> *Hank (SCC):* I was started on anti-depressants … the medications they put me on, I've never been on 'em before, they wouldn't [let me have] the ones I was on on the street.

> Because somebody somewhere cheeked [diverted] ‘em and snorted ‘em or whatever, but I’ve been on ‘em institutionally [in prisons] for 5 years and never had an issue, but all of a sudden I come to [this prison] and it’s an issue, I can’t have my medication anymore. So they’re screwing with my meds…. nobody cares.

Shifts in long-term prescriptions were particularly troublesome for individuals like Hank, who was prescribed anti-depressants that were susceptible to misuse. Anti-depressants often require weeks or months of trials to effectively target a specific medication and dosage that helps manage symptoms. Consequently, suddenly removing or changing a specific prescription—or, as Hank phrases it, “screwing with” an individual’s meds—often had serious impacts on individual wellness, creating more stress for individuals already struggling with mental health issues.

Many participants agreed that some health care requests disguised drug seeking behaviors. Brad (CRI) described this in graphic terms: “Guys are medicated and shit. One thing about this place is they fuckin feed you, pump you with meds. By the time you get out your head is looped out. It’s crazy. Antidepressants and all kinds of shit, it’s crazy. These guys they’ll medicate and get high.” Officer Steven (SCC) agreed, stating that “inmates have always tried to cheat their medication or hoard their medication.” Many individuals criticized individuals looking for unnecessary medication, suggesting they clogged up the request system. Furthermore, drug-seeking became the primary lens staff used to interpret health care requests, meaning that individuals with genuine medical needs were cut off from important medications due to prison security logics:

> *Leon (HBCC):* I have nitroglycerine on the outs for my heart, in here I can’t get my [nitroglycerine], it’s in my property … a lot of people abuse that medication so when I came here they pretty much just took me off it. I was like “I can’t be taken off it,” they go

> "oh well too bad" that's pretty much what the tell me, you're going to take me off my fucking heart medication and I've been off it my whole bit.

COs and nurses were quick to describe individuals like Leon as "drug seekers," implying that genuine medical requests were simply efforts to secure drugs which could either be abused or diverted and sold to other individuals. As Officer Liam (HBCC) described, "If we give them self-meds they'll abuse their self meds. They'll try to crush them up and snort them and then they get taken away." Consequently, individuals like Leon—who was prescribed nitroglycerine for angina and had taken this medication outside of prison for years—found themselves cut from a drug that helped them manage serious health concerns.

Health care as capricious governance

Perspectives on health care varied, especially when it came to medications. However, regardless of how individuals viewed prison staff and the delivery of medical care, many participants described experiences with prison health care as a form of capricious governance, implicitly reinforcing their losses of autonomy and liberty (Sykes, 1958). Health care was unpredictable, bureaucratic, varied in quality, and distinctively reflected the broader carceral logics of prison. As Eli (HBCC) phrased it, "[health care] gets frustrating, but then you also have to realize you're not the only person in here that needs medical attention. So, sometimes, like I said, it gets frustrating 'cause you don't get an answer like you expect to." Incarcerated people described such frustrations as another form of punishment, reflecting the punitive nature of the prisons they resided in (Crewe, 2011; Sykes, 1958).

Incarcerated people described interpersonal interactions, communication, and medication access as contributing to this sense of capricious governance. Medical access was demeaning for incarcerated people, who suggested that 'inmate' labels served as master statuses shaping how

health care staff perceived them and their requests (Becker, 1963; Hughes, 1945). As Gilbert (HBCC) described, "all you are in here is just a number, even to the guards, the nurses or whoever runs this jail. All you are is a number. They don't care if you get killed, just one less inmate, that's what they want." Examples of ill-treatment were widely shared among individuals on units, increasing tension between incarcerated people, medical staff, and COs:

> *Nicholas (RVRC):* It's ingrained in their head that it's their job to punish us. Which is ridiculous. That's not their job. You know? So they take it upon themselves to do that, mentally, physically, when they can … It's the whole prison system. Shit runs downhill. If somebody in the medical staff says this guy's bad, he's going to get punished somehow, through the COs or somebody else.

Narratives such as Nicholas describes were common. Even individuals who had positive perceptions of health care qualified such descriptions by describing how it acted as a feature of imprisonment. As Nicholas demonstrates, health care staff—who were not employees of the prison—often enacted punitive attitudes toward incarcerated people, and sided with the COs who guaranteed their safety. COs, in turn, disciplined individuals for any perceived rudeness to medical staff. Consequently, incarcerated people described learning how to perform the "correct" level of humility and respect in their health care interactions, thereby reinforcing their subordinate status within the institution (Goffman, 1959; Hughes, 1945). While humiliating and painful (Sykes, 1958), such tactics increased health care access and reduced the likelihood of formal or informal punishment from either COs or medical personnel.

The unpredictability and opacity of health care communication reinforced incarcerated peoples' subordinate role. Participants suggested that they often did not understand the instructions they had received about how to access medical care and prescriptions:

> *Roy (CRI):* [My hernias] can be pretty painful, right? I have two of them, and they won't give me anything. And they won't even see me. They don't even care. They'll give you Motrin, but you have to like push your call button for it. And you have to time it right, because they only do bed rounds three times a day. And you have to ask like an hour, or two hours before the bed[time] rounds show up. But if you ask too early, the guards won't put you down. So you have like an hour window to ask in, three times a day, but you have no clock so you have to guess the time kind of.

Roy demonstrates the difficulties many incarcerated people experienced. He was prescribed ibuprofen as needed for his hernias but had to place requests with the COs on his unit each time he wanted to receive it. The COs would then forward his request to the nurses, who brought the medication to the units at the prescribed moment. However, the nurses called at unpredictable times, meaning that if Roy forgot to ask for medication or was not on the unit at the right moment, he would not receive his medication. Such frustrations were exacerbated by inconsistent communication with nurses, and the fact that often-unsympathetic COs acted as a buffer between medical staff and incarcerated people. Consequently, participants were unable to directly address medical questions without going through the request procedures:

> *Interviewer:* How is that for you guys, do you usually get the same answer?
>
> *Kai (HBCC):* No never, you don't even get the same answers from the nurses. One person says you have to send in a write up to get your Tylenols in the evening and the next nurse is like "Why are you writing this up!", yelling at you for it, and telling you not to do it the next day.

Inconsistencies like Kai describes were common, as nurses often took individualized approaches to specific issues. Furthermore, if a nurse or CO did not have time or desire to explain a specific

issue, they consistently told individuals to "put in a request," regardless of necessity. Such approaches routinely created misunderstandings like Kai describes here.

Miscommunications were common given the hundreds of requests medical staff received each day. However, participants suggested they had little recourse to address confusing responses, meaning that such inconsistencies constantly reinforced the stigma of incarceration (Becker, 1963). This was especially the case when it came to medications:

> *Brent (SCC):* The nurses, most of them are pretty cool, they're pretty decent. That's not the issue. It's the higher ups in the system that are the problem. They set stupid rules, stupid regulations that don't fit health care. They worry about a person cheeking [diverting] a med and giving it to somebody else. Well, I can tell you for sure I ain't doing that, right. That would make absolutely no sense in the world. But that's what they're concerned about, they're concerned about a little bit of a safety issue and not a health care issue.

As Brent suggests, individuals who choose to divert medications for sale or alternative use created trouble for individuals who used medications appropriately, as institutional staff often used examples of abuse to eliminate a medication from the prison setting. For example, individuals at SCC referred to a 2010 incident where an individual overdosed on diverted OxyContin. In the wake of this incident, medical and prison administrators eliminated all access to opioids, leaving individuals like Brent to suffer from painful withdrawal symptoms with little explanation. While individuals expressed reluctant understanding of the security logics behind the institutions' approach to prescription control, many framed the blanket removal of certain medications as another capricious form of punishment reducing their quality of life.

The complexity and unpredictability of health care constantly reinforced individuals' lack of autonomy (Sykes, 1958):

> *Wyatt (CRI):* [As for] medical—the big issue is the staff don't seem to give a shit. I don't know if it's personality, guys that don't fit in anywhere else and they ship [them] here, or maybe their policies are just so tight they can't do anything and they get pissed off about it. But at the end of the day [incarcerated] guys just get so worried about it. They can't help them. It gets frustrating cause there's just a wall, there's nothing you could do about it, there's no accountability, you can't talk to anyone about it.

Crewe has described the bureaucratic nature of modern prisons, specifically the "tightness" of having to comply with unpredictable and sometimes unexplained policies, as a distinctive form of pain that impacts how individuals experience incarceration (2011, p. 522). As Wyatt's comments here suggest, health care access became a distinctive form of "tightness" for participants, as the constant and constricting unpredictability of whether or not medical concerns would be addressed drove individuals to greater and greater levels of frustration (Crewe, 2011). Consequently, restricted health care access created forms of pain and discomfort above and beyond the day-to-day experience of custody. The inconsistencies that often characterize bureaucratic communication metastasized within participants' narratives, leading them to reframe health care as a capricious and painful feature of their lives (Rennie & Crewe, 2022).

Discussion

Incarcerated people in these data express a broad range of contradictory opinions about the health care they receive. These perspectives are linked with other social problems, something demonstrated by participants who expressed positive perceptions of health care and described using incarceration to deal with chronic health care issues. While prison health care may have

played a meaningful role in helping to promote their overall wellbeing, this is not a celebration of the care provided by prisons. Rather, this finding reflects prisons' nature as ambidextrous, or Janus-faced institutions (Barker, 2012; Peck, 2010; Wacquant, 2013), ones that punish with the harsh 'right hand' of the state while simultaneously providing social support and health care with the softer, more caring 'left hand' of the state. Individuals who described positive aspects of prison health care often went on to describe experiences of abuse, homelessness, extreme drug use, and poverty, consistently demonstrating how they had fallen through the social safety net. For these individuals, incarceration represented their best opportunity to access social services (Bucerius et al., 2021). Such narratives demonstrate that gaps in social safety nets are by no means unique to the United States and represent a larger problem in socialist democracies than is often discussed (Barker, 2012; Schneider, 2023).

We can also see larger problems in how individuals critique prison health care. Many individuals suggested that the scope of the health care needs they presented were far greater than other members of the community, due to chronic health issues and injuries sustained during arrests or prison/street disputes. Participants described genuine problems in the care they received and suggested that they suffered more than needed due to the limited scope of health care available in prison. Overall, these individuals suggested that prison health care failed them, especially when serious issues were minimized via slow and bureaucratic paperwork processes.

Prison staff hotly disagreed with these points, and suggested that the larger problem was ignorance about health care delivery both in and outside of prisons, especially when relating to quality of care. Licensed nurses and doctors provided the same level of care to incarcerated people as they did to their patients in the community. Any failure to meet these standards led to official discipline from licensing college disciplinary boards, something nurses and doctors

emphatically highlighted in off-the-record conversations with me. Supporting this, medical staff told me that health care wait times were shorter in prison than they were in the community, and suggested that "whiners" were simply unaware of the systemic challenges facing Canada's overextended health care system (CBC News, 2023). Health care workers also underscored that incarcerated people had direct access to an independent government ombuds office, which possessed a muscular mandate to investigate any form of mistreatment. COs posted the ombuds complaint phone number on prison units and referred individuals to it when necessary—something I experienced during my time as a CO, when I was interviewed by the provincial ombudsperson and their legal team during a surprise inspection of the medical unit where I worked.

Institutional staff were quick to downplay individual complaints, but these narratives simultaneously highlight the role poor communication between incarcerated people and prison staff plays in shaping access to prison health care. Rather than address knowledge gaps about health care access, COs sometimes exacerbated misunderstandings by serving as hostile gatekeepers. By referring every medical question to the health care request system, rather than assisting with education, COs maintained barriers to effective health care by reducing access to the services necessary. Likewise, by treating every health care request as a form of drug seeking behavior, COs and medical staff drove home the importance of labels and the loss of autonomy that characterized incarceration (Becker, 1963; Hughes, 1945; Sykes, 1958). COs' impacts on health care are obvious in how participants discuss relationships with health care staff, as incarcerated people directly contrasted the human-centered relationships they had with nurses to the hostile relationships they had with COs.

Policy recommendations

The complex nature of relationships in prison drive home the capricious nature of institutional health care delivery, and provide us with several policy insights. First, the lack of individual autonomy and the importance of following confusing bureaucratic requirements with a minimum of instruction or direction (Crewe, 2011; Rennie & Crewe, 2022) ensures that health care access became yet another form of punishment for incarcerated individuals, who experienced distinctive forms of pain in trying to have their medical complaints dealt with (Sykes, 1958). While health care systems obviously require some sort of sorting process, the request system described here created massive amounts of frustration and anger for incarcerated people, something that unsympathetic COs exacerbated. Understanding that incarcerated people experience prison health care as a form of capricious governance—one that forces individuals to perform the 'correct' attitudes and comply with bureaucratic requirements in order to have their needs met (Goffman, 1959)—helps contextualize many of the complaints participants expressed about medical care. Addressing this may be as simple as increasing the clarity and consistency of health care messaging and education to incarcerated people, and reinforcing that COs need to take an active and supportive role in facilitating health care communication.

Second, considering health care as a form of governance also highlights the potential utility of having medical care delivered by an outside agency, as the positive relationships individuals reported with health care staff suggests that such approaches may help to reduce the negative experiences of incarceration. Likewise, prison staff suggested that having external medical administrators in charge of health care ensured that patient care was always the primary goal, even when this was not clear to incarcerated people. Considering the relationships between prison administrators and health care professionals seems like an obvious policy implication.

Third, prison administrators should consider how their policies impact the roughly 20% of participants who actively seek out health care and social services while incarcerated. A growing body of research describes prison as a place that indigent people regularly use to access uninterrupted services, and suggest that prison fills a social services gap for high-needs individuals (Bucerius et al., 2021; Crewe & Ievans, 2020; Schneider, 2023). Framing policies that consider how prison health care benefits substantial sub-populations of the prison, and creating specific policy outcomes designed to help these individuals effectively access services outside of prison seems like an obvious policy opportunity. Done correctly, social work-style interventions designed to help people find community resources before incarceration may even help to reduce overall prison populations.

Finally, this chapter demonstrates the crucial role drugs and prescriptions play in shaping perceptions of health care in custody, something that is a crucial policy implication. Bucerius et al. (2023) have recently called for drugs to serve as a central analytical lens for examining every aspect of incarceration:

> [A] profitable methodological dictate for prison sociologists is to "follow the drugs." While literally impossible (and ill-advised), this axiom highlights how foregrounding the diversity of a prison's drug situation will lead analysts into almost every facet of the institution (Bucerius et al., 2023, p. 34).

While Bucerius et al.'s thesis centers on street drugs rather than prescription medications, the central role of prescriptions in shaping how individuals perceive and experience health care provides strong support for this argument. It is impossible to ignore how the implicit role of addiction and explicit role of prescriptions shape perceptions of health care—and if anything, the quotes presented here under-estimate how important prescriptions were, as literally hundreds of

participants expressed complaints about how the prison health care system dealt with medications. Many of the complaints that participants described relate to restrictions imposed by the security apparatus on the health care providers inside prison, suggesting the most significant part of this problem relates to broader penal logics around drugs (Giffin et al., 2023). However, the broader impact of Bucerius et al.'s (2023) argument is clear: examining the role of drugs and prescription medications in prison serves as a compelling lens to understand the broader provision of prison health care, with unique theoretical implications. Given the descriptive nature of this chapter, a closer examination of these issues seems like an obvious area for both future research and for broader policy innovation around how prison health care is delivered.

Limitations

These data emerged as a secondary finding in a larger project, meaning that a more systematic effort to collect data about health care would find deeper nuances in terms of how individuals perceive prison health care. Likewise, these results are likely mediated by prison type, location and culture, something the broad overview I undertake here does not allow me to explore in detail. Finally, these data are only drawn from one Canadian prison system, limiting their generalizability.

Conclusion

Overall, incarcerated people possessed divergent perspectives about the health care they received. On one hand, a portion of the most disadvantaged participants expressed positive perceptions of health care, suggesting that they were able to access comparatively high-quality medical, psychological, and psychiatric care while in custody. Such care helped them navigate life on the streets (Bucerius et al., 2021; Schneider, 2023). On the other hand, most participants described health care as a contentious and frustrating aspect of incarceration, suggesting that the

bureaucratic and capricious nature of health care delivery reinforced labelling and the pains of imprisonment daily (Rennie & Crewe, 2022; Sykes, 1958). Overall, the lack of consistency in these narratives speaks to the importance of health care to incarcerated individuals, and drives home the need for research detailing how individuals experience health care while in custody.

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