

An Autoethnographic Exploration of Disability and Access in Manitoba Correctional Facilities

by

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Abstract

This thesis examines the issue of disability and access in correctional facilities in Manitoba, aiming to shed light on the challenges faced by incarcerated inmates with disabilities and propose strategies for improving their access to essential services and facilities. The study explores the intersectionality of disability and incarceration, recognizing the unique needs and rights of disabled inmates within the criminal justice system.

I begin by providing an overview of the prevalence of disability among incarcerated populations, highlighting the representation of individuals with disabilities in Manitoba prisons. I, explore various types of disabilities, including physical, sensory, cognitive, and mental health impairments. I focus on the barriers encountered to access to healthcare, education, vocational training, and other essential services that other able-bodied inmates benefit from.

Reflecting on my interactions and experience with disabled inmates, I try to understand the impact of inaccessibility on their quality of life and social inclusion. I also reflect on my own personal experience related to disability, particularly how culture impacts disability and accessibility. My focus is how the Manitoba Corrections facilities are not enabling disabled people's participation to enjoy the social benefits of corrections.

This study also explores the challenges faced by correctional staff in implementing these policies and the potential for systemic improvements, comprehensive assessments, and individualized care plans to address the unique needs of disabled individuals within the correctional system.

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Dedication

This thesis is dedicated to the memory of my twin brother Dr. Kehinde Taiwo.

Table of Contents

Abstract 2

Acknowledgments..... 3

Dedication 4

Chapter 1: Introduction 8

 Background and Context..... 8

 A Career in Corrections..... 12

 Research Questions 16

 Problem Statement 17

 Hypothesis..... 24

 Relevance and the Importance of the Research 24

Chapter 2: Methodology 27

 Defining Scoping Review and Analytical Autoethnography 27

 Challenges of Scoping Review 29

 Why Autoethnography 35

 Challenges to the Use of Autoethnography..... 36

 Lack of Analytical Approach and Verification..... 36

 Lack of Objectivity..... 36

 It is Unethical 37

 Methods and Sources 38

EXPLORATION OF DISABILITY AND ACCESS

Chapter 3: Literature Review	40
What is Disability?	44
What is Accessibility?	46
Chapter 4: Theoretical Approach	55
Medical Model of Disability	59
Limitations of the Medical Model	63
Social Model of Disability	64
Limitations of the Social Model	68
Pedagogy of the Oppressed	70
Ableism	73
Chapter 5: Findings	78
Chapter 6: Limitations	82
Chapter 7: Recommendations	85
Policy / Law	86
Staff Training	87
Access to Justice	87
Intake of Offenders	88
Classification, Allocation and Accommodation	88
Health Care Services	89
Access to Programmes and Services	89

EXPLORATION OF DISABILITY AND ACCESS

7

Safety and Security.....	90
Custody Release Plan.....	91
Universal Design Principles.....	92
Chapter 8: Conclusion.....	94
References.....	97

Chapter 1: Introduction

Background and Context

“Prisons are dangerous places, especially if you are racialized and disabled. Because of the ways that prisons are constructed, imagined, and maintained, rampant ableism and racism affect the daily lives of many prisoners” (Ben-Moshe et al., 2014, p. 163). People living with disability are always confronted with accessibility problems, stigma, and discrimination.

Part of my childhood was spent in different parts of Nigeria because my dad was a police officer. Each time he got transferred to a new location, we always relocated with him. When I lived in the Northern part of Nigeria (late 70’s to early 80’s) in a city called Maiduguri, I usually saw some street beggars who had either one or both hands amputated. Some had mobility impairments and walked with canes made out of tree branches, some had visual impairments, some wearing placards with inscriptions of deaf and dumb written on it. Others had hunched backs while the rest without any form of disabilities were their assistants. When I asked my dad why they have an amputated hand, he said some of those with amputated hands are not natural causes or diseases but was as a result of Sharia Law. The rest of them with one form of disability or another are begging for alms to support their lively hood.

We relocated to the South Western part of Nigeria (Ibadan) in the mid 80’s. Western Nigeria is my native town, so I had family and extended family in close proximity.

Growing up in Ibadan, a Southwestern region of Nigeria, I have observed that people with disability typically receive little support from the government. One major issue is the lack of accessibility in public infrastructure and transportation. Many buildings, including government offices, schools, and healthcare facilities, are not equipped with ramps or elevators, making it difficult for disabled people to access these spaces. Public transportation systems also

do not have adequate provisions for disabled persons, such as wheelchair ramps or designated seating.

Another challenge is the limited availability of inclusive education. While there are policies in place to promote inclusive education for disabled people, many schools do not have the necessary resources or trained teachers to accommodate their needs. Employment opportunities for disabled people are also limited. The government has not implemented sufficient measures to promote inclusive employment practices or provide vocational training programs for disabled people.

Furthermore, there is lack of social welfare programs and support services for disabled people living in this region. Many of disabled people and their families struggle to access healthcare, rehabilitation services, and assistive devices due to financial constraints. They rely on family members, non-governmental organizations, and religious groups (United Nations Women, 2019). Disabled people face stigma, discrimination, barriers accessing basic social services and economic opportunities. For example, the public infrastructure and transportation systems are often not designed to accommodate the needs of disabled people. They lack ramps and accessible seating areas.

My cousin is a wheelchair user. She lived with my uncle in the village (countryside). Each time I visited with my family, I observed the challenges she encountered due to her disability. She was confronted with negative societal attitude towards her disability. She was faced with prejudice and discrimination as the community where she lived stigmatized disability. She said some community members viewed her wheelchair as a symbol of weakness or a curse. One time I visited, I heard a group of young adults saying in the local dialect, “Omo aro yen tin bo,” which is translated as, “The lame child is coming.” Often community members avoid

having conversations with her. They view her disability as punishment for the sins of her parents. This is a traditional belief attributed to causing disability. They believe that disabilities are punishment for bad deeds or the result of witchcraft (Walmsley & Jarrett, 2021). She reiterated an experience to me about when she required help getting across a median, she had to wait several minutes while passersby ignored her. She finally received help from a neighbour. Interestingly, her spirit and determination helped to change the perception of some of the community members. Through her interactions with neighbours and friends, she challenged their misconceptions and proved that her disability did not define her worth or limit her capabilities. She explained how her curiosity and need for education remained despite the limited resources and educational opportunities.

I noticed that there were no provisions for persons with mobility impairments in the community: The roads and public spaces are inaccessible for wheelchair users; there are no buses or accessible transit; the unpaved and uneven terrain which made it difficult for her to move around freely. She told me how her wheelchair got broken because of the unpaved and uneven terrain. Unfortunately, there were no specialized technicians to fix her wheelchair, so she had to hire a local welder to fix it. I could tell the wheelchair was not in good shape. However, she had to keep using it as there is little or no support from the community or the government.

Another challenge she faced was her education and attending school in the local community. She did not own a motorized wheelchair which made it difficult for her to wheel two miles from home to school. She relied on her immediate family and some friends to attend school. She explained how the lack of ramps in school building, heavy doors, inaccessible washrooms, and transportation to and from school were major barriers for her. She told me how

her school mates would always help lift her from her wheelchair from the school corridor because there were no ramps, just stairs.

With the support of her family and a few dedicated teachers, she managed to attend a local school. The family helped raised funds to purchase a new wheelchair while some of the teachers at the school made a ramp out of wood to provide her easy access.

She explained to me the difficulties she faces accessing adequate health services. There was only one local health center in the community. However, she often misses her therapy sessions because therapy is limited by the availability of accessible hospitals and personnel who are specialized in disability inclusion and providing services for disabled people. She would have to travel to the city to access services.

These experiences and that of a neighbour's son who is hard of hearing and struggles to hear and comprehend speech, especially in noisy environments, made me wonder if there were any provisions to help him live life like other people. People in the neighbourhood viewed his impairment as something that needed to be fixed for him to function 'normally' and have a conversation just like every other hearing person.

When I was an undergraduate, I had experience with a visually impaired student in my school. I attended lectures with this student and wrote several exams in the same exam hall with him. In my encounters with this student, I noticed the attitudes and prejudice directed towards him by other able-bodied people. For example, most times the seat beside him was vacant; no one wanted to sit beside him. Hansen et al. (2018) state, "it appears that the presence of disability in public life remains disruptive in that it is capable of un-settling long-standing conventions about what belongs in cultural spaces and what does not" (p. 41).

The knowledge and awareness I had concerning people with disability through the experience with my cousin helped me understand that there is ability in disability and being disabled is not a curse. I usually sit beside this fellow student not only to prove to other students that being disabled is not a disease or a curse. It also helped me to learn more by asking him questions and listening to his stories.

Consequently, his resilience in the face of physical and societal challenges is a reminder that disabilities do not define a person's worth or potential. These early experiences stayed with me.

A Career in Corrections

Through out my life I have always been around law and enforcement. My dad was a police officer while one of my cousin's served as a Magistrate.

When I moved to Canada in 2018, I worked as a security guard at an hospital in Winnipeg with a mental health unit. This was my first work encounter with people with mental health disabilities such as anxiety disorders, depression, bipolar disorder, schizophrenia, and post traumatic stress disorder (PTSD).

I have always wanted to be a correctional officer, so I applied online and was invited for an interview. During the interview, I was asked if I could work with anyone regardless of disability and if I had any knowledge of Indigenous culture and beliefs. I was successful at the interview because of my experience and knowledge as a guard at the hospital. At the hospital I received training which included respectful workplace behaviour training, workplace hazardous material information system (WHMIS), personal health information protection act training (PHIPA), cultural diversity and much more. I explained a situation when I responded to an emergency incident (Code White) for security assistance at the hospital involving an aggressive

patient who had refused his psychotic medication and was episodic. The nurses and health aide working with the patient could not get closer to the patient considering his huge size and his behaviour at the time. The moment I arrived the scene with my partners, I immediately assessed the situation and decided to go hands-off with the patient. I used verbal strategies to deescalate the situation without resorting to physical intervention. I spoke calmly with the patient and provided assurance that he is safe, and we are only there to help him and encouraged him to take his medication as that will improve his mental health condition. This strategy was successful while security of staff members was maintained.

While in training for becoming a correctional officer, we learnt different things including civil service / government policies, tactical defense, work ethics, cultural diversity, applied suicide intervention skills training (ASIST), LGBTQ community, mental health issues and how to deal with stressful situations. Everyone in the training class stated their coping mechanisms like working out, listening to music, taking a walk, relaxing, and other strategies they apply to dealing with a stressful situation.

Unfortunately, little was taught about offenders with disability and how to assist/deal with them. The applied suicide intervention skills training (ASIST) was the closest we had on how to deal with a person with disability. But ASIST is basically understanding the pre-cursors to suicide and intervening in a timely manner. It could be applied to anyone and not necessarily someone with a disability.

Working with the Justice department provided me with an opportunity to assist offenders with the various support programs and services designed to encourage and assist in dealing with those issues that bring them into conflict with the law. Offenders engage in criminal behaviours for instance, alcohol and drug abuse, education and employment, companionship and many

more. I usually have a conversation with them to know their history which helps me understand their criminogenic needs. This way I can provide them with resources such as information on Addiction and Drug Problem (ADP), Education and Employment (EE), Companionship and many more.

I work in an adult correctional facility that houses minimum, medium, and maximum risk offenders. The security level of the prison determines the architectural design of the facility. Hence, the facility where I work is designed to conform to high, medium, and low security levels.

Offenders in minimum security units usually live in a dorm setting without the conventional bars and heavy metal doors. They spend their day attending programs like Recovering Our Identity (ROI) and learning trades/skills like bicycle repairs and sewing, while others work in the kitchen, laundry, and cleaning services. Inmates in maximum security units spend more time in their cells usually constructed with bars and heavy metal doors. They attend recreation and at times attend religious programs such as church services or sweat lodge.

The higher the security risk level, the less accessible a prison becomes. There are confined spaces with limited access doors for entry and exit. There are fewer windows depending on the units, and in some cases none at all. These restricted environments isolate prisoners from staff and each other, but they quickly have a negative impact on everyone (Wener, 2012). For example, it may increase the risk of mental health issues like depression and anxiety as well as chronic conditions like high blood pressure, heart disease and diabetes (Wener, 2012).

When I started working at the facility, I have observed some accessibility issues and architectural barriers in the design structure especially for disabled offenders. For example, some

of the hallways leading to the living units are very narrow with no ramps for wheelchair users making movement from one place to another quite challenging. I saw inmates from one of the minimum-security units heading towards the main building (max units) as the visiting department was in the main building. One of the inmates going to visiting area was a wheelchair user and had to be lifted by other inmates at certain points where there were stairs and no ramps. I thought of the cold attitudes and morose behaviour (they did not show much enthusiasm about assisting him) of other inmates towards him and felt that negativity could have been avoided if ramps were constructed. When they arrived at the visiting area, the space was so narrow he could hardly fit with his wheelchair. It took a lot of effort for him to eventually enter the cubicle with his wheelchair. Physically disabled people were not considered in the design and construction of the facility. He would have been able to move with greater independence with the construction of ramps from his unit to the main building and wider doors and open spaces in the units.

There are fewer windows to allow for light and illumination especially in the long hallways leading to the living units and other place like the visiting department and video court. the wall paint is dull blue with grayish white, low in saturation and brightness. There are few aesthetics such as paintings which could create a pleasing appearance, stimulate positive emotions, and affect mental health. Paintings and other forms of art can evoke various emotions in viewers. Colors, composition, and subject matter can elicit feelings of joy, tranquility, or inspiration. Consequently, positive emotions triggered by art can help reduce stress, anxiety, and depression, promoting overall mental well-being.

It is difficult moving physically disabled inmates when they need to attend medical appointments or court appearances. For instance, the transport van does not have ramps and they are not designed to accommodate wheelchair users. An inmate using a wheelchair would have to

be lifted into the transport van and then his wheelchair folded and kept in another compartment. Certain offenders with mental health impairments or physical impairments cannot be housed in the general population. They are vulnerable to abuse, assault, and violence from other inmates. It becomes a problem finding a specialized housing unit to accommodate them. Offenders with mobility issues or those with visual, hearing, or mental health disabilities all have a lot to contend with in the facility.

Attending the recreation, dining area, or using toilet facilities is difficult because of the structure and the way the building was constructed. The way the toilets are designed do not permit wheelchair accessibility.

The chairs and tables in the dining areas are fixed in place. I had an encounter with an inmate who had hearing impairment and cannot speak. I usually wrote on a piece of paper and passed it to him asking him to respond if he understands the instructions. Being unable to use sign language to communicate makes this process sometimes difficult when there are more instructions and messages to pass across. Myself and other officers do not have adequate training on how support such offenders. I do not understand basic sign language and I do not have adequate training on how to attend to offenders with mental health impairments such as bi-polar disorder, psychosis, schizophrenia, or mood swings. Sometimes when offenders begin acting differently, I try to talk to them, ask them questions about how they are feeling. Some may say they are hearing voices. I ask if they would like to talk to the chaplain or the elders, go for fresh air, smudge, or talk to the nurse to see if they would need medication. Other times, just asking them to go into their cell and lay down for a while also helped.

Research Questions

As a student in Disability Studies and an ally to disabled people, I am concerned by the number of disabled offenders currently incarcerated and confronted with accessibility problems. This has led me to ask the following questions.

- What is the approach to access and accommodation for disabled inmates in correctional facilities?
- What training is provided for staff regarding disabled inmates?
- What are the challenges that correctional staff encounter in addressing the needs of disabled inmates?
- What course of action is taken to advance the independence of a disabled inmate and ensure their safety?

Problem Statement

The extent to which a person with a physical impairment can function independently in an environment determines accessibility. A lack of consideration for various physical functioning and sensory impairments restricts inmates in their mobility within the physical space and their opportunities to engage in various activities. “Offenders with a hearing or speaking disability may be denied interpreters, making it impossible for them to participate in various prison activities, including counselling programmes, as well as their own parole and disciplinary hearings” (Malhotra, 2016, p. 45).

There are challenges for everyone in prison, but for trans people, there is an additional lack of support, exclusion, discrimination, and they struggle to maintain their gender identity. These challenges can stem from staff in prisons who do not feel equipped to support transgender prisoners, possibly because of a lack of training, staff support, and resources. Staff can often be unaware of the issues that trans prisoners face such as misgendering, complex family situations,

high risk of homelessness, and abuse upon release. This can result in trans offenders feeling isolated and distrustful of the criminal justice system.

Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g., hormone therapy) and individuals who identify as having no gender, multiple genders, or alternative genders. Transgender individuals may self-identify as transgender, female, male, transwoman or transman, transsexual, hijra, kathoey, waria or one of many other transgender identities, and they may express their genders in a variety of masculine, feminine and/or androgynous ways (United Nations, 2015).

In Canada, disabled people make up a 22 percent of the working age population. Aged 15 years and over (about 6.2 million individuals) had one or more disabilities (LDAC, 2021). Adult and youth correctional statistics in Canada 2018/2019 presented a national average incarceration of 37,854 adults in provincial/territorial and federal custody per day; of this number, 23,783 adults were in provincial/territorial custody and 14,071 were in federal custody (Statistics Canada, 2020). The figures relating to the number of prisoners with disabilities in Canada are scarce.

The relationship between the law and disabled people is complex. Persons with disability are not a homogenous group and this results in a complex web of factors creating barriers to accessing justice. Despite the common understanding that they are more often victims than culprits of crime, they are excessively involved in the justice system: 40% are arrested at least once in their lifetime (Mental Health Commission of Canada, 2020).

These offenders occasionally experience discrimination and human rights violations, and they are systematically denied employment opportunities, housing, and access to critically

needed health care needs. For example, Kitten Keyes, an Indigenous woman had to sleep on the jail floor for 21 days at the Grand Valley Institution because she is a wheelchair user and her cell was not accessible (Ruther & Schaser, 2016). This type of imprisonment is an example of unduly harsh punishment for offenders with disabilities. It often further worsens their situation and places a significant burden on the prison system's resources.

“In addition, people in the criminal justice system can develop mental health problems and illnesses due to confinement and other stressors that hamper recovery and healing” (Mental Health Commission of Canada, 2020, p. 1). For example, they can develop separation anxiety, which is fear of being apart from or losing a person or other attachment figure (Mental Health Commission of Canada, 2020, p. 1). “The frequency of mental health problems and illnesses among people involved with the criminal justice system is significantly higher than in the general population, a rate that has been deteriorating over time” (Mental Health Commission of Canada, 2020, p. 1). Human rights concerns relating to the vulnerable status of prisoners with disabilities and their growing numbers need to call for the development of policies and strategies to reduce the incarceration of offenders with disabilities, while ensuring that the human rights of those in prison are protected and their access needs are addressed (Atabay, 2009).

A correctional facility is a place used for the confinement of persons charged with or convicted of a crime or otherwise confined under a court order and includes but is not limited to a youth correction facility (*Correctional facility*, 2021). The government of Canada, in its Treasury Board policy on real property accessibility, said, the objective was to make sure that disabled people could gain access to and use property owned or leased by the federal government (Government of Canada, 2020). When we look at the correctional facilities in Manitoba through a disability lens, one would conclude that the designs are projecting “non-disabled” values. The

structures were designed with security as the primary objective. There was little consideration given to the accessibility requirements of the visually and mobility impaired offenders and those who are Deaf and hard of hearing. In my opinion, this approach falls short of the government policy on real property accessibility which should allow accessibility to all people regardless of impairments.

There are architectural barriers in the building (prison) designs that disabled offenders must confront. Narrow hallways, inaccessible bathrooms, lack of natural daylight, long corridors with sharp bends where you cannot see what is coming and harsh artificial materials like iron bars and gates.

Life on the inside of correctional centers in Manitoba is not easy for disabled inmates. Some of the correctional facilities in this province which house offenders sentenced to terms of two years or more are not wheelchair accessible. Security often decreases accessibility, requiring the two to be weighed against each other (Abilities Canada, 2022). In simple terms, this means that as security measures are increased to prevent unauthorized access or escapes attempts. This can make it more difficult for inmates and visitors to access or move around the prison freely. For example, an inmate from the outside living unit in the facility where I work will have to pass through multiple security gates and heavy metal doors to attend a lawyer or family visit at the visiting department which is in the main building.

Most early prisons were constructed with little if any consideration of the accessibility requirements of disabled inmates. For instance, there was no access to mental health services and adequate medical care for disabled offenders.

Certain offenders who had been committing offenses of a sexual nature for the most of their adult life had undergone numerous court-related and mental health assessments, but they kept

falling between the rigid access criteria of the different services involved. They had complex needs that required intervention, otherwise they remain at continual risk of reoffending (Lindsay & Taylor, 2018)

Accessibility is not just the absence of or inadequacy of physical structures that are designed to aid accessibility (ramps, grab bars, lift, wide doors, and wide hallways); it extends to services like medical care, accommodation, support services for the visually impaired, deaf inmates, and those with mental health disabilities (Abilities Canada, 2022). If institutional services are not easily accessible to inmates with some type of physical disability, then progress toward rehabilitation of that inmate will be limited. For instance, there is an inmate with hearing impairment who also could not speak. Such an inmate has little or no chance of accessing programs because of lack of assistive devices for inmates with this type of disability. Because of these and more, solitary confinement is used as a protection mechanism rather than revealing a person to be disabled, as doing so increases likelihood of abuse. This, however, is done at the risk of creating more long-term mental health issues due to increased stress associated with solitary confinement (Abilities Canada, 2022).

Access to justice is another major barrier faced by offenders with disabilities. They are disadvantaged at many stages of the criminal justice system. This could mean limited access to legal counsel who are knowledgeable about disability rights and accommodations, impacting their ability to receive proper legal representations. For example, Deaf prisoners are denied interpreters, making it impossible for them to participate in work programs, counselling, alcohol and substance abuse programs, medical appointments, and their own parole and disciplinary hearings (Russell & Stewart, 2002). They are sometimes indirectly discriminated against in their access to justice. Prisons and court facilities may lack proper accommodations for inmates with

mobility impairments, making it difficult for inmates with disabilities to navigate these spaces. This can prevent them from engaging in programs that would shorten their incarceration (Russell, & Stewart, 2002).

Disability training and awareness are important for disabled offenders to be treated fairly by officials. Incompetencies and abuses can occur when such understandings are not in place. “Offenders with sensory disabilities, and particularly those who are affected by multiple disabilities, will face difficulties in understanding the charges against them, unless provided in a mode that is accessible to them” (Atabay, 2009, p. 53). They will also have problems communicating during the criminal justice process. Thus, having the assistance of qualified legal counsel and appropriate support to cater for their access needs is crucial to ensure that offenders with disabilities have access to justice on an equal basis as others” (Atabay, 2009, p. 53).

Accessibility in correctional facilities is important because disability is not just for a few people; it is a part of human life which everyone would experience at some point, either temporarily or permanently. Consequently, functional architectural designs should ensure the creation of accessible environment for everyone regardless of individual impairments. The need for design requirements to achieve architectural compliance and accessibility in the correctional facilities has extended to prison staff, inmates, visitors, volunteers, community and criminal justice workers, and others who have legitimate reasons for entering a prison facility.

The Correctional Service of Canada in its forum on corrections research states as follows: In 1989, the federal government issued a Treasury Board Policy on “real property accessibility” (CSC, 2007, p. 1). The objective was to ensure that persons with disabilities could gain access to use property owned or leased by the federal government. The policy clearly states that the provisions of the Canadian Charter of Rights and Freedoms and the Canadian Human Rights Act

“make it a discriminatory practice for federal organizations to deny persons with disabilities access to property owned or leased by the federal government” (Government of Canada, Correctional Service of Canada, 2007, p. 1). This policy, including other relevant human rights legislation and the Corrections and Conditional Release Act, presents the internal and legal accessibility conditions that the Correctional Service of Canada must meet in managing its disabled inmates. The term “accessible” implies easy physical access for persons with disabilities affecting mobility, especially individuals who use wheelchairs. The term also covers access requirements for people with visual or hearing disabilities (Government of Canada, Correctional Service of Canada, 2007).

Prison administrators and architects designing correctional facilities should go beyond conventional designs and understand that new construction designs must be functional and accessible to everyone. They must create spaces designed to be user-friendly for everyone, including people who use wheelchairs, canes, mobility aides, and those with vision and hearing impairments. This includes creating appropriate lightning throughout the Correctional facility. “Architects tend to think empathically about care homes as they can imagine themselves getting old, but they never think about themselves or a relative ending up in a prison” (*Prison design: Secure and humane*, 2019).

I observed that correctional staff, visitors, volunteers, community and criminal justice professionals, and others who have reasons for entering a facility who have a disability are also confronted with these accessibility problems. Visitors or family members with an impairment may have to negotiate their way through the facility during visits because of the limited access.

Hypothesis

If the appropriate government policy, along with relevant human rights legislation and the Corrections and Conditional Release Act, are applied to set out the internal and legal accessibility requirements that the Correctional Service of Canada must meet in managing its special needs offenders, then the Correctional Services will be able to provide equality of access such that inmates with disabilities would be adequately housed achieving security and rehabilitation needs.

Relevance and the Importance of the Research

The long-term goal of this research is to ensure that people with disabilities who may enter Correctional facilities – inmates, Correctional staff, visitors, volunteers, community and criminal justice professionals, and others who have legitimate reasons for entering a facility – enjoy equal accessibility. It seeks to ensure that offenders with disabilities are adequately housed at their correct security level and provided access to the programs and services necessary to rehabilitation and wellbeing.

Research on disability and access in correctional facilities helps to identify and address barriers that may prevent offenders with disabilities from fully participating in prison programs, services, and activities. This research can inform policy and practice changes to promote equality and inclusion for all incarcerated individuals.

The safety and well-being of offenders with disability is addressed in this research. Offenders with disabilities in prisons may face unique challenges and vulnerabilities. Research on disability and access can help identify and address issues related to safety, healthcare, mental health support, and overall well-being for incarcerated individuals with disabilities.

Furthermore, this research can help prisons and authorities comply with legal requirements and policies which prohibit discrimination against persons with disabilities including incarcerated offenders.

Other research, reports and articles on a similar topic have attempted and proffered different measures through which the architectural barriers to accessibility for disabled people can be removed to achieve substantive equality of access.

I make efforts to address inaccessibility, examining both the architectural barriers and services resulting to inaccessibility for disabled offenders. I address the inaccessibility of programs for disabled offenders in prisons, and consider government policies in relation to rights and accessibility. Finally, I examine how staff, visitors, volunteers, community, and criminal justice professionals, who enter a facility with a disability are affected by inaccessibility of correctional facilities.

This research accomplishes the following:

Creating Knowledge: generating new knowledge and awareness about inaccessibility faced by inmates with disability in correctional facility.

Mobilizing Knowledge: sharing knowledge with policy makers, prison administrators, architects, and other stakeholders to enhance accessibility and inclusion for disabled offenders and other people with disability who have legitimate reasons to enter a correctional facility.

Training and Development: helps to develop capacity in policy analysis, implementation, and research.

The result of this study will be valuable to policy makers, jail administrators and architects as well as related stakeholders in developing a coherent framework of modifications

EXPLORATION OF DISABILITY AND ACCESS

26

and programs that will ensure that offenders with disabilities enjoy full participation and accessibility in the Manitoba correctional centers.

Chapter 2: Methodology

In the Fall of 2019, my course mates and I had an academic visit to the Canadian Museum for Human Rights in Winnipeg. I observed a considerable degree of limitation with the ramps in the Museum, as it appeared too steep and dangerous for use by anyone with a mobility impairment. On another occasion, at the hospital where I worked as a guard, I observed that the braille signage on the elevator in the hospital was placed so high that a person with visual impairment who is not tall could hardly reach it. Thereafter, I started working as a correctional officer at the Manitoba corrections facility in Winnipeg where I noticed barriers to accessibility for disabled inmates such as narrow hallways, inaccessible cell space for wheelchair users, inadequacy of ramps and more.

As I reflect on and ask questions about the ontological and epistemological foundations of this work, I think of the methodological choice that will capture complexities and contradictions of my research work: Autoethnography is a method that regards a researcher's own experience and examines the larger social context by combining cultural analysis and interpretation with narrative details. While I was preparing for this thesis, I considered using a type of method that would allow me express creativity and give me the most freedom to connect my experiences with those of my readers. A combination of scoping review and analytical autoethnography was adopted. I believe autoethnography is much more accessible to people with disabilities who may have different abilities.

Defining Scoping Review and Analytical Autoethnography

I took time to study what scoping review and analytical autoethnography entails. The moment I understood and felt knowledgeable, I felt it was the perfect way for me to share my

lived experiences and to then analyze and deeper understand why these experiences were occurring.

A scoping review is a type of literature review that aims to map and summarize existing research on a particular topic or research question. It involves systematically searching, selecting, and analyzing a wide range of literature sources to identify key concepts, themes, and gaps in knowledge.

Unlike a traditional systematic review which focuses on answering a specific research question with a narrow scope, a scoping review aims to provide a broad overview of the available evidence on a topic. Scoping encompasses the combination and analysis of a wide range of research and grey literature to provide greater conceptual clarity about a particular topic or field of evidence. “Scoping studies are commonly policy directed and intended to guide more focussed lines of research and development” (Davis et al., 2009, p. 1386-1400). This involves searching existing literature to gain an overview of the range and depth of research that exists for a particular research idea. While scoping reviews may be conducted to determine the value and likely scope of a full systematic review, they may also be undertaken as exercises in and of themselves to summarize and disseminate research findings, to identify research gaps, and to make recommendations for future research (Peters et al., 2015).

A scoping review involves several stages, including defining the research question or objective. This requires clearly articulating the purpose and scope of the scoping review, including the specific research question(s) to be addressed. The next stage involves identifying relevant literature. A comprehensive search strategy is developed to identify relevant studies from various sources, such as academic databases, grey literature, and reference lists of relevant articles. Studies must then be selected for analysis. Inclusion and exclusion criteria are applied to

screen and select studies that meet the predefined criteria. This may involve multiple reviewers independently assessing the eligibility of each study. Data extraction systematically collects and records relevant information from the selected studies. This may include details about study design, population, interventions or exposures, outcomes, and key findings. Data is then analyzed and synthesized to identify common themes, patterns, and gaps in the literature. This may involve qualitative or quantitative methods, depending on the nature of the included studies and research question. Finally, the scoping review process involves reporting the results. The findings of the scoping review are summarized and presented in a clear and transparent manner. This may include tables, figures, and narrative descriptions of the key findings, implications, and recommendations for future research.

According to Munn (2018), the general purpose for conducting a scoping review is to identify and map the available evidence in order to identify the types of available evidence in a given field, to clarify key concepts and definitions in the literature, to examine how research is conducted on a certain topic or field, and to identify and analyse knowledge gaps (Munn et al., 2018). The scoping review approach can inform further policy, practice, and research aims, including the feasibility for conducting a full systematic review.

Overall, a scoping review provides a comprehensive overview of existing research on a topic, helping to identify gaps in knowledge, inform future research directions, and support evidence-based decision-making.

Challenges of Scoping Review

Scoping reviews are valuable, but have limitations. This method does not formally evaluate the quality of evidence and often gathers information from a wide range of study designs and methods (Sucharew, 2019). Scoping reviews do not provide a synthesized result or

answer to a specific question, but rather provide an overview of the available literature. Another limitation is that scoping reviews require a substantial amount of time due to the wide coverage of the search in the method. This study is also limited in the sense that it stands the risk of bias from different sources.

Some limitations of the scoping review method that should be considered include limited quality assessment. Scoping reviews typically do not assess the quality or risk of bias of the included studies. This means that the findings may be based on studies of varying quality, which can affect the reliability and validity of the results.

Another limitation of the scoping review is lack of data synthesis. Scoping reviews focus on mapping and summarizing the existing literature, rather than conducting a formal synthesis of the data. This means that the findings may not be statistically analyzed or synthesized in a quantitative manner.

Scoping reviews are also limited by the potential for publication bias. Scoping reviews may be susceptible to publication bias, as they often rely on published literature. This means studies with positive or significant results are more likely to be included, while studies with negative or non-significant results may be overlooked.

Additionally, the process of selecting studies for inclusion in a scoping review may introduce selection bias. The inclusion and exclusion criteria may be subjective, and the reviewers' judgments may influence which studies are included or excluded.

Furthermore, there is a lack of stakeholder involvement. Scoping reviews may not always involve input from relevant stakeholders such as patients, clinicians, or policymakers. This can limit the applicability and relevance of the findings to real-world contexts.

Finally, difficulty in updating is also a limitation of scoping review. Scoping reviews may become outdated over time as new studies are published. Unlike systematic reviews, which have a defined protocol for updating, scoping reviews may not have a clear process for incorporating new evidence.

Despite these limitations, scoping reviews are still valuable for providing a broad overview of the literature, identifying gaps in knowledge, and informing future research directions. It is important to consider these limitations when interpreting and applying the findings of a scoping review.

Autoethnography is a research method that regards a researcher's own experience as meaningful data and a topic of investigation in its own right. In doing so, it aims to analyze and interpret taken for granted values, attitudes, and beliefs in their social context (Berger & Lorenz, 2015). It is a research method that involves the researcher reflecting on their own personal experiences and using them as a basis for understanding broader social and cultural phenomena. It is a form of self-narrative that combines personal storytelling with sociological analysis.

According to Chang (2008), autoethnography is a method that combines cultural analysis and interpretation with narrative details and consequently surpasses simple narration of the self. A crucial element of this method involves connecting writers' stories and experiences to larger social forces with the expressed goal of explicating shared and taken for granted assumptions (Berger & Lorenz, 2015).

In the context of researching disabled inmates and accessibility, autoethnography can be a valuable method for gaining insights into the lived experiences of disabled offenders within the criminal justice system. By drawing on their own experiences as an ally to people with

disabilities or as someone who has interacted with disabled inmates, I am able to provide a unique perspective on the challenges, barriers, and discrimination faced by disabled inmates.

The ethnographic quality of autoethnography requires researchers to not dwell on the self alone. The method acknowledges that the self is situated in a temporal and local context, and the goal is to use the self to understand, identify, and expose dominant cultural and social patterns.

There are some of the key considerations when using autoethnography in a study involving incarcerated offenders and accessibility:

Reflexivity: Autoethnography requires the researcher to critically reflect on their own positionality, biases, and subjectivity. It is important to acknowledge and address any potential biases or assumptions that may influence the interpretation of the data.

Ethical considerations: When conducting autoethnography, it is crucial to consider the ethical implications of sharing personal experiences and potentially sensitive information. In the context of researching disabled inmates, it is important to protect the privacy and confidentiality of individuals involved and obtain appropriate informed consent.

Triangulation: Autoethnography can be complemented with other research methods and data sources to enhance the validity and reliability of the findings. This can include interviews with disabled inmates, correctional staff, or other stakeholders, as well as document analysis or observation.

Analytical framework: Autoethnography should be guided by a theoretical framework or conceptual lens that helps to analyze and interpret the personal experiences within a broader social and cultural context. This can involve drawing on relevant theories, concepts, or literature on disability, incarceration, and accessibility.

Reflexive writing: Autoethnography involves writing and presenting the research findings in a way that is engaging, evocative, and reflexive. It is important to use narrative techniques, storytelling, and personal anecdotes to convey the experiences and emotions of disabled inmates while also providing critical analysis and interpretation.

Peer review and feedback: Autoethnographic research should undergo rigorous peer review and seek feedback from other researchers, particularly those with expertise in Disability Studies, criminology, or qualitative research methods. This can help to ensure the rigor and credibility of the research.

Autoethnography can provide valuable insights into the experiences of disabled inmates and the accessibility challenges they face within the criminal justice system. It allows for a deep exploration of personal narratives and can contribute to a more nuanced understanding of the intersectionality of disability and incarceration. However, it is important to approach autoethnography with sensitivity, reflexivity, and ethical considerations to ensure the validity and integrity of the research.

Analytic autoethnography puts the self at the center of cultural analysis. It seeks to describe and systematically analyze personal experience to understand cultural experience (Ellis et al., 2011). By breaking down the word autoethnography, we can gain basic understanding of what this form of research entails. “Analytic” meaning to discover through detailed examination, “auto-” meaning self, “-ethno-” meaning culture, and “-graphy-” meaning research. “Analytic autoethnography is the exploration of cultural, social, and political understandings and meanings through introspection and reflection on personal experiences” (Dwyer, 2017, p. 28). This means a researcher will turn the lens of inquiry to their own personal accounts of events that concern

them. “Autoethnography is both the process of doing the study and the written product at the end” (Ellis, 2004, p. 38).

Anderson (2006) notes the following key requirements when using the analytical style: First, the researcher is a complete member of the social event under study. There is awareness of the researcher’s connection to the situation under investigation and their impact on it (analytic reflexivity). Second, there is visibility of the researcher’s own experiences. Third, there is dialogue with informants beyond the self. Finally, there is commitment to theoretical analysis requiring not simply the documented experience of the event but also provide some broader understanding of the situation under investigation.

A further characteristic of analytical autoethnography is its commitment to an analytic agenda. The purpose of analytic autoethnography is not simply to document personal experience to provide an “insider perspective” or to evoke emotional resonance with the reader. Rather, the defining characteristic is to use empirical data to gain insight into some broader set of social phenomena than those provided by the data themselves (Livesey & Runeson, 2018). This may involve interviewing one’s own self and using writing to generate a self-cultural understanding. “In an autoethnography, the researcher is not trying to become an insider in the research setting. He or she, in fact, is the insider. The context is his or her own” (Duncan, 2004, p. 30).

Thus, the aim of analytic autoethnography is to recreate the researcher’s experience in a reflexive way, aiming to make a connection with the reader which can help the reader to think and reflect about his or her own experiences. As an insider in this study, it becomes easier for me to create and relate my experiences about accessibility in a correctional center in a reflexive way to connect with the reader to help them reflect on their own experiences.

Why Autoethnography

The question still arises, why use an autoethnography or narrative style when discussing disability? Epistemology is the nature of knowledge and knowledge production. Within research, what constitutes valid knowledge is questioned. Where and who does valid knowledge come from? What is the criteria to be met for something to be knowledge? (Dwyer, 2016). Narrative research is done within a transactional frame where knowledge is created in social contexts and settings (Dwyer, 2016). Narratives can give voice to the marginalized and to bring attention to the power dynamic and social justice issues in the social context (Dwyer, 2016). Traditional social science research has silenced the voices of people from the margins, using a deficit-informed approach, like the medical model, in explaining lives and experiences (Brown & Strega, 2005).

Reality is neither fixed nor entirely external; it is created by, and moves with, the changing perceptions and beliefs of the viewer. The subjective view, often criticized from a positivistic standpoint, has gradually come to be seen as an acceptable platform for the practice of research (Duncan, 2004, p. 30). Autoethnographies can be beneficial to people with disabilities and allies who are sharing similar experience (Duncan, 2004). Autoethnography is a way of understanding disability as it expresses personal and cultural factors. It connects the personal – the disabled body – with the oppression within society. This form of research provides an encompassing disability theory that draws attention to everyday experiences for people with disabilities (Neville-Jan, 2004). Only a person such as I, who is involved in working with people with disabilities in various settings, and with a background in Disability Studies would be able to write within this academic context (Duncan, 2004). Since autoethnographies reflect truths for the author, not all my results may be replicated in another person's stories. One must consider:

“What are the social/cultural/political conditions that are the circumstances of this experience happening, in this way, at this time, to this person?” (Dwyer, 2016, p. 28).

Challenges to the Use of Autoethnography

Analytical autoethnography has some limitations. For instance, the feelings evoked in readers may be unpleasant since the connections they make to narratives cannot be predicted. The limitation also entails many ethical questions which sometimes may be very difficult for the researcher to answer, making autoethnographies a complicated method to follow (Mendez, 2013). Writing in a personalised and often emotional, open, and vulnerable style challenges the widely held orthodoxy of the researcher as neutral, objective, rational and textually absent.

Autoethnography has attracted criticism from more conventional researchers, as for example Delamont (2012). These criticisms challenge autoethnography on the grounds that it lacks an analytical approach, it lacks verification, it lacks objectivity, its focus on the self is self-indulgent, it uses an overly emotional style, it is unethical, and there is a risk of false memories. However, there are methods of dealing with these challenges in analytical autoethnography.

Lack of Analytical Approach and Verification

While this criticism might be true for most forms of autoethnography, it misses the point in analytical autoethnography. The analytical approach and triangulation ensure that the approach suggested here corresponds to the analysis and verification of more conventional quantitative research. The same argument applies to another frequent criticism: that autoethnography tends to be experiential and so lacks in analytical outcomes (Delamont, 2007).

Lack of Objectivity

As the auto-ethnographer is personally involved in the research, the method has been challenged as lacking objectivity. This issue is answered by Ellis et al. (2011) who describe

autoethnography as “one of the approaches that acknowledges and accommodates subjectivity, emotionality and the researcher’s influence on research, rather than hiding from these matters or assuming they don’t exist” (p. 274). While it is true that it is difficult to avoid subjectivity in any form of research, suggesting that a method is no worse than others may be true, but is not a very positive argument. It ignores for instance that due to the literature review, the understanding and the knowledge of the issues by the researcher should be far superior to the normal understanding of survey participants who, as outlined in the introduction, are often called on to respond to questions which they do not understand or about which they have a very limited knowledge. It is likely that the answers are more considered and reflective, and therefore more objective and thoughtful (Livesey & Runeson, 2018).

It is Unethical

Auto-ethnographers are forced to involve others who were involved in the experiences discussed and who may not wish to be identified. They may also have different memories of the events but are not afforded the opportunity to put forward their point of view. This problem has been highlighted and discussed by several authors (Ellis, 2007; Adams, 2008). Whilst it is very difficult, if not impossible, to ensure anonymity in this form of research the following steps can be taken to reduce the degree to which an individual could be identified. First, rely on a significant time interval having occurred to reduce the likelihood of others identifying the event. Second, if the event occurred more recently, the place and time where the event occurred should not be identified. If the first and second are not sufficient, engage in creative non-fiction to make changes to the narrative surrounding the event that, while not affecting the substance of the experience, will render identification of the individual(s) that the researcher was interacting with more difficult. Finally, by dealing with the impact of the event on the researcher’s thoughts and

behaviour and not involving the feelings and thoughts of others, the potential to impact on the character(s) involved in the situation is reduced (Livesey & Runeson, 2018).

Autoethnography has, some would justifiably say, a reputation for just creating nice or interesting stories without much scientific value in that the findings cannot be generalized or verified. However, I have ensured that this research study is presented with an approach that makes it possible to use autoethnography by structuring the research in a conventional way: creating a theoretical framework, conducting a literature review and gathering data from past experiences.

Methods and Sources

Methods involve the particular techniques of research design, measurement, observation, and data analysis (Berger & Lorenz, 2015). As a qualitative researcher, I will use different methods that will conform to my ontological realities. My personal experiences will inform my epistemology. I use a combination of scoping review and analytical autoethnography because my study involves humans (inmates), to satisfy ethical considerations, and to work within various constraints including time. I search existing literature related to disability and accessibility to help me gain an overview of the range and depth of my study. “Narratives, field notes, personal diaries, storied poetry, discussions, interviews, letters, family tales, documents, pictures, memory boxes, personal-family-social artifacts and life experiences” (Clandinin & Connelly, 2022, p. 101).

I analyze relevant documents such as such as policies, reports, and legal documents, as well as existing quantitative data on disability related incidents within the Manitoba correctional facilities to identify patterns and trends related to disability and accessibility.

To gather data for this study, a search of electronic databases on relevant topics, using search engines Google, Google Scholar, ERIC, University of Manitoba online library, articles, and relevant literature adopted by various fields in conducting research related to Disability and Accessibility in Manitoba Correctional facilities. Discovered literature is evaluated, compared and considered for the purpose of this study. Access to internet and library service are given the utmost consideration as these are the primary means to access data sources. Invariably, only literature that meets the criteria of the study is adopted as key terms for conducting this study. Disability, accessibility, disabled offenders, disability rights and laws, problems of accessibility, and others form the key terms of the study.

Chapter 3: Literature Review

Much research centers on correctional programming and successful reintegration; however, little work explores how incarcerated people with disabilities (IPWDs) perceive accessibility and accommodations in such programs. Given that this population has a higher recidivism rate than others, it is important to better understand unique problems faced by incarcerated people with disabilities. (Ruffin et al., 2021, p. 59–65)

In this chapter, I survey relevant scholarly articles and documents which contain information, ideas, data, and evidence on my research topic to situate my work in relation to existing knowledge. As an insider and a person that worked directly with disabled inmates, I will be drawing attention to the challenges faced by incarcerated offenders with disabilities in accessing essential services and facilities within the correctional system in Manitoba. My autoethnography focuses on the medical model of disability, the Pedagogy of the oppressed (Freire, 2005), and the social model of disability. These areas of literature are the basis that best support the structure of my study and facilitate how my experiences as a correctional officer helped my understanding of why inmates who have disabilities are faced with accessibility challenges and barriers in the prison facility.

Many writers such as Titchkosky, Imrie and Kumar, Correctional Service of Canada (2007), United Nations Office on Drugs and Crimes (2009), have all attempted research access and disability in correctional facilities. I explore their research including the gaps and suggest recommendations on how to tackle the issues of accessibility facing offenders with disabilities in the correctional facilities in Manitoba.

My review begins by providing an overview of the prevalence of disabilities among the inmate population in Manitoba correctional facilities. I highlight the disproportionate

representation of inmates with disabilities and the specific types of disabilities encountered, including physical, sensory, cognitive, and mental health impairments.

Furthermore, I explore the legal framework and policies governing disability rights within Manitoba correctional facilities. This review analyzes the Manitoba Human Rights Code and other relevant legislation, assessing their effectiveness in ensuring equal access and reasonable accommodations for disabled inmates. I also examine the challenges faced by correctional staff in implementing these policies and the potential for systemic improvements.

My review also highlights the importance of staff training and disability awareness. I observed the need for training programs that promote disability awareness, sensitivity, and inclusive practices among correctional staff. I noticed the importance of collaboration between correctional institutions and disability advocacy organizations in improving access.

The prevalence of disabilities among the inmate population in Manitoba varies depending on the specific disability and the data sources. According to a report by Canadian Center on Disability Studies (CCDS, 2018), persons with disabilities are overrepresented in the criminal justice system, including correctional facilities. The report highlights that people with disabilities face several barriers that contribute to their involvement in the justice system, such as lack of access to appropriate support services, discrimination, and limited employment opportunities.

However, it is important to note that a significant proportion of inmates in correctional facilities have a history of mental health issues, substance abuse, and cognitive impairments, all of which can be considered disabilities.

What does it mean to be an offender living with a disability in prison? Being an inmate with a disability can present unique challenges and considerations. Accessibility, discrimination,

harassment, safety, stigmatization, accommodation and inadequate support services are major challenges that an inmate living with a disability will have to deal with.

Several questions come to mind as I reflect and try to understand the impact of accessibility in the prison institution on disabled inmates' quality of life and social living. Clearly, the issues of accessibility and inaccessibility are more complex than merely the difference between using a ramp or climbing stairs. The challenges faced by people with disabilities do not just involve physical obstacles. It could also mean barriers in accessing healthcare services, mental health support, and rehabilitation programs. This could also include lack of appropriate accommodations and specialized care for disabled offenders.

The World Health Organization (WHO) definition of barriers according to the Centers for Disease Control and Prevention (CDC) states

Barriers are factors in a person's environment that, through their absence or presence, limit functioning and create disability. These include aspects such as a physical environment that is not accessible; lack of relevant assistive technology (assistive, adaptive, and rehabilitative devices); negative attitudes of people towards disability; and services, systems and policies that are either nonexistent or that hinder the involvement of all people with a health condition in all areas of life. (CDC, 2018, December 3)

A typical day for me as a correction officer in the institution starts with morning briefing. I attend morning briefing where I receive updates on any incidents or issues that occurred during the previous shift. At the briefing, information about any high-risk inmates or specific task for the day is shared. Following the briefing, I conduct security checks in the location that I was assigned to work to ensure that all areas are secure. This includes checking doors, windows,

cells, common areas and other restricted areas for any signs of contraband or unauthorized activities.

Once I ensure that the location is secure and safe, I resume inmate supervision, monitoring their activities, enforcing rules and regulations, maintaining order and responding to any disturbances or conflicts that may arise. At random intervals, I count the number of inmates in my location and provide the central control unit with the number of inmates in my location at designated times. I also supervise feeding of the inmates in my assigned location and oversee the movement of the inmates between the different areas of the prison such as recreation periods, visits, or medical appointments.

I am required to randomly conduct searches of inmate cells and other areas for unsanitary conditions, contrabands, fire hazards, and any evidence of infractions of rules. I also do case work with offenders who are assigned to me. I have regular meetings with the inmates where we typically set a goal through case planning and work on life skill sessions designed to assist with the criminogenic needs of the offender.

Throughout the day, I document incidents, inmate behaviour, and any other relevant information. If it becomes necessary, I may need to write reports detailing incidents, disciplinary actions, or any unusual occurrences.

Finally, at the end of my shift, I provide a detailed handover to the incoming shift, briefing them on any incidents, issues, or concerns that occurred during my shift.

A typical day for an offender may include feeding, cleaning, attending appointments such as court, medical, visits from lawyers, probation officers and family members. It also includes attending programs like life changing skill programs, recreation, religious services, work assignments, and many more. An offender who has a disability will certainly have to negotiate

his way around in the jail in order to live a daily life and achieve goals just like any other offender without a disability. This is because of the barriers to accessibility in the prison environment creating disability.

What is Disability?

First, I would like to begin with the concept of disability to provide a broad perspective and understanding of the research topic. The word 'disabled' is used as a blanket term to cover many people who have nothing in common with each other, except that they do not function in exactly the same way as those people who are called 'normal.' Consequently, this large number of people are considered 'abnormal;' they are different, considered problem people, lacking the capacity for social integration. But the truth is, like everybody else, they have a range of things they can and cannot do, a range of abilities both mental and physical that are unique as individuals. "The only difference between disabled people with other people is that people with disabilities are viewed through spectacles that only focus on inabilities, and which suffer an automatic blindness - a sort of medicalized social reflex -regarding abilities" (Brisenden,1986, p. 173 - 178).

Disability is often defined as an unfortunate tragedy that happens to a few individuals. We almost always hope that such a tragedy will not happen to us. Some people are regarded by the Canadian government as people 'with disabilities,' insofar as they are people with an 'abnormal condition.' Moreover, this condition is understood as a thing that happens to some individuals either at birth or later in life because of an accident, illness, or disease (Michalko & Titchkosky, 2009). In my working experiences, I have encountered inmates with mental health disabilities. In fact, there is a living unit designated for inmates with mental health impairments. I have also met inmates who have hearing and speech impairments, visual impairments, and

wheelchair users. Some of the wheelchair users are amputees, older inmates, or with impairments caused by illness or diseases. Also included in the list are transgender inmates and those with chronic diseases. This group of inmates are classified as having one form of disability or the other.

“Disability and impairment are largely understood as individual deviations presented in terms of defect and illness in need of correction or treatment” (Hansen et al., 2018, p. 40). However, others view disability as a social construct. That is, it is not an individual’s impairment or adjustment but the socially imposed barriers – the inaccessible buildings, the limited modes of transportation and communication, the prejudicial attitudes – that construct disability as a subordinate social status and devalued life experience, this is referred to as the social model of disability (Berger & Lorenz, 2015).

In addition, the Centers for Disease Control and Prevention defined disability as “any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions)” (CDC, September 16, 2020). From this definition, according to World Health Organization, disability has three dimensions: First, *impairment* is in a person’s body structure or function, or mental functioning. Examples of impairments include loss of a limb, loss of vision, or memory loss. Second, *activity limitation* includes difficulty seeing, hearing, walking, or problem solving. Lastly, *participation restrictions* occur in normal daily activities such as working, engaging in social and recreational activities, or obtaining health care and preventive services.

Disability could also be associated with developmental conditions that become apparent during childhood. For example, autism spectrum disorder (ASD) and attention-

deficit/hyperactivity disorder (ADHD). Long-standing conditions like diabetes can cause disability such as vision loss, nerve damage, or limb loss (CDC, 2020).

Some of the inmates in the living unit designated for offenders with mental health disabilities have been diagnosed to have some or mixture of these problems. Fetal alcohol spectrum disorders (FASD), anxiety disorders, bipolar affective disorder, depression and post-traumatic stress disorder (PTSD). These problems reduce their ability to function, creating a need for accommodation.

What is Accessibility?

Accessibility, according to the Centers for Disease Control and Prevention, is when the needs of people with disabilities are specifically considered, and products, services, and facilities are built or modified so that can be used by people of all abilities (CDC, 2018, December 3). The Government of Canada website defines a barrier as

anything—including anything physical, architectural, technological or attitudinal, anything that is based on information or communications or anything that is the result of a policy or a practice—that hinders the full and equal participation in society of persons with an impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment or a functional limitation. (Government of Canada, *the Accessible Canada Act*, 2019).

There are several barriers to accessibility in prison that can hinder the ability of incarcerated offenders with disabilities to access essential services and facilities. Some of these barriers include physical barriers. Many correctional facilities are not designed or equipped to accommodate individuals with physical disabilities. This can include inaccessible entrances, narrow doorways, lack of ramps or elevators, and inadequate bathroom facilities. These physical

barriers can make it difficult or impossible for individuals with mobility impairments to navigate the prison environment independently. There are also communication barriers, inadequate options for communication which pose significant challenges for offenders with hearing or speech impairments. Limited access to sign language interpreters, captioning services, or assistive communication devices can hinder effective communication with prison staff, healthcare providers, and other inmates. Lack of assistive devices and technologies is another challenge. Many correctional facilities do not provide necessary assistive devices and technologies for inmates with disabilities. This can include wheelchairs, hearing aids, visual aids, and other assistive technologies that promote independence.

Inadequate healthcare service is another barrier. Offenders with disabilities often require specialized healthcare services and accommodations. However, many correctional facilities lack the necessary resources and expertise to provide appropriate medical care, rehabilitation, and mental health support for disabled inmates.

There is limited access to education and vocational training. Correctional facilities may not offer accessible educational programs or vocational training opportunities for offenders with disabilities. This can limit their ability to acquire new skills, pursue educational goals, and prepare for reintegration into society.

One of the major barriers to accessibility in prison is insufficient staff training. Correctional staff may lack training and awareness on disability issues, leading to a lack of understanding and sensitivity towards the needs of disabled inmates. This can result in inadequate accommodations, discrimination, and a failure to provide necessary support.

Finally, stigma and discrimination are another form of barriers to accessibility in prison: Disabled inmates in prison may face stigma, discrimination, and social isolation from both staff

and other inmates. This can further exacerbate the barriers to accessibility and hinder their ability to fully participate in prison life.

Addressing these barriers requires a comprehensive approach that includes policy changes, facility modifications, staff training, and collaboration with disability advocacy organizations. By recognizing and addressing these barriers, correctional facilities can work towards creating a more inclusive and accessible environment for incarcerated offenders with disabilities.

‘Accessibility.’ ‘Disability.’ We hear these words all the time, but what do they really mean? Are we doing all we can to make correctional facilities in Manitoba accessible for offenders living with a disability? Just like people living with a disability, for incarcerated offenders, accessibility means living in an obstacle or barrier free environment that would enable them to enjoy the same kind of freedom as everyone else. Inmates with disabilities without adequate access to support services often struggle to cope in prison and often experience bullying, harassment, and physical violence.

Due to lack of staff sensitivity and training, prisoners with disabilities often face excessive force and are sometimes locked up in solitary confinement for hours. In the absence of social contact and meaningful mental health services, the stress of a closed and heavily monitored environment is particularly damaging for prisoners with disabilities (Hansen Edwards, 2006). “In other cases, due to lack of training, prison staff use unnecessary, excessive, and even malicious force against prisoners with disabilities” (CCR, 2018, June 13).

Training is important so prison staff are equipped with the knowledge, skills, and attitude to perform their duties well and with respect for the rights and dignity of offenders. Prison work is complex and requires a variety of skills. Many new recruits will not have any knowledge of

prison work beforehand. Correctional programs, services and supervision must be designed or modified to fit the diverse needs of disabled offenders. Staff will need to be knowledgeable, sensitive, creative, and flexible in finding new ways to manage disabled offenders.

Inaccessibility issues are so prevalent around us that many times we are not bothered by them. For instance, in the corrections facility, due to architectural barriers like narrow hallways, lack of ramps, cramped or tiny cells, location of visitor's room and recreational facilities, prisoners with mobility impairments may be unable to access dining areas, libraries, sanitary facilities, work, recreation and visiting rooms. Disabled offenders with vision impairments cannot read their own mail unassisted or prison rules and regulations unless they are provided in Braille. They are unable to use the libraries, unless taped materials or books in Braille are available. "Offenders with a hearing or speaking disability may be denied interpreters, making it impossible for them to participate in various prison activities, including counselling programmes, as well as their own parole and disciplinary hearings" (UNODC, 2009, p. 45).

In my epistemic justification, the extent to which a person living with a physical disability can function independently in an environment determines accessibility. A building is only accessible if you can get in and use all the areas in it. This means that we can only talk of an accessible prison environment when an inmate with disability can function independently.

However, the Correctional Service Canada in its research report states:

the government of Canada, in its Treasury Board policy on real property accessibility, said, the objective was to make sure that disabled people could gain access to and use property owned or leased by the federal government. This policy, along with relevant human rights legislation and the Corrections and Conditional Release Act, set out the

internal and legal accessibility requirements that the Correctional Service of Canada must meet in managing its special needs offenders. (CSC, 2015. Pg. 10 - 11).

The Correctional Service of Canada attempts to provide equality of access so that inmates with disabilities are adequately housed at their correct security level, in the region, and, to the extent possible, in an institution that provides access to the programs and services deemed necessary to their rehabilitation and wellbeing. The guidelines stipulate that all minimum and medium security institutions must eventually have several accessible beds and cells, as well as program areas to accommodate inmates with disabilities (CSC, 2015).

Moreso, section 28 of the Corrections and Conditional Release Act requires the Service to take all reasonable steps to place an inmate in an institution that provides the least restrictive environment for that offender, taking into account security requirements; accessibility to the inmate's home community; a compatible cultural and linguistic environment; and the availability of appropriate programs and services. (CSC, 2022, p. 24)

Further to this, the Manitoba Government Accessibility Plan (MGAP) emphasizes the need for enhanced accessibility of the built environment stating that it is necessary to adhere to the requirements of the Manitoba Building Code, providing access in a manner that does not establish or perpetuate differences based on a person's disability. Barrier-free universal design principles should be integrated for accessibility when undertaking government projects for current and new buildings, leased spaces, upgrades and refreshes (Government of Manitoba, 2023).

Implementation plans or the design professionals and architects are ableist. "If we include people with disabilities in the planning of our social structures, the accessibility gets built in and

the need for accommodations disappear” (Kuttai, 2010, p. 127). It is important to understand that regardless of being an inmate in prison with individual impairments, the dignity and independence of all persons must be maintained. Everyone should have equal opportunity to full participation in the society and the right to barrier-free and accessible communities.

Some of the offenders living with disabilities occasionally end up in solitary confinement, often allegedly for their safety due to a lack of suitable alternative facilities. The prison atmosphere is difficult to manage for everyone, but it is complicated for those with disabilities.

Physically challenged inmates are constantly at risk of being put in solitary confinement and all the negative consequences that come with it. This situation can exacerbate pre-existing disabilities or chronic diseases, primarily if prisoners are not provided with adequate care and treatment. (Faiz. 2022)

Contrary to this, the facility where I work has been able to address placement of inmates in solitary confinement to the barest minimum such that inmates do not have to spend extended periods in segregation. The jail administrators and the justice department have modified the segregation policy so much that, if possible, an inmate would not be placed in segregation. However, this move countered the notion of placing inmates with disability in solitary confinement for safety purposes. The administrators are making efforts to provide alternative placements for inmates with disability, especially those with mental health disabilities. They provided housing units where these inmates can be safe and provided with essential services to meet their needs.

Ben-Moshe et al. (2014) found that it is difficult for people to get access to any counselling and mental health services in prison. When people do get access to these supports,

they are rarely offered in an ongoing way or over the long term because psychologist/psychiatrist available to prisoners work for Correctional Services Canada and because there is no confidentiality and privacy during therapeutic sessions. Thus, these sessions may not provide the support needed (Ben-Moshe et al., 2014).

However, contrary to this claim, services and supports, counselling, psychologist/psychiatrist, therapeutic and mental health services in the prison facility where I worked has improved. There is evidence of ongoing and long-term services offered especially to inmates with mental health impairments.

It is important to understand that disability matters. It is part of our lives as everyone will experience one form of disability or another at some point in life. Disability is a social and political construction and we need to address this in our work and lives (Michalko & Titchkosky, 2009). Staff need awareness and training about disability. This will address the general attitude and belief that inmates with disabilities ‘do not belong here,’ and that they are a ‘burden’ and staff do not want to deal with the extra work or services required by inmates with disabilities.

The representation of disability within academic approaches tend to get tangled in debates between social and medical models of disability.

The United Nations (UN) stated that disabilities are “long-term physical, mental, intellectual or sensory impairments which, when interacting with different attitudinal and environmental barriers, hinders full and effective participation in society” (United Nations, 2009, p. 51). The concept of disability is gradually seen less in a medical sense and more commonly as an interaction between the individual and the environment. Proponents of the social model of disability sees the issue of ‘disability’ as a socially created problem and a matter of full integration of individuals into the community. It is a complex collection of conditions, many of

which are created by the social environment. For instance, a person with hearing loss is not disabled by the hearing loss itself, but by the environment not providing the appropriate resources for that person.

This takes me back to an experience with an inmate with a hearing loss who could not speak. This inmate faces disability in the prison environment because there is no adaptive technology or specially trained staff to assist the inmate to function independently. Mike Oliver, a pioneer of the social model of disability in the 1980s, based the model on his belief that individual limitation is not the cause of the problem; rather, it is society's failure to provide appropriate services and adequately ensure that the needs of disabled people are considered in societal organization (Grover, 2021).

Inmates in need of assistance with daily activities like showering, getting dressed, taking medications, accessing legal libraries, or shopping at prison commissaries rely heavily on the services provided by corrections officers.

Inmates with disabilities must have equitable access to the same programs, services, and perks as inmates without disabilities. They must have access to practical communication tools, including videophones, audio documents, Braille documents, captioned TV, and other media available to people without impairments. "Prisons are required to provide equal access by making reasonable adjustments, modifications, or other accommodations. Though the terminology might be vague, the intention is obvious" (Faiz, 2022).

"One of the biggest challenges for offenders with physical disability is that prisons have not been designed for people with limited mobility. Therefore, it is challenging for these offenders to get to places like the library, dining halls, or medical facilities. As a result, inmates

miss meals, miss out on access to books and learning opportunities, and may miss out on many other social activities in prison” (Core-Admin, 2022).

The staff working at the intake department have the duty to assess the potential accommodation needs of inmates with known disabilities. It is expected that not only will they need accommodations, but these may differ in relation to whatever program or service that they are involved in. It is vital to establish facility correctional standards that include classification and placement procedures that generally place inmates with disabilities in facilities offering the same programs and opportunities as afforded to prisoners without disabilities. Therefore, the programs must be accessible to inmates with disabilities.

Some jail and prison facilities allow inmates to earn sentence-reducing credits based on their non-violent behavior record. There are programs available to participate in to earn this credit. In the facility where I work such available programs include life skill development programs, bike repairs shop where inmates learn to repair and fix bicycles, and a tailor/sewing shop. Other facilities may have them participate in the maintenance of public lands and manual tilling of farms, however, they require specific eligibility qualifications. Inmates can earn the right to participate in these programs by conforming to the facility rules, but they also must be physically fit, carefully screened, and medically cleared. It is up to the facility to be creative and find work-around ways for inmates with disabilities that meet the behavioral criteria aside from the physical standards of their disability. Luckily, program accessibility may be achieved by several methods. The facility should explore possible program expansion to include a wider range of program opportunities to achieve its goal of having equal opportunity to earn release time (Ballinger, 2020).

Chapter 4: Theoretical Approach

“Prison is both detrimental for people with disabilities and responsible for creating new experiences of disabilities [...] [T]here has been little research conducted about the experiences of disability in carceral spaces” (Ben-Moshe et al., 2014). I will attempt to connect my experiences from the vantage point of an insider as a correctional staff who has direct access and contact with inmates living with a disability in Manitoba corrections. My autoethnography focuses on three theories related to disability and accessibility to support and inform understandings of why disabled inmates are faced with accessibility problems in prison. These theories are the Medical Model of Disability, Social Model of Disability and Pedagogy of the Oppressed.

According to the Canadian government’s Accessible Canada Act, disability means any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment or a functional limitation-whether permanent, temporary or episodic in nature, or evident or not, that, in interaction with a barrier, hinders a person’s full and equal participation in society. (Accessible Canada Act, 2019)

This is evident in Manitoba corrections facilities as there are inmates who needed to negotiate their ways daily in the prison environment because they have an impairment.

One day while at work, I saw an inmate who was incarcerated a couple of days earlier. What caught my attention was the wheelchair I saw in his room while he laid on the mattress. The inmate was an amputee and had to use a wheelchair to negotiate his way around in the living unit. He could not leave his wheelchair outside his cell door to create more room for himself in his cell because other inmates will either play around with the wheelchair, or they could break

off parts of the wheelchair and turn it into a weapon which was a safety concern. It was particularly challenging when he had to shower as the bathroom space was small and there are no grab bars and handles in the shower. He was provided with a shower-chair to use for bathing but had to return the shower-chair and his wheelchair to the small space in his cell. He could not leave the shower-chair in the bathroom as other inmates will have to use the same bathroom to shower. This was a revealing moment for me that led to doing my research on disability and accessibility in Manitoba corrections. I thought that inmates with disabilities – including those who use wheelchairs – need to be able to enter their cells and move around inside them, using the cells features without assistance.

Accessible cells need to contain the same features as other cells for inmates housed at the same classification level. For instance, where other cells contain writing desks, accessible writing desks are needed in accessible cells. What makes this possible? Careful planning and design will incorporate elements such as a wider entrance door, adequate clear floor space, appropriate placement and models of fixtures and furniture, and grab bars.

It is remarkable that we continue to build physical environments that primarily serve able-bodied people given how common it is for almost everyone to experience aging and other forms of bodily impairment at some point in their lifetime. Accessible cells do not compromise the security of prison personnel; they increase security by maximizing inmate independence and minimizing assistance from guards (ADA, 2005).

The more common disability types in Manitoba correctional facilities are hearing, vision, cognitive, and/or physical disabilities. Other types are chronic disease like diabetes.

It can hardly be doubted that there is an almost universal negative response on the part of human beings towards other human beings who are perceived to be different. This is not

to say that such attitudes are not sometimes mixed with more positive ones, but nonetheless, prejudice directed towards those who are different has always been a major component in social problems. (CSC, July, 2007)

For instance, other inmates in the same living unit with the amputee inmate will make random jokes about his wheelchair and how he is different from others especially when he needs to shower. The quick intervention of staff, sometimes reminding other inmates that there is progressive discipline for acts of discrimination and stigmatization, helps to correct those negative behaviours and attitudes.

Many times, throughout history, and well into the twenty-first century, the nature of our humanity has been questioned. It appears that the presence of disability in public life remains disruptive in that it is capable of un-settling long-standing conventions about what belongs in cultural spaces and what does not. [...] Society does not usually perceive disability as a minority or human rights issue. Rather, cultural understandings of disability tend to be highly medicalized, focusing on defect, weakness, and available means of correction. (Hansen et al., 2018, p. 41).

Some people are regarded by the Canadian government as people “with disabilities” insofar as they are people with an “abnormal condition.” Moreover, this condition is understood as a thing that happens to some individuals either at birth or later in life because of an accident, illness, or disease (Michalko & Titchkosky, 2009).

However, there has never been any reliable evidence to support the contention that persons with intellectual impairments are more inclined to commit criminal acts than non-disabled persons (CSC, 2007). The labeling and treatment of disabled people by medical and judicial institutions has historically been intertwined with notions of social danger, deviance, and

criminality, resulting in the disproportionate confinement of disabled people in incarcerating spaces such as prisons and, jails.

According to Zaks (2023), disability is constructed two ways: Firstly, features of a society can manufacture inability. If a society expects young adults to form and run their own households independently, someone needing daily life support is likely to be viewed as inept and a burden. Yet in a society where many intergenerational members of a family remain together across the lifespan, providing one another support and care, the same person may blend seamlessly into the household (Barnes, 2018). If workers are expected to energetically labor for many hours with few breaks under strenuous conditions, individuals with body and brain differences may not be able to participate, leaving them vulnerable to poverty and reinforcing the notion that they are unemployable. Yet if the same individuals can access slower-paced or less physically rigorous economic opportunities, they may participate with ease (Barnes, 1992; Wendell, 1996). In a country with universal healthcare and a robust welfare system, a disabled person may experience few or almost no frustrations related to being disabled. However, in a country lacking either or both, the same disabled person may inadvertently blame the limitations of their bodies and brains for their difficult life circumstances (Albrecht, 2002).

Secondly, historical events can produce disabled bodies and brains. For example, advance medical care allows many soldiers to survive horrific injuries that were previously fatal but that leave them disabled (Andrews, 2020). “People can be disabled by interconnected experiences of colonialism, racism, violence, environmental injustice, and other harmful and oppressive acts” (Zaks, 2023).

There are different ways of thinking about disability. These ways of thinking, the values that underpin them and the presumptions that flow from them can be described by the models below.

Medical Model of Disability

Traditionally, in many cultures around the world, people with physical, sensory, or mental impairments were thought of as under the spell of witchcraft, possessed by demons, or as penitent sinners, being punished by God for wrongdoing by themselves or their parents (*Ableism History*, 2024). Ancient societies used to place deformed or otherwise disabled babies upon concrete slabs outdoors exposed to storms and other harsh elements, thus killing them gradually over the course of a few days (*Ableism History*, 2024).

With the Age of Enlightenment in the 18th century, came a more scientific understanding of the causes of impairment and, with it, a sense of confidence in medical science's ability to cure, or at least rehabilitate, disabled people. Some disabled people (often for social or political reasons) were deemed incurable and placed in long-stay institutions and special schools (or, today, in day-care centres). (*Ableism History*, 2024, para. 2)

A notion of 'normality' was invested with great pseudo-scientific significance. It was based on assessments of impairments from a deficit point of view against normality; it considered what one cannot do instead of what one can do. This has been called 'medical model.' This is not to deny the very necessary role of medical science in keeping many disabled people alive and reducing their pain and discomfort, but disabled people should not be reduced to just their impairments.

The medical model sees disabled people as 'the problem.' They need to adapt to fit into the world as it is. If this is not possible, then they should be shut away in a specialised institution

or isolated at home, where only their most basic needs are met

(<http://www.daseastsuffolk.org/the-social-model/>). The emphasis is on dependence, backed up by the stereotypes of disability that bring out pity, fear and patronising attitudes

(<http://www.daseastsuffolk.org/the-social-model/>). Usually, the focus is on the impairment rather than the needs of the person. The power to change disabled people seems to lie with the medical and associated professions with their talk of cures, normalisation, and science. Often, disabled people's lives are handed over to these professionals. Their decisions affect where disabled people go to school, what support they get, where they live, what benefits they are entitled to, whether they can work, and even, at times, whether they are born at all, or allowed to have children (Ableism History, 2023).

The medical model of disability says people are disabled by their impairments or differences. These impairments or differences should be fixed or changed by medical and other treatments, even when the impairment or difference does not cause pain or illness. The medical model looks at what is 'wrong' with the person and not what the person needs. It creates low expectations and leads to people losing independence, choice, and control in their own lives (Disability Nottinghamshire, 2020). Take for example an inmate who is a wheelchair user trying to access a living unit entrance that has stairs but no ramp. According to the medical model, this person's difficulty with entering the building is due to their mobility impairment, rather than because the building's entrance does not have a ramp. In essence, the medical model places the burden of disability on the individual, focusing on what is 'wrong' with the person, rather than what is wrong with the situation, context, or environment.

More emphasis was placed on the medical model of disability which did not explicitly identify the environment as a factor in disability. The medical model of disability is rooted in an

undue emphasis on clinical diagnosis, resulting to less consideration and inhibiting a holistic view of the disabled individual. This belief in treatment of impairments extends not just to inmates with physical disabilities but to others with cognitive disability. For instance, inmates with mental disabilities are believed to behave and function normally after their disabilities are corrected medically. This belief does not consider the environment and socialization as part of the disabling factors. Imagine when an inmate is locked up in his cell for most of the day or denied access to participate in social activities because of his mental impairment. The absence of meaningful interaction could be more disabling for inmates who already have mental impairments.

In order to understand disability as an experience, as a lived thing, we need much more than the medical 'facts,' however necessary these are in determining medication. The problem comes when they determine not only the form of treatment, but also the form of life for the person who happens to be disabled (Brisenden, 1986). Derksen (1980) notes that the medical model of disability assigns disabled people to a 'sick' role within society, where their sole responsibility is to regain health and return to the 'norm.' In many cases, the 'patient' is treated as a child and is expected to follow orders from doctors or other health professionals in the field (Derksen, 1980; Barnes, 2010). These individuals lose almost all their rights and are denied access to society (Lovell, 2010). Constricted view of disability projects negative attitudes, such as that of a burden or being limited, and stereotypes about disability in the community (Kitchin, 2000).

The medical field treats people as bodies made up of parts that are meant to be manipulated and rehabilitated until they are whole, in which case they give up their ability to make decisions or think for themselves (Hamraie, 2017). A consequence of the medical model of

disability is that people with disabilities often report feeling socially excluded, undervalued, and treated as if they are completely incapacitated or objects of pity. But for many, the main disadvantage of living with a disability is less about their own body and more about society's response to them. This response often comes in the form of an unwelcoming reception in terms of social attitudes and institutional norms, as well as built physical environments that promote exclusion.

Interestingly, the literature repeatedly highlights the way the medical model of disability emphasizes the importance of normalization via treatment and rehabilitation. In the correctional facility, an offender with a disability is expected to overcome his or her 'defects' and live independently. When this is not possible, they are stigmatized by separating them to solitary confinement for their safety and needs.

The medical model sees disability as something that is 'wrong' with a person's body or mind. For example, this model might suggest that a disabled person is 'suffering' from an illness, disease, genetic defect, or injury that would ideally be treated and cured. This way of thinking often makes people want to help by 'fixing the problem,' maybe using drugs, surgery or other interventions. This way of thinking may also make people want to help by preventing transmission of the problem to other generations. Sometimes this is acted on by promoting interventions such as sterilisation or contraception. The medical model is said to make the following assumptions: The person (their body or mind) is the problem. The problem may make difficult for the person to make good decisions about their own life. They are likely to need professionals to look after them. If the problem cannot be fixed, they will never be equal to other people.

Limitations of the Medical Model

The medical model of disability has been criticized for its limitations in understanding and addressing the experiences and needs of disabled individuals. Some of the key limitations of the medical model include individual focus; it tends to view disability as an individual problem or defect that needs to be fixed or cured. It places the responsibility on the individual to adapt to the existing environment rather than addressing the barriers and societal attitudes that contribute to their exclusion and marginalization (Fovet, 2020). This approach pathologizes disability, reinforcing negative stereotypes and stigmatization of disabled individuals, and perpetuating the idea that disability is inherently negative or abnormal.

Furthermore, lack of social context is another limitation of the medical model of disability. It overlooks the social and environmental factors that contribute to disability and hinder the full participation of disabled individuals in society. It fails to recognize the role of societal barriers, discrimination, and lack of accessibility in creating disability-related limitations.

The medical model has limited focus on empowerment and self-determination, often positioning disabled individuals as passive recipients of care and support, rather than active agents in their own lives. It can undermine the autonomy and agency of disabled individuals by prioritizing medical interventions and decisions made by healthcare professionals.

The medical model has a narrow definition of disability, typically focusing on physical or sensory impairments and may overlook the experiences and needs of individuals with cognitive, developmental, or psychiatric disabilities. This narrow focus can lead to a lack of understanding and support for individuals with non-visible disabilities.

The medical model often fails to consider the intersectional experiences of disabled individuals, such as the impact of race, gender, sexuality, and socioeconomic status on disability-related experiences and barriers. This can result in a limited understanding of the unique challenges faced by disabled individuals from marginalized communities.

The medical model is criticized for seeing the impairment as the most important part of the person and suggesting the person is helpless to do anything about this. It is said to be deterministic as it suggests a particular problem will always mean a person cannot be equal.

Because it has its roots in the scientific method, the medical model can only really incorporate phenomena that are measurable and quantifiable. What is important to note is that when disabled people say that something is inaccessible it means that they have had to waste their time and, in the case of the built environment (prison), they may be in danger or in distress because of it. For example, limited access to a washroom or emergency egress, and not necessarily by fixing their disability. This has led to a more progressive social understanding of disability.

Social Model of Disability

To address these limitations, there has been a shift towards adopting a social model of disability which emphasizes the role of societal barriers and the need for inclusive and accessible environments. The social model recognizes disability as a result of the interaction between individuals and their environment. It promotes the removal of barriers and the empowerment of disabled individuals to fully participate in society.

Contrary to the medical model, the social model considers disability a social construct. The model suggests that if societies were set up and constructed in a way that was accessible for people with disabilities, those individuals would not be restricted from full participation in the

world around them. In other words, the social model of disability views the origins of disability as the mental attitudes and physical structures of society, rather than a medical condition faced by an individual (Buder & Perry, 2023). The social model of disability seeks to redefine disability to refer to the restrictions caused by society when it does not give equitable social and structural support according to disabled peoples' structural needs. For example, a wheelchair user wants to get into a building with a step at the entrance. Under a social model solution, a ramp would be added to the entrance so that the wheelchair user is free to go into the building immediately. Providing ramps for inmates who are wheelchair users, accessible bathrooms and accessible cells will enhance independent living.

Essentially, the social model says that individual limitations are not the cause of disability. Rather, it is society's failure to provide appropriate services and adequately ensure that the needs of disabled people are considered in societal organization. Simply constructing sidewalks and entrances that are wheelchair accessible, for example, can negate disability (Buder & Perry, 2023). "This implies that what makes someone disabled is not their medical condition, but the attitudes and structures of society" (Goering, 2015, p. 134–138). The social model faults the common idea of viewing disability as a problem that exists in a person's body and requires medical treatment to fix the disability, to approximate normal functioning, or perhaps as a last measure, to help the individual adapt and learn to function despite the disability (Silvers, 1998). This implies that inmates living with one or more impairments are disabled by barriers in the prison environment, not by their impairment or difference.

Barriers can be caused by people's attitudes to difference, like assuming disabled people cannot do certain things. "The social model projects disability a consequence of environmental,

social and attitudinal barriers that prevent people with disabilities from full participation in society” (PSAC, 2013, para 2).

This model suggests that people with impairments are actually disabled by the way in which society acts. All people are unique and different from each other, all people have unique circumstances which have to be dealt with by the society in which they live. Some people are born with (or develop) an impairment, if they do not have their needs met by society they are being disabled by society’s choices and attitudes. Attitudes and structures in society tend to further exclude disabled children and deny their gender, their sexuality, their race and even their rights as human beings.

People with disabilities have fought hard to have their rights acknowledged. They have ignored and rejected the medical, individual, personal tragedy models of disability and have focused on a theory where disability is created through a social relationship. Within this relationship, society creates an environment that is both physical and attitudinal which disables people (Stone & Priestley, 1996). This disabling environment is created by the people in society and is produced by the culture that people with disabilities live in. The environment can be structurally oppressive for people with disabilities because of how we facilitate or run organizations and services (Stone & Priestley, 1996).

The social model points towards disabling barriers as the reason disability is present in society. This perspective of disabling barriers contrasts with the more common understanding of disability as personal tragedy or a medical problem that needs to be remedied. The social model identifies areas or barriers that require political action or activism to create change. By directing our efforts towards these barriers and creating changes, society could remove social exclusion for people with disabilities. The social model of disability not only views disability in a positive

light, but it also provides solutions to inaccessibility (Barnes & Mercer, 2004). The concept of “Universal Design” was coined by Ron Mace to reflect a type of design allowing all users to be accommodated. Under his leadership, the center for Universal Design at North Carolina State University defined universal design as the design of products and environment to be useable by all people, to the greatest extent possible, without the need for adaptation or specialized design (Crews & Zavotka, 2006). Design standards set by the federal and provincial regulations for the construction of correction facilities must be met, but universal design allows designers and architects to be more flexible to creatively approach solutions.

The social model of disability in relation to accessibility explains how inmates are disabled by barriers which can be physical or related to service provision, not rooted in their impairment or differences. Environmental barriers within the prison are socially imposed on the offenders which are caused by the way the society is organised rather than by their own impairment. Inadequate health care service and inaccessibility to programs are other form of barriers experienced by offenders depriving them of equal access and opportunities to the benefits in correctional facilities.

Ultimately, the social model of disability proposes that a disability is only disabling when it prevents someone from doing what they want or need to do. This idea changes how we typically think of disability by placing responsibility on society rather than the individual. This means that changing aspects of the built environment can change how we think about disability. But changing how we talk about disability can also change how we think about it. The social model of disability makes an important distinction between ‘impairments’ and ‘disability.’ Impairments can be thought of as the functional limitations an individual might face (i.e., not

being able to walk). Disabilities, on the other hand, are the disadvantages imposed on individuals by a society that views and treats impairments as abnormal and hence worthy of exclusion.

Physical and mental impairments are a natural and common part of being human that are deserving of accommodations and civil rights protection. They can (and frequently do) happen to anyone at any time via illness, accidents, genetic conditions, aging, and more. If sufficient accommodations are provided, however, impairments do not need to equate to disability. It is only right for society to design its physical and social infrastructure around this fact of life. (Huemann, 2020, p. 42)

Limitations of the Social Model

While the social model of disability has been influential in shifting the understanding of disability from an individual deficit to a societal issue, it also has some limitations. Some of the key limitations of the social model of disability include overemphasis on physical barriers. The social model primarily focuses on physical barriers and environmental factors that hinder the participation of disabled individuals. While these barriers are important, the social model may overlook the impact of individual impairments and the unique challenges faced by individuals with complex disabilities.

The social model tends to downplay the individual experiences and subjective realities of disabled individuals. It may overlook the personal and emotional aspects of disability, such as pain, suffering, and the impact on mental health and well-being (Terzi, 2004). It is criticized because of its insistence that disability can only be addressed through action to change society and does not recognise the real impact that people's impairments can have on their lives.

The social model of disability has limited applicability to all disabilities. It may not fully capture the experiences and needs of individuals with certain types of disabilities, such as

cognitive, developmental, or psychiatric disabilities. These disabilities may require more nuanced approaches that consider both social and individual factors. While the social model acknowledges the impact of societal factors on disability, it may not fully address the intersectional experiences of disabled individuals. Factors such as race, gender, sexuality, and socioeconomic status can intersect with disability to create unique barriers and challenges that may not be fully captured by the social model alone (Terzi, 2004).

Another limitation is the potential for over-reliance on accommodations. The social model often emphasizes the need for accommodations and environmental modifications to promote accessibility. While accommodations are crucial, there is a risk of placing the burden solely on disabled individuals to adapt to existing environments, rather than addressing the underlying structural and attitudinal barriers (Terzi, 2004).

Furthermore, the social model may not adequately address the medical and health-related aspects of disability, such as access to healthcare, rehabilitation, and assistive technologies. These aspects are important for the well-being and quality of life of disabled individuals and may require a more integrated approach (Terzi, 2004).

Despite enthusiasm for the social model, cracks in the idealist hope for a completely accessible society full of variant human beings with equal opportunities grew by the 1990's (Shakespeare & Watson, 2010). The social model's original disruption of the inhumanity of the medical model unearthed a seemingly intractable problem: "While most disabled people have spoken out against medical care that seeks to normalize variant bodies and brains, some disabled people want, need, and can benefit from medical treatments in certain situations" (Shakespeare & Watson, 2002.). Not all the challenges a disabled person faces are due to social conditions.

The role of healthcare, treatments, and cures in the lives of disabled people has become a contentious issue.

It is important to recognize these limitations and consider a more holistic and inclusive approach that combines elements of both the medical and social models of disability. This can help to address the diverse needs and experiences of disabled individuals and promote a more comprehensive understanding of disability.

Both the medical model and the social model may be helpful in improving people's lives, but both models may also create difficulties. It is becoming more common for people to develop more nuanced models of disability which recognise the impact that society has whilst also recognising the impact and experience of people's individual impairments.

Pedagogy of the Oppressed

People are oppressed for a diversity of reasons – race, class, gender, age, nationality, ethnicity, religion, sexuality, and ability. This is a result of social identities where there is a hierarchy – a social status with dominant and non-dominant groups. “As with race, dominant members can bestow benefits to members they deem normal or limit opportunities to members that fall into other categories” (National Museum of African American History & Culture, 2019). Freire, a Brazilian educator and philosopher who was a foremost advocate of critical pedagogy, endeavoured to help the oppressed fight back to regain their lost humanity and achieve full humaneness.

The concept of "Pedagogy of the Oppressed" can be applied to the experiences of disabled inmates. This pedagogical approach emphasizes the need for critical consciousness, dialogue, and transformative action to challenge oppressive systems and promote liberation. I

have witnessed a situation where an inmate had challenged the policy and procedures in the jail system and eventually got his desired results.

When applied to disabled inmates, the Pedagogy of the Oppressed can help to address the unique challenges and barriers they face within the correctional system. This is not to advocate that inmates become rebellious or organised for the purpose of riot, but through constructive action they can challenge the oppressive system and promote liberation. Here are some ways in which this pedagogical approach can be relevant:

It is important to support and encourage the development of critical consciousness among disabled inmates. These involves recognizing and questioning the oppressive structures and systems that contribute to their marginalization. Disabled inmates may also develop critical consciousness regarding the intersectionality of their identities and reflect on the barriers they face within the correctional system, such as lack of accessibility, discrimination, and limited opportunities for rehabilitation and reintegration. This awareness can lead to a deeper understanding of the unique challenges they face and a commitment to addressing these issues.

Dialogue and communication are an essential aspect of the rehabilitation and reintegration process for all inmates. In the context of disabled inmates, this can involve creating spaces for open and inclusive dialogue between inmates, correctional staff, and disability advocates. This dialogue can help to raise awareness, challenge stereotypes, and foster understanding and empathy. It is important to recognize that disabled inmates have the right to be heard, understood, and actively participate in their rehabilitation and reintegration. Addressing the communication needs of disabled inmates will promote inclusivity, equal participation, and effective dialogue within the correctional system.

Participatory learning: In the case of disabled inmates, this can include involving them in decision-making processes, program development, and policy discussions related to disability access and support within correctional facilities. This could help learning process, development of new skills, gaining confidence, and enhance personal growth.

Empowerment and agency: Disabled inmates can be supported in developing self-advocacy skills, accessing resources and support networks, and participating in activities that promote their well-being and personal growth.

Transformative action: The Pedagogy of the Oppressed encourages individuals to take action to transform oppressive systems and structures. In the context of disabled inmates, this can involve advocating for policy changes, raising awareness about disability issues, and promoting inclusive practices within correctional facilities.

Freire's pedagogy theory states that within any power imbalance with oppressors and the oppressed, the oppressed must liberate themselves. Initially, his theory was not used for people with disabilities, but since has been used by many oppressed groups in society.

To become free the oppressed group must reject the image of the self that the oppressor has created and replaced it with autonomy and responsibility. Freedom then becomes the result of praxis, or informed action, when a balance between theory and practice is reached. (Freire, 2005)

Freire's pedagogy has two stages, the first being the oppressed understand that they are oppressed and then commit to change (Freire, 2005). The second stage of the pedagogy begins when the reality of oppression has been changed, and the pedagogy no longer exists, seeing both groups of people permanently liberated (Freire, 2005).

By applying the principles of the Pedagogy of the Oppressed, correctional facilities can create a more inclusive and empowering environment for disabled inmates. This approach can help to challenge the oppressive systems and barriers that contribute to the marginalization of disabled offenders within the correctional system and promote their rights, dignity, and well-being.

In relation to disability, the oppressed group are prisoners with disabilities. The oppressors could be anyone supporting a person with disability, or anyone who is providing a service to people with disabilities. This can be the design architect, the prison administrators and prison staff and can also include the health care service providers in correctional centers. People with disabilities seem to be oppressed by anyone who is nondisabled. This is a form of discrimination and social prejudice against people with disabilities commonly referred to as ‘ableism.’

Ableism

Ableism is a system of oppression comparable to racism, sexism, and homophobia that subject's people with disabilities to “political, economic, cultural, or social degradation” (Berger & Lorenz, 2015, p. 2). Ableism assumes that some people (and bodies) are normal and superior while other people (and bodies) are abnormal and inferior, and it entails institutional discrimination based on this distinction (Berger & Lorenz, 2015). The presumption that everyone is non-disabled encourages the development of environments that are inaccessible to disabled people. It is a system by which mainstream society denigrates, devalues, and thus oppresses those with disabilities, while privileging those without disabilities. Siebers (2008) calls ableism the ideology of ability, which in its simplest form constitutes a preference for able-bodiedness, but which in its most radical form defines the baseline by which humanness is determined,

setting the measure of body and mind that gives or denies human status to individual persons. As a dominant or hegemonic ideology, ableism is so taken for granted that it remains unconscious and invisible to most people, even though it constitutes an overarching political, economic, and social regime that structures the lives of people with disabilities (Berger & Lorenz, 2015).

Ableism refers to discrimination or prejudice against individuals with disabilities. When it comes to disabled inmates, they may face additional challenges and discrimination within the criminal justice system. Disabled inmates may encounter barriers in accessing necessary accommodations, such as wheelchair accessibility, sign language interpreters, or assistive devices. These barriers can limit their ability to fully participate in programs, services, and activities within correctional facilities. Furthermore, they experience higher rates of abuse, neglect, and mistreatment compared to their non-disabled counterparts. They may be more vulnerable to physical, emotional, and sexual abuse due to their disabilities.

In some cases, disabled inmates may also face difficulties in receiving appropriate medical care and treatment. Their specific healthcare needs may not be adequately addressed, leading to worsened health conditions or unnecessary suffering. Contrary to the claims about inadequacies in provision of specific health care needs, in the facility where I worked, I have witnessed inmates with chronic diseases like diabetes getting medication and medical supplies to check and record their blood sugar level regularly, and they also get a diabetic appropriate diet from the kitchen.

Ableism is rooted in the assumption that disabled people require fixing and defines people by their disability. According to Lewis (2022), “ableism is a system of assigning value to people’s bodies and minds based on societally constructed ideas of normality, productivity, desirability, intelligence, excellence, and fitness”.

Ableism creates a societal meta-narrative in which society perceives disabled persons to be damaged, defective, and less socially marketable than non-disabled persons (Haller, 2010). Professional ideologies in architecture and interior design reproduce cultural assumptions about disability that lead to disabling environment. For instance, there are many elements of the built environment (ableist ideology) that architects and prison administrators transmit into the design structure of the correctional facility that are inaccessible for many and disabling for some.

Historically, the laws regulating the construction of buildings, like building codes, have assumed that everyone using those buildings will be able-bodied. This is because they were originally drafted in the 1900s when people with disabilities were not expected in public spaces. These regulations were meant to ensure the safety of the public in building design and construction but only the able-bodied public.

The history of the regulation of the built environment in Canada reveals an absence of people with disabilities both as decision makers about what we build and intended end users of public space. An understanding of why the built environment does not meet the needs of people with disabilities in Canada could influence how Canadian law and policy makers solve the problem of inaccessibility in the correctional institutions. Today, most academic or policy discussion about disability addresses the importance and desirability of the shift from the medical to the social model of disability.

The social model of disability was transformational when it began to influence public policy to view disability as societal construct rather than an individual problem. However, critical disability theorists argue that it is not enough to identify disabling barriers. We also ought to acknowledge the relational aspects of these barriers; disabled people encounter barriers because of able-bodied privilege.

Everybody is different. Some have differences that no one notices while others are different in very apparent ways. We all look different from others, sometimes by chance, sometimes by choice. Some people move on foot, while others use wheelchairs or other ways of getting around. We communicate in a variety of languages and dialects and by using hand signs. Our behaviour patterns have incredible variety, even within our own families. We all have unique physical strengths and limitations as well as different learning abilities, creative talents, and social skills.

According to Siebers (2008), “people with disabilities want to be able to [...] live with their disabilities, to come to know their body, to accept what it can do, and to keep doing what they can for as long as they can”. They do not want to feel dominated by people on whom they depend for help, and they want to be able to imagine themselves in a world without feeling ashamed (Berger et al., 2013, p. 4).

In almost every case, Siebers (2008) adds,

People with disabilities have a better chance of enjoying a fulfilling life if they accept their disability as a positive aspect of their identity that provides them with a unique and at times contentious way of being embodied in the world.

Addressing ableism and the needs of disabled inmates in correctional facilities is crucial for promoting equality and ensuring the well-being of all inmates within the system. The Manitoba Correctional facilities must prioritize the implementation of inclusive policies and practices. This includes providing reasonable accommodations for disabled inmates, such as accessible housing units, wheelchair ramps, and assistive devices. It is also crucial to train staff members on disability awareness and sensitivity, ensuring they understand the unique challenges faced by disabled individuals and can provide appropriate support.

Additionally, correctional facilities should prioritize healthcare services that cater to the specific needs of disabled inmates. This includes providing accessible medical equipment, ensuring accessible transportation to medical appointments, and offering specialized care for individuals with physical or mental disabilities. They should actively involve disabled inmates in decision-making processes and provide opportunities for their voices to be heard. This can be achieved through the establishment of disability advisory committees or by including disabled individuals in policy development and program planning.

Overall, addressing ableism and advocating for the rights of disabled inmates is crucial to ensure a fair and just criminal justice system that respects the dignity and rights of all individuals, regardless of their disabilities.

Chapter 5: Findings

I had the opportunity to work in different departments and units in the corrections facility where I work. This helped my knowledge and understandings on the procedures of how inmates are processed on arrival from the intake department and assigned to specific living units depending on several factors including their security ratings, gang affiliations, separation from other inmates, mental health disability and many more.

I have also worked with all categories of inmates at different living locations whether living with a disability or not. The minimum-security inmates are usually located on the outside living location. Inmates living in the outside locations are usually inmates with lesser charges and jail terms. Their buildings are separate from the main building where medium and maximum-security offenders are located. Working in all these locations and with all categories of inmates provided me direct contact and experience of what life is like for an incarcerated offender living with a disability.

My findings reveal that there is little information on the data and population of disabled inmates in the Manitoba correctional institutions. Determining the number of individuals with disability who are incarcerated in Manitoba's criminal justice institutions is difficult as statistics surrounding this population are scarce.

There are architectural barriers, such as lack of ramps in certain entrances to some of the units, heavy metal doors that are difficult for a wheelchair user to access, long hallways with no windows for illumination, bathroom spaces too small for wheelchair users and without grip bars in the showers for offenders using crutches and/or wheelchairs. Offenders with visual, hearing and mobility impairments may be unable to access dining areas, libraries, sanitary facilities, work, recreation and visiting rooms. The inaccessible environments are a form of "design

apartheid” where the planners and architects are creating environments that lock disabled people out. “This occurs because planners and architects are interested in how the building looks or how it will be used by the majority and not the minority” (Imrie, 1996). “People with disabilities are not really supposed to be there, and their presence is tentative and unexpected” (Titchkosky, 2011).

Individuals with disabilities in the correctional facilities often face discrimination and stigma. They may be subjected to negative attitudes, stereotypes, and limited opportunities for participation in programs and activities.

Transgender inmates often face unique and accessibility issues within corrections facilities. I have seen instances where inmates with physical disabilities are housed in maximum security units. For safety, I will suggest that the placement officers review the criteria for placement rather than using a blanket criterion, even for inmates living with a disability.

Transgender inmates are usually faced with the difficulties of housing and placement as many facilities have policies that assign housing based on the inmates assigned sex at birth rather than their gender identity. This can lead to safety concerns and increased vulnerability for transgender inmates. Access to appropriate medical care is crucial for transgender inmates. This includes access to hormone therapy, gender affirming surgeries, and mental health support. However, many of the facilities lack trained medical staff who are knowledgeable about transgender healthcare needs. Transgender inmates are at risk from other prisoners and therefore it is the staff’s responsibility and duty of care to ensure the safety of a trans offender and to adapt their ways to fit their needs. Transgender inmates may face challenges related to clothing and grooming as the corrections facilities have strict dress codes and grooming policies that may not align with inmate’s gender identity. They also experience higher rate of mental health issues

including depression, anxiety and gender dysphoria. Corrections staff should receive education and training on transgender issues to create a more inclusive and supportive environment.

Correctional facilities in Manitoba does not provide adequate rehabilitation and support services for offenders with disabilities. This includes access to vocational training, educational programs, and mental health support.

Offenders with disabilities are overrepresented in the correctional system. This may be due to a lack of community-based support services, limited access to healthcare and treatment, and systemic barriers that prevent offenders with disabilities from fully participating in society.

Another important finding is the inadequate training for staff on how to provide services and assistance for offenders with disability. A lot of the staff lack basic training in providing services especially to inmate with mental health disabilities, transgender inmates, inmates who are hard of hearing, speaking disabilities, and those with unique access needs.

Further findings also reveal the inadequacies in the provision of health care services. A lot times, offenders with disabilities such as mental health are kept on a long waiting list in order to see the psychologists and the psychiatrist. Also, access to therapist is either limited or not available for disabled inmates that require therapy while incarcerated.

Offenders with disabilities encounter difficulties in participating in prison activities that do not take account of their access needs such as attending programs or even the recreation yard.

Some offenders with mental health impairment experience discrimination and violence from other inmates which sometimes results in the offender with disability getting placed in segregation. The prison administrators need to ensure the safety and protection of inmates with disabilities.

Offenders who are ethnic and racial minorities and lesbian, gay, bisexual, and transgender with disabilities are at risk of intense discrimination, abuse, sexual assault, and other forms of violence in the prison setting.

My findings revealed that many social benefits of offenders are terminated when they enter the prison system. Offenders cannot receive income assistance or general assistance.

Compared with non-disabled incarcerated offenders, disabled incarcerated offenders were more likely to report previous residence in both punitive and therapeutic institutions. Although therapeutic institutions are intended to provide medical care and be more humane than punitive institutions, they often reinforce social control and structural oppression through mechanisms such as involuntary commitment.

The disproportionate representation of disabled people in prisons in part reflects heightened risk of incarceration. Compared with non-disabled offenders, disabled offenders have high levels of contact with the criminal legal system. Both medical and judicial institutions have played a role in the identification and treatment of disabled people in ways that link disability to notions of social danger, deviance, and criminality, ultimately contributing to high levels of confinement of disabled people in prison institutions (Bixby et al., 2022).

Addressing disability and accessibility issues in correctional facilities requires collaboration between correctional administrators, disability advocates, healthcare providers, and policymakers. It is essential to develop comprehensive policies and practices that prioritize the rights and needs of individuals with disabilities.

Chapter 6: Limitations

Within all forms of research, there are limitations, and my research is not the exception to this. The first limitation is my place of privilege in the writing. I am a non-disabled person who did not require support or accommodation of any kind. I am writing about my experiences as an ally to people with disabilities and not from the viewpoint of a person with a disability.

Another limitation in my research is the lack of engagement with people with disabilities. Whenever possible, people with disabilities should be included in the research process. They should be included in the creation of the research question, the process that is being used, and the outcome of the research. By including them within the research, we are providing them with the power as the researcher. When someone is researched, they become an object without stories or agency, but by including them as researchers, we are allowing them to make their own decisions (Smith, 2012).

Further, my research is conducted around the justice environment. When conducting research in a prison setting, the context is different from other research situations in which physical or mental health is being studied. The prison context influences such factors as confidentiality, obtaining consent, and other issues like my position as a rational authority.

My research does not include information about all impairment types as I can only speak to experiences I have had with people in direct contact and relationship. Many of my earlier personal experiences are connected to the experiences of those people with developmental disabilities, while my latter experiences are from the viewpoint of various disabilities. The etiology (or cause) of inmate's disability is unknown, as my study is not designed to assess whether a disability is congenital, genetic, or biological, illness or disease related, or caused by something in the environment (e.g., a gunshot wound). As such, the temporal relationship

between disability onset and incarceration is unknown. For this reason, it is inappropriate to infer causation or correlation between disability status and criminality.

My study does not ask how often or how severely the disability limits or impairs an inmate's ability to function (e.g., daily struggles). There is an environmental or social component to disabilities which can frame how individuals view themselves and their impairments. For example, the effects of some impairments can be minimized with the proper medical treatment and accommodations (e.g., a cane). With the proper accommodations and support, inmates may or may not consider themselves to have a disability.

My study has a small sample size which may limit the generalizability of the research findings. The experiences of inmates with disabilities in a correctional facility in Manitoba may not necessarily reflect the experiences of those in other facilities.

Some of the sources of data in my study rely on self-report data, which can be subject to bias. Offenders may underreport or overreport their experiences, and their perceptions may be influenced by factors such as social desirability or memory recall.

Autoethnography research is often criticized (Duncan, 2004). Typically, a marginalized group of individuals use autoethnographies to portray their truths. I, myself, am not part of the marginalized group of people with disabilities, but I am an ally to them and have many experiences as a staff and a friend. Autoethnography is not expected to be a representative example; my experiences will not be replicated in every person. This is one reconstruction of an individual's narrative, but it is not the only one. Another person may have completely different experiences, views, and ideas regarding the same topic due to their own lived experiences (Yin, 1989). Form and content cannot be separated. The form of representation that I use as a researcher shapes the form of understanding for the reader (Richardson & St. Pierre, 2005). The

writing in itself is analysis, but the way in which it is conducted impacts the reception of the work.

Lack of intersectional analysis is another limitation. Intersectionality, which considers how multiple social identities intersect and interact, is often not adequately addressed in research on disability and accessibility in correctional facilities. This can result in an incomplete understanding of the experiences of inmates with disabilities who also belong to other marginalized groups, such as racial or ethnic minorities.

This research study primarily focuses on the perspectives of incarcerated inmates with disabilities, while not fully considering the perspectives of correctional staff, administrators, or other stakeholders. Including a range of perspectives can provide a more comprehensive understanding of the issues at hand.

Despite the limitations in my research, my topic is quite relevant as little has been done using the autoethnography method. It also plays a crucial role in identifying challenges and informing policy and practice. My goal is that my readers finish this reading with a thorough understanding of the opportunities and advantages related to access and disability in correctional facilities so that they may be able to create change that is needed. I urge my reader to think critically about the growing waves of incarcerations and disability and question the norms that they may now notice related to access and disability in correctional facilities.

Chapter 7: Recommendations

People with disabilities are liable to face discrimination directly or indirectly throughout their lives, despite legislation in many countries prohibiting such discrimination. The discrimination persons with disabilities face in society are intensified in prison. Offenders with disabilities encounter difficulties in accessing services, complying with rules and participating in prison activities that do not take account of their access needs. Due to architectural barriers, offenders with mobility impairments may be unable to access dining areas, libraries, sanitary facilities, work, recreation and visiting rooms. Offenders with visual disabilities cannot read their own mail unassisted or prison rules and regulations unless they are provided in Braille. They are unable to use the library, unless taped materials or books in Braille are available. Offenders with a hearing or speaking disability may be denied interpreters, making it impossible for them to participate in various prison activities, including counselling programmes, as well as their own parole and disciplinary hearings. Offenders with disabilities can be routinely denied participation in work programmes outside prison, sometimes significantly lengthening their periods of imprisonment.

Transgender inmates are at risk from other prisoners and therefore it is the staff's responsibility and duty of care to ensure the safety of a trans offender and to adapt their ways to fit their needs. To better support trans people in prison, there must be dedicated spaces and support for them. Additionally, supplying them with information on charities and support services in the community when they are released is essential as part of their resettlement.

Correctional officers can request support or training to feel better equipped to support those who are LGBT+. Along with this, it must be made clear to the staff why misgendering is harmful and undermines other people's identities.

Policy / Law

This work includes calling for enforcement and funding of existing disability laws, increased support for resources that allow disabled offenders to live like any other offender, such as robust medical care.

Adhere to the requirements of the Manitoba Building Code, providing access in a manner that does not establish or perpetuate differences based on a person's disability.

Integrate barrier-free Universal Design principles and work environment accessibility when undertaking government projects for current and new buildings, leased spaces, upgrades and refreshes.

Explore the addition of Beacon technology, a form of digital accessibility, to correctional facilities to assist individuals with vision impairments.

Provide reminders to all building managers that they need to provide notice when an accessibility feature will be unavailable (including parking, entrances or elevators).

Require trainers and facilitators to have an understanding of accessibility and create training materials and representations that are inclusive and accessible.

Provide adequate training for staff on how to deal/relate with offenders with a disability.

Sensitization and promoting awareness of accessibility in public and government newsletter such as training reminders, updates on standards and tips. Changing how we talk about disability can also change how we think about it.

Systematically screen offenders for all types of disabilities upon entry into the prison and provide reasonable accommodations. Ensure offenders with disabilities have adequate access to support and mental health services.

The attitude of staff is a key element in ensuring the protection of the human rights of prisoners with disabilities and reducing discrimination in prison. Where resources allow, the appointment in each prison of a member of staff to act as a contact point for prisoners with disabilities, as well as adviser to the prison management on policy issues and the needs of prisoners with disabilities should be considered.

Staff Training

Staff training needs to emphasize that prisoners with disabilities have the same human rights as all other prisoners and that they should not be treated more harshly, isolated or taunted due to their disability and difficulties arising from their condition. Appropriate techniques of dealing with prisoners with disabilities, when difficulties arise, should be included in staff training.

Staff should be trained to undertake effective supervision of prisoners with disabilities to prevent their abuse and ill-treatment by other prisoners, which should complement the allocation of prisoners with disabilities away from possible risk groups. Staff should also be trained to detect signs of distress in prisoners with disabilities and coordinate with the prison psychologist and medical officer, as relevant, to prevent mental disabilities from arising and worsening (UNODC, 2009).

Access to Justice

In order to ensure that persons with disabilities can access justice on an equal basis with others, prisoners with disabilities should have prompt and regular access to legal counsel similar to all other prisoners from the outset of their detention, and assistance should be provided for their communication with lawyers. Access needs relating to their disability should be provided during the entire criminal justice process to ensure that they can participate in the procedure on

the same basis as others. Staff need to be trained and sensitised to the needs of prisoners with disabilities, demonstrate sensitivity, and assist them in accessing appropriate support (Atabay, 2009).

Intake of Offenders

Prisoners with disabilities should be given an opportunity to declare any disability and provide information about their special needs on entry to prison and they should be provided with information about the prison and prison rules in a format that is understandable to them (e.g., in Braille or audio taped for prisoners who have serious visual impairments and large print for those with lesser visual disabilities). Prisoners should be allowed to keep in their possession any form of aid relevant to their disability such as wheelchairs and crutches, unless there is a genuinely justifiable security reason not to do so. If there is deemed to be a risk involved, suitable alternatives must be provided. Prisoners with disabilities need to undergo an induction programme appropriate to their needs to identify their capabilities and special requirements, especially including health care and educational needs, and to determine the level of and type of support they require. They should be given information on who to contact if in need and procedures should be carefully explained (Atabay, 2009).

Classification, Allocation and Accommodation

Like all prisoners, prisoners with disabilities should be housed in the minimum-security conditions required for their safe and secure custody, including accommodations suitable to their needs to help them cope with their new environment. For example, handrails can be provided in their cells, steps can be painted in bright colours and marked to make them visible for those with visual disabilities. Portable ramps can be used to facilitate the access of those using wheelchairs. Health care services should be easily accessible. The risk of abuse by other prisoners should be

taken into account when determining the allocation of prisoners with disabilities to ensure their protection. Female prisoners with disabilities are at increased risk of abuse. Their need for protection should be taken into account in their allocation (Atabay, 2009).

Health Care Services

The Manitoba Correctional facilities should collaborate with healthcare professionals to provide specialized medical care and treatment for disabled inmates. This includes regular check-ups, medication management, and access to necessary therapies or interventions. Prisoners with disabilities should have equal access to all health care provided to other prisoners, which should be equivalent to that in the community. They also need to have access to the same level of specialist health care available in the community. This may include physiotherapy, speech and occupational therapy, treatment for sensory disabilities, as well as access to adequate assistive technology. Prison authorities will need to cooperate with community health services to ensure that such needs are met to the maximum possible extent. Due to the difficulties associated with coping in the prison environment, including bullying, taunting and sometimes violence by other prisoners, prisoners with disabilities are also likely to need specialist mental health care which should be provided by specialist staff. Where prisoners with disabilities have problems with communication (e.g., prisoners with sensory disabilities), assistance should be provided to ensure that they have equal access to counselling programmes (Atabay, 2009).

Access to Programs and Services

The Manitoba corrections should offer training and support programs tailored to the needs of disabled inmates. Corrections should take all possible measures to ensure the equal access of offenders with disabilities to prison activities, including educational and vocational

training programmes, counselling and recreation. However, prison authorities need to make sure that alternative means ensuring prisoners with disabilities' access to services are in place.

These programs aim to enhance their skills and abilities, promoting self-sufficiency and independence. For instance, vocational training programs may be provided to develop job skills and increase employability upon release.

Cooperation with organizations of civil society should be established to design and run programmes suitable for the needs of prisoners with disabilities. Such cooperation will ease the burden of prison staff, ensure that prisoners with disabilities are given an opportunity to participate in programmes designed for their needs, and increase contact between the prisoners and the outside world. This will have a beneficial effect on their mental well-being. Where groups of prisoners with similar disabilities exist, suitable group activities can be organized with the assistance of outside organizations. Libraries should provide books in alternative formats to cater to the needs of prisoners with disabilities. For example, materials in Braille, audio taped books for those with visual disabilities, and sign language interpreted videos for prisoners with hearing disabilities. Where access to libraries is difficult for those who have mobility impairments, books may be delivered to cells/dormitories using library trolleys. Information about organizations providing assistance to persons with disabilities should be displayed on the walls of the prison and provided in an accessibly formatted information package and handed to prisoners with disabilities on entry (Atabay, 2009).

Safety and Security

To ensure the safety of disabled inmates, the Manitoba corrections need to implement comprehensive risk assessments and develop individualized safety plans. The need to take into account safety and security concerns during the allocation of prisoners with disabilities is

important. Offenders with disabilities should not only be held in a safe environment, but like all other prisoners, they also need to feel safe so that their mental well-being is protected. This may require some small additional measures and considerations, such as identifying potential hazards and mitigating risks specific to the disability, conducting the searching of prisoners with disabilities with special sensitivity, or informing prisoners with visual disabilities when approaching them due to the anxiety this may cause in the coercive and sometimes violent environment of prisons. Placing prisoners with disabilities in isolation cells can have extremely harmful consequences due to the psychological distress suffered by this group of prisoners, which is likely to be exacerbated by isolation. Such punishment should be avoided as far as possible and only be used as a measure of last resort for the shortest possible period. Prisoners with disabilities should be able to defend themselves during disciplinary hearings and all necessary assistance should be provided to ensure that this happens (for example, sign language interpreting for those with hearing and speaking disabilities).

Staff members should be trained to provide appropriate assistance and support, ensuring the well-being of disabled inmates in emergency situations. Prison authorities need to ensure that prisoners with disabilities have equal access to complaints procedures. If they have difficulties making complaints, due to their disability, suitable assistance should be provided (Atabay, 2009).

Custody Release Plan

The assistance of probation services, welfare agencies and appropriate organizations of civil society should be sought in preparing prisoners with disabilities for release. The process of cooperation with outside agencies should begin as early as possible during the preparation process. Appropriate advice on employment and housing should be provided in cooperation with such agencies and continuing care should be arranged in the community for those in need.

Prisoners with disabilities should have equal access with others to early conditional release. The fact that they may have been unable to participate in the requisite number of prisoner programmes due to their disability should not disadvantage them in deciding early conditional release. Compassionate release should be considered for those who do not pose a threat to society and whose disability leads to serious difficulties in coping with prison conditions and thus undermining efforts of social reintegration (UNODC, 2009).

To ensure the equal treatment of prisoners with disabilities and their social reintegration, prison authorities need to take affirmative action. A prison service policy statement, clearly prohibiting discrimination against prisoners with disabilities and actively promoting equality of treatment should be developed and displayed prominently in all prison establishments.

Data collection and assessments should be undertaken on a regular basis, bearing in mind the scarcity of information and record keeping on prisoners with disabilities, to identify shortcomings and good practices, and to improve the situation of prisoners with disabilities.

Universal Design Principles

Implementing universal design principles in correctional facilities involves creating an inclusive and accessible environment that accommodates the diverse needs of all individuals, regardless of their abilities or disabilities. By incorporating these principles, Manitoba correctional facilities can ensure that everyone, including inmates, staff, and visitors, can navigate the facility safely and comfortably.

Universal design principles focus on removing barriers and promoting equal access for all. In the Manitoba correctional facilities, this means designing spaces that are wheelchair accessible, providing clear signage and wayfinding systems, and ensuring that all areas are easily

reachable for individuals with mobility challenges. Additionally, incorporating visual and auditory cues can assist inmates with visual or hearing impairments.

Moreover, implementing universal design principles in correctional facilities extends beyond physical accessibility. It also involves considering the needs of inmates with cognitive disabilities, such as providing clear and concise instructions, using plain language, and utilizing visual aids to increase comprehension.

By embracing universal design principles, Manitoba correctional facilities can foster an environment that promotes inclusivity, dignity, and equal opportunities for all individuals. It not only benefits those with disabilities but also enhances the overall safety, functionality, and efficiency of the facility.

Offenders who are ethnic and racial minorities and lesbian, gay, bisexual, and transgender prisoners with disabilities are at risk of intense discrimination, abuse, sexual assault, and other forms of violence in the prison setting. The principle of non-discrimination enshrined in the United Nations Standard Minimum Rules (UNODC, 2015) should be understood to cover prisoners with disabilities. More specifically the principles contained in the United Nations Convention on the Rights of Persons with Disabilities adopted on 13 December 2006 apply to all persons with disabilities, including those facing criminal prosecution, detainees, and prisoners (Atabay, 2009).

Chapter 8: Conclusion

The intent of this research was to discover the barriers to accessibility for offenders with disabilities through autoethnographic analysis of my own experiences as an ally to people with disabilities. My goal in research was to determine what barriers to accessibility offenders with disabilities face while incarcerated, unearthing the underlying reasoning for these barriers, and providing specific examples of accessible prison environment that could aide independent living.

I have been impacted positively through this research work and I hope that this research work will also serve as basis for another research project in the same field. My study on accessibility in relation to disability informed me that it is sometimes difficult to be an optimist when the facts show that our society has a negative view of disability. My research has allowed me to gain a greater understanding of the experience's offenders living with disabilities have with accessibility in the prison environment.

The social integration needs of offenders with disabilities are rarely served in prisons and their imprisonment should be avoided as far as possible, taking into account the offence committed and public safety requirements. However, Carson (1989) "argues that the criminal process is not only designed to administer punishment to offenders; it is also designed to protect accused persons from wrongful conviction". His point is that, if a person with an intellectual disability is diverted from the ordinary correctional stream into some form of confinement in a non-penal facility designed to serve handicapped individuals generally, he or she will lose some of the legal protections guaranteed to prisoners, including the right to release after a predetermined period of time (CSC, March 1991).

Where possible, persons with disabilities should be diverted from the criminal justice system at the first point of contact with law enforcement officers. If not, diversion should be

possible throughout the criminal justice process — during prosecution, trial and on imprisonment.

Prison sentences should be used as a last resort in all cases. This principle should be fundamental in deciding whether to imprison offenders with disabilities, and especially those who have committed non-violent offences, taking into account the level of care they are likely to receive in prisons.

The development of suitable non-custodial programmes for those with disabilities, combining treatment where relevant with supervision in the community, would comprise a more humane and effective way of dealing with such persons' needs while ensuring public safety (United Nations, 2009).

Throughout this project my thinking has changed. I had to question what I had come to believe were truths, and had to question where these truths came from, and what was actually occurring. My hope is that my research on disability and access will encourage further study into eliminating barriers and creating accessibility in the prison environment for all regardless of impairment.

Prison administrators, design architects, government, individuals and communities are responsible for creating change for offenders living with disabilities. As stated by Hansen (2009),

There is no magic solution, but we must confront the question about how much more could be accomplished if disabled people were better able to make their way in the world on their own terms. Much of their energy is spent trying to gain the “right” of passage; to cope with the negative attitudes, the poorly arranged surroundings, the constant fear of being “on approval”

in non-disabled space: surely, much more could be achieved if this energy were expended in other, less negative ways. (p. 263)

Furthermore, when an individual's disability is not taken into consideration during community release planning, and specialized supports are not accessible, the individual's ability to effectively re-integrate into the community, adhere to conditions of probation, and behave in acceptable pro-social ways are limited.

My thesis should provide readers with the information to challenge their beliefs and attitudes on a personal level, to promote inclusion and participation for people with disabilities, and to ensure all environments, particularly correctional facilities, are accessible. Inclusion means that all products, services, and societal opportunities and resources are fully accessible, welcoming, functional, and usable for as many people as possible.

It is my hope that this study will contribute to the growing research and literature about accessibility and disability in the correctional facilities in Manitoba. This contribution will add to the already existing theory on the experiences of offenders living with disabilities and barriers they face with accessibility, what approach is taken to create access and accommodation for disabled inmates in Correctional facilities, what training is provided for staff regarding disabled inmates, and what course of action is taken to advance the independence of an inmate who is disabled while ensuring their safety.

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