

CHAPTER 7



Older and Geriatric Offenders: Critical Issues for the 21st Century

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Over the past several decades, the level of attention directed toward managing aging prisoners has risen substantially. Internationally, research from the United Kingdom (Howse, 2003; Wahidin & Cain, 2006); Sweden (Fazel & Grann, 2002); France (Steiner, 2003); Canada (Gal, 2002); Australia (Grant, 1999; Dawes, 2009); and Japan (Johnson, 2000) indicate these countries, along with the United States, are all grappling with nearly identical issues associated with an aging prison population. Without timely attention to the experiences of geriatric offenders, officials globally will undeniably be presented with a crisis that, in return, would negatively impact all aspects of the correctional system. Despite the fact that nations around the globe are confronted with the dilemma of managing increasingly large numbers of older offenders, prisons have been slow to respond to the social, physical, and mental health needs of this special subgroup of inmates. Although a number of countries have commissioned studies to examine and make policy recommendations, the body of knowledge available on forecasting future policies for aging prisoners remains limited (Sterns, Lax, Sed, Keohane, & Sterns, 2008.)

Correctional officials are now realizing the enormity of their responsibilities for addressing age-related needs in the areas of health, safety, protection, recreation, and socialization (Aday, 2003). The primary aim of this chapter will provide a voice to aging prisoners' experiences and highlight approaches for addressing these concerns. In the process, we will identify characteristics officials use in defining older offenders, distinguish among types of elderly offenders, and discuss how various medical and mental health problems, left unaddressed, negatively affect institutional adjustment. Looking to the future, we will shed light on concerns such as major advantages of age—segregated housing, the growing need for assisted living, nursing home or hospice units—as well as the demand for compassionate release, medical parole, and community-based alternatives to incarceration. Finally, consideration will be given to examining the impact the challenges associated with managing the geriatric prison population today will have on sentencing practices in the 21st century.

GRAYING OF AMERICAN PRISONS

During the past several decades, there has been significant interest given to the prevalence of criminal activity among older adults. During the 1980s, the notion that the country was experiencing a “geriatric crime wave” received considerable media attention (Flynn, 2000). Although offenders age 50 and older continue to maintain the lowest overall crime rate of all adult age groups, Table 7.1 indicates the number of arrests among individuals in this age category are rapidly increasing. For example, the number of age 50 and over arrests increased from 473,162 in 1998 to 895,419 in 2009. As Table 7.1 clearly shows, the near doubling of older citizen arrests actually has occurred during the past five years. Significant increases in criminal activity are obvious for both males and females and approximately 15% of older adult crimes are serious felonies leading to incarceration. Table 7.2 supports the notion that older adults are involving themselves more frequently in drug and often related property crimes.

The majority of older males, however, are incarcerated in state prisons either for murder, sexual crimes, or drugs while females are more likely to be serving time for murder or drug-related crimes (Aday, 2003; Aday & Krabill, 2011). As the baby boom population continues to swell the ranks of older adulthood, the number of

Table 7.1

Gender Differences in Number and Percentage of Arrests for All Crimes Age 50 and Over (1998–2009)

	Number of Arrests (1998–2009)			
	1998	2004	2009	Percentage Change
Males				
50–54	194,912	266,395	377,048	+93.4
55–59	98,742	127,852	190,341	+92.7
60–64	51,319	59,614	85,009	+65.6
65+	53,325	49,672	64,082	+20.1
Total	398,298	503,533	716,480	+44.4
Females				
50–54	38,805	62,340	99,500	+156.4
55–59	17,457	26,702	42,964	+146.1
60–64	8,300	11,597	18,592	+124.0
65+	10,302	10,638	17,883	+73.5
Total	74,864	92,639	178,939	+139.0
Grand Total	473,162	533,969	895,419	+89.2

Source: U.S. Department of Justice, Bureau of Justice Statistics (1998, 2004, 2009). *Sourcebook of Criminal Justice Statistics*.

Table 7.2 Gender Differences in Number of Arrests for Crime Index for Persons Age 50 and Over (1998–2009)

	Number of Arrests (1998–2009)							
	1998		2004		2009		Percentage Change	
	M	F	M	F	M	F	M	F
Violent Crimes								
Murder	477	85	498	88	614	82	+28	–03
Rape	1,135	10	1,160	7	1,306	10	+15	NC
Robbery	885	102	1,490	169	2,234	299	+152	+193
Agg. Assault	16,115	2,456	17,454	3,225	24,007	5,133	+49	+109
Property Crimes								
Burglary	2,800	590	4,254	883	7,286	1,432	+160	+159
Larceny-Theft	23,372	13,167	30,321	16,809	43,801	27,420	+87	+108
Auto Theft	1,167	163	1,627	238	1,796	316	+53	+93
Arson	345	99	409	118	505	132	+46	+33
Selected Crimes								
Drugs	23,676	3,855	42,184	8,186	63,809	13,725	+169	+256
Other Assaults	41,955	6,519	44,182	9,580	64,992	15,366	+54	+135

Source: U.S. Department of Justice, Bureau of Justice Statistics (1998, 2004, 2009). *Sourcebook of Criminal Justice Statistics*.

arrests and certain incarceration will no doubt continue in the foreseeable future creating any number of end-of-life challenges for correctional officials.

With the graying of America, the increased use of punitive sentencing policies leading to selective incapacitation, and greater numbers of older adults committing violent offenses, all have contributed to the unprecedented growth of aging prisoners (Aday & Krabill, 2011; Auerhahn, 2002). With a massive construction in prison beds, correctional administrations nationwide have been pressed with increased responsibilities for receiving and responding to older adult populations. In 1990, the Corrections Yearbook indicated there were 33,499 inmates who were age 50 and over residing in state and federal institutions. This number tripled to 113,358 by 2000 comprising 8.2% of the total prison population at that time (Aday, 2003). This growth trend continued and in 2010 that number had risen to over 200,000 or about 13% of the total prison population. This number includes over 7,000 incarcerated females age 50 years and older representing about 6% of the older adult population. Of those grouped in the older prisoner category, over 112,000 are 55 years of age and older with 16,405 being over 65 (American Correctional Association (ACA), 2010; Sabol, West, & Cooper, 2009). Assuming sentencing trends

remain constant, it has been predicted that offenders 50 and older will account for one third of the inmate population by 2030 (Rikard & Rosenberg, 2007; Williams et al., 2006).

While prison administrators have primarily been interested in the management of older male offenders, officials also have begun to devote increasingly more attention to the experiences of women aging in prison. Even though women over 50 account for only 6% of all offenders (Sterns et al., 2008), the graying of our nation's prisons cannot be understood apart without regard for gender-specific issues older women present to management (Aday & Krabill, 2011; Williams et al., 2006). In addition to addressing concerns common to other geriatric offenders (educational deficits, histories of unemployment), response to this population includes assistance in overcoming stressors associated with extensive histories of abuse and prior involvement in prostitution or work in the sex industry. With older women, administration must also recognize the impact that the onset of menopause has on offenders' qualities of life. While the small number makes it more challenging to offer the range of services available in men's facilities, states are recognizing the impact a failure to act will have on the aging women now and after postrelease. Thus, many are developing instructional activities with consideration to the need for an intersection between age and gender sensitivity (Aday & Krabill, 2011).

DEFINING THE OLDER OFFENDER

Defining *old* as it applies to the prison setting is an extraordinarily challenging task for correctional administrators due to biological, psychological, and social positions of offender populations. Working with geriatric offenders, for example, entails treating those whose lives have been fraught with excess alcohol consumption, smoking, sexual promiscuity, and heavy manual labor that, taken together, have impacted healthy aging. Following the entrance into the prison setting, any preexisting symptoms are vulnerable to further deterioration as medical services tend to lag behind mainstream medicine in terms of offering necessary treatment (Deaton, Aday, & Wahidin, 2009; Vaughn & Collins, 2004; Watson, Stimpson, & Hostick, 2004). Concerns such as psychiatric, neurological, dermatological, gastrointestinal, respiratory, musculoskeletal, and cardiovascular conditions, for example, have been reported to remain untreated in older adult offenders (Fazel, Hope, O'Donnell, & Jacoby, 2004). Coupled with environmental hazards associated with residence in this institutional setting, elders may discover it nearly impossible to avoid the early aging process that has been discussed extensively throughout the extant literature.

The inability to agree on what constitutes an elderly offender is one of the more troublesome aspects of comparing research outcomes. A review of the literature reveals that care must be taken to account for the fact that background socioeconomic statuses, lifestyle choices, access to preventive health care, and now, institutional stressors make offenders 10 to 15 years older physiologically than their chronological age (Aday, 2003; Wahidin & Aday, 2010; Wick & Zanni, 2009; Williams et al., 2010). The National Institute of Corrections defines older inmates as those 50 years

of age or older and the American Correctional Association recommends that prisoners should be classified by level of physical impairment, regardless of age (Wick & Zanni, 2009). Although states may use various criteria to classify this subset of the inmate population, the ages 50 and 55 are the two most widely recognized ages utilized for early intervention (Sterns et al, 2008). However, caution should be used when using chronological age exclusively to define the onset of old age. As in the general population, some individuals are considered old at 50 or 60 because of excessive chronic conditions while other may be comparatively young from a health standpoint at age 70 or 80. With some individuals thriving in this environment, sensitivity must be granted to inmate diversity and care taken to ensure the climate is one conducive to supporting all offenders into their later adulthood years.

OLDER OFFENDER TYPES

Correctional management must recognize that aging prisoners are truly a diverse group, with varying background demographics, experiences with the criminal justice system, health problems, or service needs. Sentence histories and lengths, for example, may often be key determinants of stressors faced while incarcerated, engagement in health-seeking behaviors, and coping mechanisms adopted for adjustment purposes (Loeb, Steffensmeier, Kassab, 2011; Reed, Alenazi, Potterton, 2009). In creating a climate most responsive to their concerns, care should be taken to distinguish among the needs of new, chronic, or aging offenders (Aday, 2003, Smyer & Gragert, 2006). The chronic offender or multiple recidivists may spend a significant amount of his or her life revolving in and out of prison. Typically the crimes committed would more likely mirror those of a younger offender.

However, today much attention is being directed toward the management of the new elderly offenders or those who have entered prison relatively late in life. It has been noted that this group of inmates entering prison after the age of 50 collectively comprise slightly less than half of the total geriatric prison population (Wahidin & Aday, 2010). As a whole, this group is more likely to commit violent crimes (murder or sexual offenses) against another person compared to the vast number of chronic offenders. In working with these offenders, sensitivity must be communicated to problems inherent to the nature of their crimes. The following provides some of the unique characteristics of first-time offenders that typically provide challenges for prison staff:

- Frequently suffer from prison shock/difficulties in coping with late-life imprisonment
- May be estranged from families due to violent crimes committed against family members
- May have grief issues related to loss of family, friends, and life on the outside in general
- May have guilt issues due to sexual offenses/homicides against family members
- May experience fear associated with late-life incarceration, especially for frail vulnerable inmates

- May isolate themselves from the larger social milieu, spending much time in their cells
- May experience suicide ideation, common among inmates entering prison with mental health issues
- May have unrealistic expectations about prison health care often comparing with outside experiences

Given the problems new elders have coping with incarceration, assistance must be given to ensure they receive sufficient stimulation, nourishment, and rest until they become acclimated with the subculture and adopt strategies for adaptation.

Another group of elder offenders for whom administration must provide supportive services, long-term offenders, are identified as having arrived at prison prior to age 50 and having served twenty or more years behind bars. Typically, these elders face complex problems in the areas of preserving external relations, establishing and maintaining internal relationships, physiological deterioration, prison environments, and indeterminate sentencing practices (Aday, 2003; Flanagan, 1995, Leigey, 2010). Inmates soon realize that family and friends on the outside cannot place their lives on hold for the duration of the inmates' sentences, and thus, neither wish nor request their loved ones make personal sacrifices or to be burdened by them (Aday, 2003).

In terms of the environment, long-term offenders and lifers hold numerous concerns about issues centered around aspects of institutional living as the dining hall, commissary, opportunities for personal hygiene (showers, laundry, haircuts), security, medical care—with such reservations being documented in both men's (Paluch, 2004) and women's (George, 2010) facilities. It has been argued, due to the sentence length, these inmates have begun to view these prison facilities as their "permanent home," and thus, desire and request officials to afford them basic amenities that would make the time occupied in this setting more tolerable (Aday & Krabill, 2011). In managing these offenders, consideration must be given to addressing the following:

- Many have outlived family members or have slowly disengaged from them
- The strain of knowing that separation from outside contacts may be permanent
- The lack of social skills, training, and resources to make successful community transition
- The realization that dying in prison is likely and the fears associated with the process
- Lack of prison work roles to enhance self-esteem and promote purpose of life
- Locating family/community members who will accept aging inmates eligible for parole
- Loss of ability to make own decisions due to dementia or other mental health disorders
- Gradual decline in functional health conditions restricting prison movement

Understanding these and other special needs of the older prison population is important as inmates attempt to construct an orderly "life" behind bars. In order for this process to occur, the environment must be responsive to inmates as they *age in place*.

ASSESSING OLDER INMATES' HEALTH

Today the level of attention invested in improving the quality of life that each of the above mentioned groups experience as they travel along the life course is truly phenomenal—with many advocating in support of a bio-psycho-social approach to understanding the concerns touching the lives of the geriatric offender (Kerbs, 2000). Specific to the prison setting, this approach recognizes the link between health or well-being and variables such as the geriatric offenders' imported demographic histories, patterns of substance abuse, housing assignments, cellmate and/or peer interactions, victimization, staff support, available coping mechanisms, sentence length, quality of health care, community support, and plans for reentry back into the communities at large. While Chapter 5 discusses the various issues of chronically ill inmates in the general population context, the following subtopics address important health and social indicators that offer considerable influence in the successful adjustment to prison life among older and geriatric inmates.

Physical Health Indicators

When examining the health status of older inmates, it is important to include prior life experiences in combination with current health changes during incarceration (Marquart, Merianos, Herbert, & Carroll, 1997). Older inmates are usually in worse health than their counterparts outside prison because they develop health issues much earlier due to their previous lifestyle, socioeconomic factors, and the prison environment (Glamser & Cabana, 2003). This rapid decline or accelerated biological aging has been attributed to the following factors (Aday, 2003; Fabelo, 1999; Fattah & Sacco, 1989):

- Tendency to engage in high-risk behaviors (smoking, drugs, alcohol, unhealthy diets) prior to incarceration
- Lack of preventive health care prior to incarceration due to lack of access and not practicing healthy aging behaviors
- Unhealthy lifestyles fostered in prison, including poor diets and general lack of exercise
- Greater rate of infectious disease than persons of the same age on the outside
- Harshness and stressors of prison life, especially those housed in maximum security prisons
- Stressors associated with an abusive past, alienation, and sleep disturbances.

Unarguably, creating a system within which medical needs can be accommodated must begin with identifying the physical and functional impairments most likely to affect this special needs population. Recently, large-scale, nationwide surveys conducted on health-related concerns experienced by a graying inmate population have directed our attention to the specific medical needs that geriatric offenders present officials. Sterns and colleagues (2008) projected an estimated 45% of offenders ages 50 and older and 82% of those 65 and older have chronic health problems. In general,

aging prisoners rate their health as fair to poor, having deteriorated since incarceration and with a high degree of comorbidity. On average, older male samples report several chronic conditions—including arthritis, hypertension, heart diseases, emphysema, diabetes, and intestinal problems—as leading problems (Aday, 2003; Smyer & Gragert, 2006). In fact, 46% of inmates over the age of 50 reported having health problems at the time of their arrival into prison (Beckett, Peterneli-Taylor, & Johnson, 2003). As a result, older inmates generally need more medical and mental health services than younger people (Cohn, 1999).

In particular, the issue of penal health care is of primary importance for aging female inmates, who as a general rule, place a greater demand on prison medical and psychiatric services than males (Caldwell, Jarvis, & Rosefield, 2001; Gibbons & Katzenbach, 2006). Research has found that women seek health care two and one half times the rate of males, but frequently prisons fail to adjust staffing ratios in female institutions (Ammar & Erez, 2000). Exposed to high rates of violence and victimization, many female inmates enter prison already highly marginalized in the wider society. With backgrounds of poverty and unemployment and a history of prior drug abuse, most have suffered from personal stress, trauma associated with sexual and physical abuse, and fear in many stages of their lives (Morash, Bynum, & Koons, 1998). A large five-state study of 327 older females (Aday & Krabill, 2011) concluded that females had similar health problems as men with the addition of menopausal problems. However, the older women did report, on average, slightly over four (4.2) chronic health conditions.

Functional Health Status

As a microcosm of larger society, correctional institutions also hold a growing number of elders who are disabled and unable to negotiate environmental demands. Similar to other older adult populations, aging prisoners may experience complications performing various Activities of Daily Living (ADL) (i.e., bathing, eating, dressing) or Instrumental Activities of Daily Living (IADL) (i.e., taking medications, managing personal finances). Others, however, may be unable to engage in various tasks specific to survival in the given setting. Prison Activities of Daily Living (PADLs) may be challenging for individuals of advanced age to complete include standing in line for counts, dropping for alarms, and hearing staff orders. In recent years, the prevalence of functional impairments among aging prisoners has been projected to be approximately 10% for older men and slightly higher (16%) for geriatric female offenders (Colsher, Wallace, Loeffelholz, & Sales, 1992; Fazel, Hope, O'Donnell, Piper, & Jacoby, 2001). It is important to note, however, that when specific prison issues are considered, the percentage may rise as high as two thirds of older offenders (Williams et al., 2006). Since these concerns may elevate the offenders' risk of fall or injury, lower their morale, cause them to fear for their personal safety, and dissuade them from participating in the larger prison routine, staff must be encouraged to remain sensitive to potential signals of concern prior to needed interventions.

The activities that older people can engage in are important indicators of both how healthy they are and what services and environmental accommodations they need in order to cope with chronic conditions. Table 7.3 provides an interesting

Table 7.3 Gender Comparisons for Functional Health Status

Characteristic	Males = 302	Females = 327
Vision problems	39.3	87.6
Hearing problems	72.9	32.4
Difficulty walking long distances	48.6	57.2
Difficulty standing up to 15 minutes	37.5	59.3
Incapable of ascending/descending stairs	51.4	33.1
Require ground level housing	60.2	49.7
Require a flat, even terrain for walking	52.5	38.6
Require a lower bunk	68.9	84.1

Source: Aday (2001). *A comprehensive health care assessment of aging and infirm inmates*. Tennessee Department of Corrections; Aday (2009). *Health indicators for women aging in prison*. National Commission for Correctional Health Care Annual Conference.

Note: Mean age for males is 65; mean age for females 56.

comparison of the gender differences in the functional health status of two large samples of older inmates housed in southern states. Although the functional health status of the male sample was assessed by nursing staff and their counterpart's assessment based on self-reports, it is still apparent that both groups are limited in their abilities to negotiate a prison's physical environment. Obviously, the more frail and infirm the elder is, the greater challenges administration will face in encouraging involvement with the outdoor pursuits. Taken together, concerns such as the need to walk distances between buildings (particularly in inclement weather) or take periodic breaks while engaged in the activities themselves, can place the older adults involved in positions where they feel pressed to decline opportunities for involvement (Aday, 2003; Aday & Krabill, 2011; Harrison, 2006).

MENTAL HEALTH NEEDS

In addition to the vast number of chronic illnesses found in this subgroup of offenders, research has also shown that mental health issues are much more prevalent in prison than in the community (Haugebrook et al., 2010; Maschi, Morgen, Zgoba, Courtney, & Ristow, 2011; also refer to Chapter 6). Given their backgrounds, lifestyles, environment, and abuse histories, aging prisoners can present officials with a variety of mental health conditions requiring care. Following the deinstitutionalization movement of the 1970s, administrations have been fraught with the ever-increasing responsibilities for providing care to offenders who would have once received treatment in other contexts (Baillargeon, Bingswanger, Penn, Williams, & Owen, 2009). In fact, large-scale, nationwide surveys have projected the number of geriatric offenders with mental illness to be in the range of 40% (James & Glaze, 2006).

Other research based on small convenience samples report that, in select institutions, the prevalence of specific mental conditions may be much higher, occasionally exceeding half of the older prison population (Barak, Perry, & Elizur, 1995; Fazel et al., 2001; Taylor & Parrott, 1988).

Middle-aged offenders have been reported to require treatment for issues including depression, anxiety, substance abuse, personality disorders, and schizophrenia whereas those of advanced age may need support for Alzheimer's and other dementias (Caverly, 2006; Cox & Lawrence, 2010; Meeks, Sublett, Kostiwa, Rodgers, & Haddix, 2008; Regan, Alderson, & Regan, 2002).

Female inmates typically have higher rates of mental health problems than males (James & Glaze, 2006). Aday & Krabill (2011) reported that in a group of 327 older women (mean age = 56) only 23% scored within a normal depression range. One third of this sample was diagnosed with moderate depressive symptoms while one fourth scored in the high range and one in five reported severe levels of depression. Although there were no racial differences found, the authors did find that older incarcerated women with abuse histories were far more likely to suffer from depression and other mental disorders. These findings support other research that have found a significant link with childhood and adult traumatic experiences and life-event stressors as predictors of comorbid psychiatric conditions including anxiety, depression, PTSD, drug and alcohol abuse, and associated health problems (Haugebrook et al., 2010; Messina & Grella, 2006). For those entering prison with a low sense of self-esteem and fractured external support group, the prison environment can also serve as a source of stress leading to a further decline in mental well-being (Aday & Krabill, 2011).

Older inmates with multiple health conditions and who are mentally fragile frequently find themselves engaging in frequent thoughts about dying in prison (Aday, 2005–2006; Deaton, Aday, & Wahidin, 2009). To many inmates, dying in prison is one of the most dreadful things they can encounter (Byock, 2002) and one of the biggest regrets (Bolger, 2004). The notion of dying in a foreign place, in a dependent and undignified state is a very distressing thought. Contributing to the death anxiety of older inmates are the thoughts often associated with getting sick in prison or having to rely on prison health care in a time of crisis. Based on past experiences where medical staff have been found to humiliate inmates, to deny giving care such as withholding or delaying essential medications (Vaughn & Collins, 2004), inmates remain anxious about end-of-life issues such as dying in prison. Stoller (2003) reports that in many cases, health care access is “continually thwarted by rules, custodial priorities, poor healthcare management, incompetence, and indifference” (p. 2263). Inmates also frequently report negative experiences associated with watching other inmates die in prison and the lack of respect they received (Deaton, Aday, & Azrini, 2009).

As an increasing number of inmates continue to *age in place*, the onset of dementia is becoming a more common occurrence. It has been noted that Alzheimer's effect 15 to 25% of individuals who are 65 years and older (Sterns et al., 2008). Wilson and Barboza (2010) estimate that currently over 3,500 inmates currently possess symptoms of dementia. However, due to the frequency of comorbidity found among aging inmates and the regimented lifestyle of prison, this figure is expected to be

much higher since few health care systems screen for cognitive impairments (Aday, 2003, Sterns, et al., 2008). While in the modern correctional environment, elders are expected, and required to maintain some general abilities for problem solving (Roof, 2010; Sottile, 2009; Williams et al. 2009). In any given day, surviving and thriving in the larger prison subculture requires elders to perform tasks such as familiarizing themselves with, identifying and adhering to staff commands, presenting themselves for structured activities, avoiding potentially conflict-ridden situations, and following medical's prescribed instructions. As dementia progresses, inmates may have difficulty performing Activities of Daily Living or being mentally oriented to their surroundings to the degree that they can remember to take medications, handle their personal possessions such as managing their financial account. In some cases, it has been noted that some cognitively impaired inmates may not even recall why they are incarcerated (Sottile, 2009; Wilson & Barboza, 2010).

Unfortunately, though, geriatric mental health experiences are not easily diagnosed or treated from within this setting. As a collective, older adults have very low utilization rates for available services (Hooymann & Kiyak, 2011). In the prison setting, many discover, clientele are highly unlikely to disclose their problems or symptoms when treatments are available (Yorston & Taylor, 2006). Instead, elders desire to preserve their image among prison peers—denying or suppressing their true emotions in favor of a more socially desirable appearance (Vega & Silvermann, 1988). Any problems with conditions such as depression, for example, are more likely to be of a somatic nature—with few elders explicitly identifying or calling attention to mood or affective concerns. Older adults who suffer from depression may simply reduce their activity level, withdraw, and become invisible (Sterns et al., 2008).

Isolation and Social Needs

Understanding the social world experienced by older inmates is an important component for responding to their special needs (Aday, 2006b). Sykes (1958) in his classical work, *The Society of Captives: A Study of a Maximum Security Prison*, observes that prisoners have to endure a variety of structural deprivations termed as the *pains of imprisonment*. Generally, these deprivations include losses of liberty, autonomy, security, products and services, and heterosexual relations. Prison offers a new subculture, a foreign set of rules, and language that can be overwhelming for mentally-fragile inmates. Goffman (1961) has referred to the entry into the total institution as a “civil death” (p. 16) which results in inmates being exposed to a series of social and psychological attacks that negatively undermine the sense of self. In particular, for geriatric inmates to adapt to prison life can be a challenging task where stark living environments evoke a wide range of human emotions including “frustration, anger, fear, sadness, and resentment” (Haney, 2006, p. 169). Older more frail inmates may devote a substantial portion of their day-to-day existence trying to minimize the dangers of imprisonment. Creating an effective social milieu is one of the most crucial, yet most challenging tasks that prison administrators will likely be presented with when preparing to manage a growing geriatric prison population.

Despite more liberal visiting and correspondence policies in recent times, inmates still must relinquish substantial contact with family and friends of the outside. For example, the Bureau of Justice Statistics reports that in 1999 only 43% of inmates housed in state prisons had received a personal visit from at least one child since incarceration (Mumola, 2000). Although Aday and Krabill (2011) reported that one third of a large sample of older females never receive face-to-face family visits and another 25% only do so once or twice a year, about 80% do remain in contact with family either by visits, letters, or by phone. The literature reports a number of barriers exist that currently that serve to reduce inmate-family interactions. Prior research has reported that inmates are less likely to receive personal visits when families live greater distances from the prison (Arditti & Few, 2006; Christian, 2005). Inmate families can incur enormous expenses when traveling long distances that also require lodging and other related expenses. Institutional barriers also exist which include restrictive visitation times and rules (Hoffmann, Dickinson, & Dunn, 2007) and lack of access to phones or excessive financial charges associated with long-distance calls (Wahidin, 2004).

Overall, geriatric offenders have much smaller social networks than other segments of the inmate population (Bond, Thompson, & Malloy, 2005). Although the presence of a cohesive network is a significant positive predictor of institutional adjustment (Sabath & Cowles, 1988), incarceration is considered to be a time when bonds tend to deteriorate. A significant number, for example, spend their later adulthood years in this environment single, separated, or divorced (Aday, 2003; Aday & Krabill, 2011; Kratcoski & Babb, 1990). Due to circumstances not always within the offenders' immediate range of personal control, other relationships as well are highly fragile, volatile, and vulnerable to deterioration or dissolution without formal intervention and assistance. While these individuals advance in age in correctional settings, loved ones (parents and siblings) are growing older in community settings. With this transition, many may be experiencing their own declines in health, strength/stamina, or desires to exert the energy necessary to sustain meaningful connections over extended periods of time.

Being separated from family members can prove to be difficult especially for many older female inmates. Not being able to fulfill the role of parent or grandparent everyday can be frustrating. Some older female inmates serving life sentences have been unable to interact with their children or grandchildren in the "free world." This can be a tremendous strain for a grandmother, who knows she cannot provide her grandchild the emotional support she formerly did, and for the grandchild who continually inquires as to when grandma will be returning home. For some older inmates serving long sentences, visitation from family or friends on the outside can cause a continuous grief reaction with each visit. For these inmates, it becomes easier to do the time by requesting their families and members of the free world not visit. This technique of compartmentalization is one way some older females tend to cope with long-term incarceration and family separation (Aday & Krabill, 2011; George, 2010; Williams et al., 2006).

There has been an ongoing debate about whether to house older offenders in the prison mainstream or in special needs facilities (Aday, 2003; Kerbs & Jolley, 2009). The mere physical condition and architectural structure of the institution create

significant problems for the elderly inmate with functional limitations. In the past, prison systems were basically designed to house primarily young, active inmates. Now, older more frail offenders often find the prison environment to be unfriendly due the prison design which may challenge an inmate's mobility capabilities as well as a living environment with age-appropriate lighting, climate controls and noise levels. As we move forward, states will have great difficulty providing specialized, assisted living facilities for all the older and disabled offenders who might otherwise qualify (Sterns et al., 2008). With overcrowding and skyrocketing health care costs coupled with severe budget crises in any number of states, dedicating enough beds to this high-risk population will, no doubt, be problematic.

Studies have found that older inmates report feeling unsafe and vulnerable to attack by younger inmates, and expressed a preference for rooming with people their own age (Marquart, Merianos, & Doucet, 2000; Walsh, 1990). When they are housed in mainstream facilities, the presence of psychological, financial, physical, and albeit infrequently, sexual abuse is a continual fear to be fought (Kerbs & Jolley, 2009). This can be particularly true for the new elderly offender coming into unknown environment late in life and ripe for potential victimization. Vega and Silverman (1988) reported that abrasive relations with other inmates were the most disturbing incidents elderly prisoners had to cope with while incarcerated. Fifty-five percent of their respondents indicated that abrasive situations occurred on a daily basis. These factors, among others, often result in fear and increasing stress for the older inmate. An inmate's perception of the danger of possible abuse may be intensified as the inmate ages. The simple "fear of victimization" by younger inmates is also extremely prevalent among elderly inmates. Wilson and Vito (1986) found that inmates housed in a geriatric unit felt vulnerable simply because the most dangerous and unpredictable inmates were held in close proximity.

AGING PROGRAMS AND SERVICES

Housing Accommodations

Prisons have not been traditionally geared to the needs and vulnerabilities of older people (Abner, 2006). However, over the past 20 years, numerous states have had no choice but to build special needs facilities or secure nursing homes to accommodate the increasing number of geriatric inmates. A little over half of the states now provide geriatric accommodations, ranging from selected clustering, dedicated units, free-standing prisons, or dedicated secure nursing home facilities (Abner, 2006; Aday, 1999; ACA, 2001; Sterns et al., 2008). Some states have converted old tuberculosis or mental health hospitals into special facilities for aged and infirm inmates (Aday, 2003) while others have relied on new construction. Grouping inmates with similar health care needs is considered a more efficient way for correctional personal to respond effectively to the unmet needs of elderly prisoners.

Special geriatric accommodations provide aging inmates with a quieter living environment and are considered safer than living in the general prison population

(Marquart et al., 2000). Handrails, lower bunks on main-floor tiers, elevated toilets, and wheelchair accessibility are provided in most specialized units (Aday, 2006a). When prisons have low security risks, the facilities often permit the older offender increased privacy by designing rooms with doors. Additional amenities in newer facilities include prison-controlled thermostats, fluorescent lighting, strobe lighted fire alarms, and non-slippery flooring services (Falter, 1999). In the Oregon Department of Correction's geriatric unit (Anno, Graham, Lawrence, & Shansky, 2004), inmates are provided hospital-style beds equipped with extra padding, toilets, sinks, and showers that are handicapped accessible and inmates use a therapeutic gym equipped with a pool table configured at a lower height to accommodate wheelchairs. Closed-captioned television and specially equipped phones are available for the hearing impaired.

While the majority of elder inmates indicate they would prefer to live in age-segregated housing (Aday, 2006a), this option is not always possible. The prisoner's medical condition and security level are factors that must be taken into consideration before he or she is placed into an aged-infirm unit. Distance to living relatives is also a consideration when thinking about living in a special needs facility. Also, beds in special needs facilities are limited, with some units having long waiting lists (Aday, 2003; Sterns et al., 2008). Others may actually wish to remain in mainstream housing where they can remain more engaged, mentor younger peers, and to feel younger themselves (Aday & Krabill, 2011; Gallagher, 2001).

Although states differ markedly in terms of the breadth and range of activities being occupied specifically to accommodate this special needs group (Lemieux, Dyeson, & Castiglione, 2002), research has estimated that approximately 15 states currently provide at least some form of structured recreational program to target geriatric inmates (Anno et al., 2004). Several having psychologists, social workers, or other similar professionals on staff with specializations in geriatrics has made significant advancements in terms of designing programming to accommodate the various biological, psychological, and social changes that accompany the aging process. Popular activities that administration are being encouraged to adopt for use with the geriatric offender, for example, include age-appropriate work and educational opportunities, religion, assorted leisure pursuits (arts, crafts, gardening, woodworking), group work activities, and individual psychotherapy.

Florida, Ohio, Pennsylvania, Alabama, Georgia, Virginia, and Louisiana are a handful of states that have offered more ambitious programming for older offenders. However, the most comprehensive best practice model worthy of recognition in illustrating how programming can be designed and implemented to accommodate the special needs of the geriatric offender is the Structured Senior Living Program (SSLP) at the Northern Nevada Correctional Center (Harrison, 2006). The men are housed together in a separate unit and given a set of physical, social, and mental activities to perform on a regular basis. One of the most critical components responsible for the success of the True Grit program is the highly-structured eligibility requirements, which have been revised as necessary throughout the program's history (Harrison & Benedetti, 2009). Box 7.1 provides a summary of the program rules and diverse activities targeted at both cognitively and physically impaired inmates. The significance of SSLP can't be overstated given the fact that it was built on sheer creativity and community partnerships.

Box 7.1 True Grit: Structured Senior Living Program (SSLP)

By Ronald H. Aday

Northern Nevada Correctional Center

The Structured Senior Living Program (SSLP) was established in 2004 as a response to the unique needs of an increasing number of vulnerable elderly inmates. Primary goals of SSLP are to make available daily activities that include the encouragement of “personal, mental, emotional, and spiritual growth” among its 130 participants. The program also requires for each inmate to participate in educational activities which directly confronts their reason for incarceration (i.e., drug or sex offenses). Since its inception, the program has served 265 men including 38 who died while in prison and another 92 who were successfully paroled. The program uses no state tax dollars and relies on a cadre of inmate and community volunteers.

Participants: The age limit is 60 years and inmates must be referred by a caseworker, have a positive history of prison adjustment, and be willing to abide by strict rules.

Program Rules: Each True Grit participant must sign a contract when entering the program and each participant is required to complete the following activities:

- Initialing the daily program sign-in sheet, and reading the activity board for a listing of the daily program activities
- Maintaining personal hygiene: grooming, showering, and wearing clean clothing
- Maintaining personal living area including making the bed, ensuring food items are properly stored, cleaning the inmate’s personal living area, and adhering to all housing unit and personal living area rules
- Initialing the daily work assignment sheet and completing the assigned SSLP daily tasks, which normally include cleaning hallways, activity rooms, bathrooms, showers, and other general living areas
- Maintaining personal SSLP and state-issued clothing ensuring that all clothing items are clean and in good repair

Program Diversity: Diversion therapy activities that are considered to be highly effective in enhancing the participants’ overall qualities of life include the following:

Life skills training. Through guest speakers and the use of current periodicals, the Community Involvement Program helps participants increase interpersonal and social skills that are important whether they remain in prison or reintegrate into the free world. Such activities and skills include: meal planning on a budget, nutrition, microwave cooking, decision making, time management, goal setting, victimization (elder abuse, identify theft, and telephone and Internet scams), financial planning, and acquiring or reacquiring necessary identification documents.

Music appreciation. With a comprehensive collection of cassette tapes and compact discs (CDs), participants enjoy jazz, big bands, 60s, 70s, and 80s rock & roll, country & western, contemporary, and classical music. Each day a different type of music is featured in the SSLP activity rooms.

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Music groups. Several music groups provide a variety of activities and opportunities for social engagement. The SSLP Choir—a 20-man ensemble—performs weekly, the SSLP Doo-Wop group, along with rock, country and spiritual groups frequently practice and entertain fellow inmates.

Art appreciation. Many SSLP members are talented artists and a successful drawing and painting program is an active component of True Grit. Led by a talented, retired art teacher from a nearby college, the program emphasizes drawing with pencils, charcoal, and pastels, and painting with acrylics and oils.

Beading. Beading provides enhanced cognitive function and improved manual dexterity and is a regular activity that provides participants with the opportunity to learn how to create beaded jewelry, wrist or headbands, decorative beaded art objects, and other unique items.

Puzzles and games. Active participation in puzzles and games provides cognitive therapy, problem solving, and coping skills training. Many of these activities are designed to stimulate areas of the brain damaged by dementia and Alzheimer's disease while offering an opportunity for socialization and fun.

Crafts program. As a means of enhancing and maintaining physical dexterity for those with arthritis, the program provides materials for latch-hooking rugs, crocheting afghans, and creating needlepoint art. Several dozen men work regularly on individual projects in this voluntary diversion therapy activity.

Physical fitness activities. The SSLP's physical fitness program includes an assortment of weekly aerobic exercise opportunities, game, and activities. These include the use of exercise equipment, weight training, stretching, volleyball, tennis, softball, horseshoes, Ping-Pong, basketball, billiards, and walking.

Pet therapy. With the assistance of the local area Delta Society, every month, two or three dogs make visits to the program, providing the men (many of whom are serving life sentences) companionship and the opportunity to bond with therapy dogs.

Writing groups. This program assists men who will be serving, in effect, life sentences, the opportunity to prepare themselves physically, mentally, spiritually, and emotionally for end-of-life issues.

Physical fitness: True Grit offers an impressive selection of sporting activities designed with the needs of geriatric offenders in mind. For those confined to wheelchairs, wheelchair softball, basketball, and bowling, provide attractive opportunities for involvement.

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Harrison & Benedetti (2009) have documented a number of program successes for the True Grit program. For example, according to the nursing staff, the number of infirmary visits by elderly inmates has decreased and the amount of psychotropic and psychoactive medications has also declined. The general feeling of well-being of the men in the program has increased markedly. One inmate serving a life sentence communicated the importance of the program when he stated, “Before True Grit, I spent 23 hours a day in my rack. Now I am in the program, writing and performing songs.” Another 87-year-old participant who enjoys wheelchair basketball games mentioned, “I haven’t had this much fun in years” (Harrison, 2006, p. 48). Due to the successful nature of the men’s program, a similar program has been established for 38 women housed at the Women’s Unit. Although a more elaborate evaluation of the program will help document more formally the program’s outcomes, True Grit does show significant promise as a best-practice model.

PROGRAMS FOR HEALTHY AGING

Because of the high prevalence of physical and mental health care needs among older inmates, this group of offenders requires more frequent, complex, and costly medical services.

In meeting this challenge, several promising approaches are being explored and adopted for use in enhancing the quality of life for men and women who are advancing in age within correctional settings. Despite the accelerated aging process, many aging prisoners earnestly desire to engage in health-seeking behaviors and report positive outcomes. In fact, many define their health in remarkably favorable terms—noting their conditions have remained the same, improved slightly, or even greatly while they have been incarcerated (Loeb, Steffensmeier, & Myco, 2007). Similar to their mainstream counterparts, these individuals highly commend the system for affording them opportunities to become involved in pursuits that not only leave them feeling healthier, but also assist them in improving their self-esteem, alertness, energy, motivation to engage in pleasurable activities, coping mechanisms, and sleeping habits (Loeb, Steffensmeier, & Lawrence, 2008). Older lifers, in particular, speak in remarkably favorable terms about viewing prison as prime locations where they have, over time, learned to maximize any opportunities presented before them (Leigey, 2010).

In recent years, the use of chronic care clinics has been identified as a highly effective and cost-efficient approach to disease management for this population (Anno et al. 2004; Mitka, 2004). Numerous states such as Florida, for example, have established clinics well-regarded for responding to geriatric oncology, endocrine, gastrointestinal, cardiovascular, and renal problems (Florida Corrections Commission, 2008–2009). For patients utilizing these services, clinics provide a wealth of much needed information and assistance in overcoming barriers that traditionally interfere with recovery and management of the conditions. Chronic care clinics, for example, provide highly welcomed forums through which time and space is granted toward discussion of issues such as diagnoses, treatments, side effects, or even the effects that delays in

treatment would most likely have on their overall well-being (Linder & Meyers, 2007). In establishing clinics to serve the intended purpose, though, care must be taken to protect against potential problems (i.e., poly-pharmacy, violations to inmate privacy) that can originate from addressing and responding to each condition on an independent basis.

Since factors such as education are considered to be essential to shaping the geriatric offenders' health (Bishop & Merten, 2011; Loeb et al., 2011), administrations have begun to examine their roles or responsibilities in teaching geriatric offenders practical skills they can adopt and integrate into their daily routines to maximize positive outcomes. With the growth of the geriatric population, institutions have developed structured programming with the needs of older adult audiences in mind. Among these include age-appropriate nutrition and exercise programming as well as various seminars oriented toward providing elders guidance in examining health attitudes. Ohio Department of Rehabilitation and Correction (1999), for example, reports offering the following health-related programs for geriatric participants:

- Age-specific stress reduction, anger management, AA and NA programs
- Courses on memory improvement, with emphases on providing strategies and practical tips on immediate, short-term, and long-term recall
- Medication education and management, with lecture and activities oriented toward familiarizing them with issues such as drug classification, benefits to adherence, side effects of commonly dispersed drugs
- Programming, in conjunction with the Central Ohio Area on Aging/OSU Health Services Center, to teach them to recognize and respond to specific health-related changes—including sensory/mobility impairments, osteoporosis, depression, and dementia
- Seminars oriented toward providing education on enrollment in Medicare, Medicaid programs, as well as other topics highly recommended and effective for use with those will be returning to the communities

Without question, activities of this nature must be accompanied by changes within the larger operations to best promote healthier lifestyles. Unarguably, two of the most widely recognized and cited areas focus on the need for improving the elders' diets and exercise. Today, for example, much emphasis is now being placed on encouraging administration to reconsider the nutritional content of available meals and offer individuals greater varieties in terms of fruits, vegetables, and foods lower in starch and sugar content (Aday & Krabill, 2011). In the process, challenges that must be overcome include the limited resources with which food services have to operate and the intense pressure to serve large crowds within relatively brief periods of time (Wick & Zanni, 2009). Enhanced sensitivity, for example, must be directed to the fact that individuals with conditions such as dysgeusia, dysphasia, or dental problems receive more time to eat or that those requiring light snacks between the evening meal and breakfast the next morning receive them.

Although much less is known about the long-term benefits that geriatric offenders may receive from early intervention, evidence suggests that these offenders do

have an orientation to the future in mind and think about health maintenance in terms of continuity of established routines. Given the number of health conditions related to lifestyle choices, most involve some form of educational component that encourage personal responsibility. Since aging prisoners may not always be aware that opportunities for self-improvement exist (Formby & Abel, 1997; Loeb & Steffensmeier, 2006; Loeb et al., 2011), education encourages self-confidence (Loeb et al., 2011), and that practices engaged in today affect their maintenance of health-seeking behaviors following release (Loeb et al., 2007), encouraging preventative care, early detection, and intervention will undeniably remain a major priority of policymakers and officials in the 21st century. Ideally, lessons learned during incarceration would be reinforced by community networks and family support to ensure healthy lifestyle changes are long lasting (Higgins & Severson, 2009).

OTHER END-OF-LIFE PROGRAMMING

Over the last several years, our nation has witnessed a remarkable rise in the number of programs oriented toward delivering quality end-of-life care to inmate populations. Although research has not maintained records of the specific number of facilities with formal hospice services, some have estimated the number of states with hospices to be in the vicinity of 25—with several including California, Texas, and New York having multiple hospices throughout the state (Anno et al., 2004; Linder & Meyers, 2009)—and growth projected to continue well into the 21st century (Hoffman & Dickenson, 2011). In the process, heightened attention is being placed on examining issues such as admission standards, need for interdisciplinary care, narcotics, special privileges, family support, and discharge procedures (Linder & Enders, 2011; Linder, Enders, Craig, Richardson, & Meyers, 2002). It is now well accepted, for example, that administration follow a mixed-model approach to care—pushing for curative treatment and transitioning over to a palliative-based focus only after no improvement to medical statuses can be achieved (Dubler, 1998).

Without question, the key to establishing and maintaining effective prison hospice programming and services must begin with support from a wide range of parties. Correctional administration, other facilities, and community agencies must all be in agreement and willing to offer assistance and guidance as the need arises. Additionally, connections to the National Prison Hospice Association can be considered an enormous asset and advantage to those in the formative stages of development. In locations where there may only be one facility in the state that has (or plans to have) to operate a hospice, connections to other prisons in the region can be a much needed and welcomed approach to identifying patients who may have otherwise remained overlooked, and thus, uninvited to obtain the benefits that the program may have to offer (Bronstein & Wright, 2006). Prior to their involvement in patient-centered care, staff members receive orientation and instruction in infusing hospice concepts or principles into the prison environment with specialized training modules prepared and delivered in accordance with their particular responsibilities in mind (Boyle, 2002; Linder & Enders, 2011; Linder et al., 2002).

Most importantly, prison hospices are structured in a manner that recognizes the entire prison community—the patients, family, staff, peers, and volunteers—as being touched and deeply affected by the dying experience. Nationwide, development of hospice programming is considered to be most effective when there are bereavement-oriented services in place to respond to complex emotions that all represented parties have throughout the entire ordeal. Supportive outreach services, for example, must be planned to specific problems likely to be encountered, goals each may want to have in mind for involvement in support services, materials that would prove useful for those supporting offenders through their final days of life to have in their possession, as well as tools for evaluating client satisfaction or outcomes (National Palliative Care and Hospice Organization, 2009). In terms of correctional officers, for example, it may be strongly recommended to have resources available (complementing training in hospice) to assist them in remaining focused on the responsibilities at hand in the midst of inmate death (Taylor, 2002).

Understandably, many of the fears that correctional officers must respond to in their work with terminally ill offenders are unique to the given atmosphere and culture. Prison deaths, for example, differ markedly from those occurring in other environments in terms of concerns such as pain management, autonomy, and opportunities for exchanging social support (Bick, 2002; Mezey, Dubler, Mitty, & Brody, 2002; Tillmam, 2000). Given the nature of the crimes, most do not have freedom to either express their need for powerful narcotics or to have brokers advocating on their behalf. Although facilities may permit inmate use of morphine or patient-controlled analgesia pumps, policies remain restrictive in comparison to mainstream settings. Instead, care is still largely dependent upon staff on call, sick call hours, and the offender's willingness to disclose symptoms to the provider (Linder & Meyers, 2007). In most facilities, records of criminal histories may prevent optimum care in that such care dissuades physicians, nurses, and other providers from engaging in the open communication patterns needed to establish treatment regimen and execute them to completion (Smyer, Gragert, & Martins, 2006). Of course, in prisons, other inmates may have their own insecurities (such as fears of deserving punishment, relapse, or violating religious convictions) that cause reservations about accepting certain medications whenever they may be available (Linder & Meyers, 2009).

Other structured programming is also now available to cognitively impaired inmates who are considered terminal. For example, the recently established Dementia Unit at Fishkill Regional Medical Unit in New York, offers specialized care for patients with dementia-related conditions like Alzheimer's, Parkinson's, or Huntington's disease, and other assorted psychiatric or medical disorders (Sottile, 2009). All workers at the dementia unit—nurses, corrections officers, housekeepers—go through a 40-hour training course focusing on working with the cognitively impaired. Housed on the third floor of the prison's medical center, this 30-bed unit offers a wide range of fitness-related programming including bowling, miniature golf, stretch/exercise games, as well as a wide range of other outdoor and indoor options aimed at encouraging movement and physical activity. Moreover, administration

recognizes the influence that addictions and interpersonal activity have had on shaping their patterns of conduct—offering ASAT (substance abuse), ART (anger management), and individual or group counseling to assist in promoting well-being. Additionally, leisure activities such as classical music or movie hours, bingo games and puppies behind bars are readily available to keep those cognitively-impaired elders who would otherwise be vulnerable to vegetation in other prison settings. Other facilities, such as the Deerfield Special Needs Unit in Virginia, who also cater to offenders suffering from the dementias, report comparable programming activities/services to ensure this segment of the population is fully integrated into programming with a purpose (Badgett, 2006).

POLICY IMPLICATIONS

As the aging prison population continues to increase, managing the special needs of this population poses a number of dilemmas that deserves special recognition among policy makers. While it is apparent that correctional officials and politicians are becoming more sensitive to the unique challenges created by the graying of our American prison system, barriers will continue to interfere with the ability for states to respond effectively. States continue to be faced with rising health care costs associated with caring for inmates who are older and sicker than ever before (Wahidin & Aday, 2010). While sentiment continues for establishing special needs facilities, the economic feasibility to provide special housing and treatment for such an emerging group of geriatric inmates is probably not realistic. With many states in dire economic duress and faced with federal mandates for providing medical care to all those incarcerated, this crisis in corrections will continue into the foreseeable future. In fact, age will be considered one of the biggest issues facing the criminal justice system in the foreseeable future.

A major barrier in responding fully to the special needs of the aging inmate is the lack of adequately trained prison staff (Cox & Lawrence, 2010; Knapp & Elder, 1997–1998). To meet this challenge responsibly, a professionally trained prison staff that can work comfortably with geriatric inmates will be essential. Prison staff needs to be specifically trained to understand the social and emotional needs of the older adult population, dynamics of death and dying, procedures for identifying depression, and a system for referring older inmates to experts in the community. Functional assessment providing early and accurate identification of the complex needs of older inmates will be critical for case management. Maintaining good communication between custody staff and health care providers will play an important role in the management process. Researchers should also continue to examine current prison conditions and programs to recommend policies and procedures to standardize the management approach to the crisis.

Considering the number of geriatric and terminally ill inmates, discussion must also focus on identifying more promising alternatives. One of the most commonly cited solutions to issues raised in this chapter focuses on the notion of compassionate release. Currently, an estimated 43 states have formal policies in place permitting

terminally ill offenders to return home and occupy the final days of life peacefully, restfully, and contentedly with family and friends (Anno et al., 2004). Although each state uses slightly different criteria for determining eligibility, most consider characteristics such as prior criminal histories, security threats, remaining sentence lengths, and projected life expectancies in the process. In addition, most take into close consideration the fact that geriatric offenders have remained largely removed from mainstream society for extended periods of time, and thus, require from them evidence of a place of future residence before considering their applications. Without family, friends, or nursing homes willing to accept the individuals back into the community and offer supportive services while they make the needed adjustments, release can be even more unsettling or terrifying than institutionalization itself. Provisions, for example, must be taken to protect against homelessness (Williams et al., 2010). Perhaps the most critical issue to be addressed in preparation for the release of the older offender focuses on issue of how and by whom the population would be managed following reintegration into mainstream society. Given the number of citizens who continue to harbor reservations about this population and hold rigid views that persons released could enter nursing homes, cause injury to other residents, or continue to need more structured discipline than could ever be afforded outside the context of corrections, early release remains undersupported (Boothby & Overduin, 2007; Chiu, 2010). In order to facilitate a smooth, effective transition, policymakers must address whether decisions to release these individuals merely redirects or deflects the burdens of responsibility for their care onto other parties (Rikard & Rosenberg, 2007; Chiu, 2010). Very frequently, record-keeping making comparisons among the expense associated with care by each of the available alternatives can be a highly effective approach for boosting public confidence.

The Project for Older Prisoners (POPS) has been advocating the early release of elder prisoners since 1989 (Aday, 2003). Although early release is clearly out of the question for some, many of the older and geriatric inmates are considered to have an exceptionally low risk of reoffending. In fact, the POPS program has been directly responsible for the release of approximately 500 older prisoners with not a single one returning to prison. As a whole, less than 3% of older inmates released back to society are found guilty of reoffending (Aday, 2003). By using a careful screening and placement process, there is little doubt that early release of aging inmates should be given more consideration by policy makers. In particular, a large number of older female inmates would be prime candidates for early release, many of whom were severely battered before turning to criminal activity (Aday & Krabill, 2011).

In concluding our discussion of the special needs of the geriatric offender, some degree of attention must be placed on sentencing concerns. It has long been argued that sentences have a differential impact on elders in comparison to their younger counterparts (Muelher-Johnson & Dhami, 2010). For older adults, even the presence of five to ten year terms can often become the equivalent of life sentences. Due to the stressors discussed throughout this chapter, reform is necessary—with policy-makers reevaluating statuses that promote lengthy, mandatory minimums. Punitive

three-strikes policies, for example, must be restructured to ensure that men and women are not detained unnecessarily into their later adult years (Auerhann, 2002; Kerbs, 2000; Mauer, King, & Young, 2004). In looking to the future, it may appear more humane to determine sentence lengths for older adults only after carefully weighing issues such as the percentage of the individuals' lives that are likely to be remaining and related health problems. Regardless, any number of strategies will have to be implemented to manage the aging prison population and its impact on the correctional system.

DISCUSSION QUESTIONS

1. Discuss the various factors that have contributed to the graying of our nation's prisons over the last several decades.
2. Attention has often been placed on the distinctions between new, chronic/repeat, and long-term offenders. In working with aging prisoners, why would knowledge of these various subgroups be important in responding to their special needs?
3. Discuss why many states use the age of 50 as a marker for treating older offenders as a special needs category.
4. Mental illness is considered a major problem when designing programs to address the special needs of older offenders. What specific challenges do correctional face in responding to inmates with dementia and other related disorders?
5. What are some of the major advantages to housing geriatric offenders with their similarly aged counterparts raised in the literature in discussing mainstream versus segregation options?
6. How does the True Grit model program presented in the chapter address the most commonly cited problems with housing and treating the age-specific needs of geriatric programs?

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WEB RESOURCES

- Summary of research findings and policy implications for the state of Florida: <http://www.schmalleger.com/schmalleger/corrections/aginginmates.pdf>
- Jonathan Turley, director of the Project on Older Prisons, discusses the options available to prison systems in dealing with thousands of inmates growing old behind bars. NPR. 30 minutes: <http://www.npr.org/templates/story/story.php?storyId=130837434&ft=1&f=1070>
- A National Survey of Older Prisoner Health, Mental Health and Programming is presented here: <http://law-journals-books.vlex.com/vid/survey-older-prisoner-mental-programming-56047532>
- This Vera Institute website provides several reports on geriatric inmates including *It's About Time: Aging prisoners, increasing costs, and geriatric release*. <http://www.vera.org/search/node/geriatric+inmates>
- YouTube provides several short documentaries on issues associated with aging in prison. <http://www.youtube.com/watch?v=SnsB92HegIg>

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