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UNINTENDED CONSEQUENCES OF SENTENCING POLICY: KEY ISSUES IN DEVELOPING STRATEGIES TO ADDRESS LONG-TERM CARE NEEDS OF PRISON INMATES

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FINAL REPORT

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EXECUTIVE SUMMARY

Introduction

Changes in sentencing policy, including longer and more numerous mandatory sentences, have contributed to changes in the prison population. The number of inmates overall has increased as has the number of older inmates. Chronically ill and/or disabled individuals of any age can need long-term care. However, older people have been found to be in need of assistance with activities of daily living (ADLs) such as bathing, dressing, eating, toileting and transferring from the bed to a chair at a higher percentage than younger people. Adding to the number of inmates with the potential of needing ADL assistance are inmates with AIDS. As the overall number of inmates needing assistance with ADLs increases, decisions must be made related to the provision of long-term care in the prison setting. Yet, little is known about the ways in which such care is provided. As a basis for policymaking and planning, more information is needed regarding the models or strategies that are currently being used to provide long-term care to prison inmates. In this study, the models used in one state system of corrections are identified and examined.

Methodology

The state level of corrections was selected as the focus of this research because there are many more inmates in the combined state systems than in the federal system. In addition, the length of sentences for inmates in the state system is longer than that of inmates in the local systems; inmates with longer sentences are more likely to develop long-term care needs in prison than those with shorter sentences.

The state correctional institutions (SCIs) in the Pennsylvania system were selected as the units of analysis in this study because the Pennsylvania Department of Corrections has begun to address the increasing need for long-term care through the establishment of a hospice program and of a prison facility for the provision of long-term care to inmates. In addition, a preliminary study of the Pennsylvania system in terms of long-term care had been conducted.

Phase One

In order to obtain basic information as to the need for, and the current provision of, long-term care in the Pennsylvania system, the principal investigators:

- sent a written survey to the superintendents and the Corrections Health Care Administrator (CHCA) at each of the state's 25 SCIs,
- conducted a conference telephone call with all of the SCI superintendents and/or CHCAs in order to explain the survey form and to answer questions and
- interviewed the superintendent and/or the CHCA of each of the SCIs, with three of the interviews being conducted on site with accompanying tours of the facilities, and the remainder of the interviews being conducted by telephone.

Phase Two

A response rate of 100 percent was obtained in each step. In order to obtain more in-depth information about the models or strategies used in providing long-term care, seven SCIs were selected for on-site visits. Selection of the SCIs was based on the way in which long-term care was provided at those SCIs and special characteristics of each SCI. Primarily, diversity was sought in the SCIs' approaches or models for providing long-term care. Secondarily, these SCIs were diverse in total numbers of inmates, numbers of inmates needing long-term care, age of the physical plant, geographical location in the state and security level of the SCI. At each of these SCIs, the principal investigators conducted two group interviews, one with corrections and health care staff and one with inmates who either need long-term care or who provide assistance to other inmates. In addition a tour of each of these facilities.

Findings

Quantitative Findings

In the quantitative component of the written survey, respondents were asked the number of inmates needing assistance, including those who require only additional prompting. These findings included the following:

- twenty-two of the system's 25 SCIs reported having at least one inmate (range=1 to 90) needing assistance;
- inmates from 18 to 89 years of age were reported as having ADL impairments;
- of Pennsylvania's total state inmate population, the results indicate that 1.8 percent has a need for assistance with ADLs;
- women inmates experience the need for assistance at virtually the same percentage as does the total inmate population;
- more younger inmates (n=480) than older inmates[1] (n=192) were reported to have ADL impairments[2]; and
- of inmates 40 years of age and over, 4.2 percent need assistance, while 23.8 percent of inmates 65 years and older need assistance, indicating that a greater *percentage* of older inmates than younger inmates need assistance with ADLs.

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[1]The term, "older inmate", generally refers to an inmate who is 55 years of age or older.

[2]Given the higher total number of younger inmates, this finding is not surprising.

On-site interviews revealed that the numbers of inmates included on some of the written surveys represented an undercount of inmates needing assistance, especially those who need only additional prompting to perform ADLs. Further research, therefore, could result in higher numbers.

Models/Strategies for Providing Long-Term Care

Certain models for providing long-term care, similar to those in the free population, were identified. The implementation of the models, however, is different in the prison setting. Findings regarding the models in general include:

- the models/strategies of providing assistance that have evolved at the various SCIs have developed more on an ad hoc (as needed) basis rather than from a comprehensive plan;

- the "long-term care prison", however, emerged from a combination of:
  - a need for assistance on the part of an increasing number of inmates,
  - insufficiency of the then-current model for providing such care to meet this growing need,
  - the existence of a state mental hospital that was no longer needed for that function and that could be transferred to the Department of Corrections,
  - the presence of health care workers from the former state mental hospital who were willing to be trained to work at the "new" prison facility and
  - Department of Corrections leadership willing to provide the impetus to bring about this (partial) answer to the growing need;

- the SCIs are more likely to use a combination of models rather than a single model for providing assistance;

- the places where assistance is provided include such areas as the showers, the dining hall, the chapel, the walkways, the yard, a variety of special units, the infirmary and (less often) the inmate's cell; and

- individuals who provide assistance to inmates include health care personnel, corrections staff and other inmates.

The models (presented by using the names employed in the free population) include the following:

1) The **transfer model**, in which inmates who need assistance with ADLs are transferred to another SCI, is used especially in SCIs that lack an infirmary. An inmate who is housed in an SCI without an infirmary and who needs more than 23 hours of observation or care is transferred to a nearby SCI that has an infirmary. An inmate transferred in this way generally does not return to the first SCI. Rather the inmate stays at the second SCI or is transferred to another SCI, depending on the inmate's need for care.

2) One version of the **nursing home model** is no longer used. In that model, inmates were housed in a state-run nursing home. PDOC provided guards. In the currently used model, the SCI infirmaries serve in a nursing home capacity for some inmates.

3) In the**"home" care model,** the inmate needing assistance lives in general population and is provided assistance, as needed. The inmate's "home" is the cell, extended to include areas for showering, eating, etc. To a more limited degree than might be available to individuals in the free population, assistance with ADLs is provided in the inmate's "home". Additional prompting to perform ADLs may be provided by correctional staff and/or from devices such as lights (rather than bells) that are used to let deaf inmates know, for instance, that it is time to go to the dining hall. A cell might be modified for use by an inmate with disabilities, for instance, by adding grab bars near the toilet in the cell. Showers may be modified for use by inmates in wheelchairs. Chronically ill or disabled inmates may be assigned to the bottom bunk of a lower tier (floor) cell or to a "handicapped" cell. In some instances, for instance when an inmate is going blind, an outside agency may be called upon to provide training for that inmate to prepare him or her to deal with blindness in the prison setting.

4) The **personal care attendant model** (which can be seen as a subset of the home care model) is evident when an inmate, either as a volunteer or as paid employment, provides certain assistance, often as a wheelchair pusher, for another inmate. In the free population, a personal care attendant may help the individual get to work or to school or other locations and may stay with the individual, continuing to provide help in those settings. The situation is similar in the prison population. However, the helper inmate typically provides less assistance.

5) In the **adult day services model** in the free population, a non-institutionalized individual needing assistance may go to a center during the day to receive assistance with ADLs. In this model in the prison setting, an inmate who needs assistance is housed in general population but goes to the infirmary for various services and for varying lengths of time during a 24-hour period. Such a situation may occur with a terminally ill inmate who prefers to remain as independent as possible and to remain in general population as long as s/he can. In addition, an inmate may come to the infirmary for only one need. For instance, some inmates move too slowly for the regular shower line. They may shower in the infirmary.

6) The **assisted living facility model** is most often reflected in the special needs units (SNUs) and transitional housing units (THUs). In these units, additional assistance with ADLs is generally provided–even though the primary reason that an inmate is housed in these units may not be related to ADL needs. For instance, although inmates are housed in a SNU primarily as the result of current mental health problems, numbers of these inmates also are in need of ADL assistance.

Another adaptation of this model is found when inmates who have difficulty getting from place to place are housed in a general population unit near the infirmary, dining hall and commissary. This model is particularly useful in prisons that are located on hills and/or in areas with extended periods of snow and ice and/or that have extended distances between buildings. Each of these factors increases the difficulty of cane, crutch or wheelchair assisted mobility.

7) The **hospice model** is implemented through formal and informal programs for terminally ill inmates. Although there is only one formal hospice program, a three-bed unit in one SCI, informal hospice programs have been developed on an ad hoc basis in a number of SCIs. For various reasons, an inmate who is facing death may stay in his current SCI rather than be transferred to the SCI with the hospice unit. Female inmates cannot be transferred to the all-male SCI with the hospice unit. Staff members may build on their previous work experience in a hospice and/or they may call upon the local hospice for help in developing an informal hospice approach for caring for these dying inmates.

8) The **continuing care retirement community** (CCRC) **model** is seen at the SCI which is dedicated to the housing and care of inmates who need assistance. Various levels of assistance are provided, ranging from minimal assistance to complete assistance with ADLs. In a CCRC in the free population, independent living, assisted living and skilled nursing care are provided in different areas of the CCRC campus. At the long-term care prison facility, some inmates live in skilled care units. Each unit is fairly self-contained, with inmates needing to leave the unit only for visits and chapel. Inmates with less severe functional impairments live in a type of assisted living unit where a lower level of assistance is provided. Some of these inmates are able to hold inmate jobs, for instance wiping tables.

A waiting list exists for the long-term care prison, with inmates who need assistance "backing up" in other facilities, especially in the infirmaries of those SCIs. Transfer to the long-term care prison is not possible for female inmates or for inmates with a high security level (unless the level is lowered) or with severe psychiatric problems.

Issues for Policymakers and Planners

The study revealed a number of issues that need to be addressed by policymakers and planners regarding the care of inmates who need assistance with ADLs. They include:

1) existing physical facilities (including prison infirmaries) that were not designed with a functionally impaired inmate population in mind and considerations regarding prisons in the planning stages;

2) needs related to medical care as well as long-term care of inmates, including the cost of care (added to the already growing costs of incarceration) which can be more than three times greater for older, infirm inmates than for younger, healthy inmates;

3) staffing needs related to long-term care, including related training needs and the potential need for nurses aides for care delivery and social workers for release planning;

4) concerns related to inmates helping other inmates, especially with regard to related American Correctional Association standards;

5) the tension between custody/control and care in determining the ways in which long-term care is be provided;

6) the safety of infirm inmates, especially with regard to the potential for predatory abuse of older inmates by younger, healthier inmates;

7) the housing and care of female inmates (a small but growing part of the inmate population) who need assistance;

8) modification of inmate jobs to accommodate inmates' functional impairments;

9) release planning for inmates with ADL assistance needs, with the accompanying difficulty of placing such individuals in long-term care facilities;

10) the housing and care of dying inmates, especially in correctional systems in which compassionate release of terminally ill inmates is infrequently utilized.

Recommendations

The recommendations include the following:

1) Policymakers and planners in the various state Departments of Corrections would be well advised to plan for the needs of inmates with functional impairments, including release planning. Identification of inmates currently needing long-term care is essential for planning, as is the identification of inmates who are likely to need long-term care in the future, e.g., current older inmates and younger inmates with long, mandatory sentences. Studies of state systems in terms of long-term care, similar to the one reported here, can provide information upon which to base decisions. Such efforts should include not only group interviews with staff and inmates but also individual interviews.

2) Departments of Corrections, lacking a compelling reason to do otherwise (such as a decision to send all inmates needing long-term care to one facility), might do well to allow considerable variation in the ways in which long-term care is provided to inmates. Given the differences among the various prisons within a system, in terms,

for instance, of age and condition of the facilities, the imposition of a uniform model could prove ineffective. In prison systems, however, where great similarity among facilities exists, a more uniform approach would have greater likelihood of success.

3) A reassessment is needed of the role of inmates in assisting other inmates with ADLs. Wide variation exists in the interpretation of ACA guidelines regarding the type of care one inmate can provide to another. If inmate-to-inmate care (whether paid or unpaid) is limited, other issues arise, such as the need for additional prison staff.

4) The training needs of individuals, staff members and inmates, who provide assistance should be identified and appropriate training programs should be developed and implemented.

5) The role of community organizations in supporting efforts to assist inmates should be addressed.

6) The current, descriptive study did not include an evaluation component. Therefore, no recommendations related to evaluation are provided. However, a recommended focus for future research efforts is the identification of the relative merits of the various models through which long-term care is provided, including the circumstances under which a particular model might be the preferred strategy.

Additional recommended research foci include the specific long-term care needs of female inmates, the interconnection of mental health and long-term care needs, the impact of AIDS and hepatitis C on long-term care needs, and the impact of the Americans with Disabilities Act on prison operations.

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SECTION 1: INTRODUCTION

Sentencing policies that call for longer sentences, mandatory sentences, and "life without parole" sentences are bringing about unintended consequences. One consequence is the growing number of inmates in general; some of whom need long-term care. A more specific consequence is the growing number of older inmates and, in turn, the increasing need for long-term care in the prison setting.

There are three general categories of older inmates, including those who:

1) were given a long (or life) sentence when they were younger and have aged as they have been serving that sentence;

2) are currently serving the latest in a number of sentences throughout their lives; and

3) are first-time offenders.

Of Michigan inmates who are 60 years of age or older, 42 percent were convicted of criminal sexual offenses. Almost 75 percent of these prisoners were without a prior criminal record in the state (Favier, 1998: 126). Some states in the U.S. are reporting that older inmates, when compared with younger inmates, are being given longer sentences (Lyons & Bonebrake, nd and Wheeler, Connelly & Wheeler, 1995). Statistics indicate that one reason for the increase in older first-time offenders is that older individuals are being convicted of more serious crimes than in the past. A related factor is the greater health and physical ability of the current older population (Chaneles, 1987: 47-48).

The population, in general, is aging, with the fastest growing segment being the 85-year-and-older group (1990 Census of Population and Housing). The prison population also is aging. Older prisoners have doubled in number in most areas since the mid 1980s (Cripe, 1997:278). The inmate

population 55 years of age and older is growing both in numbers and in percentage of federal and state prison system populations (Morton, 1992). Concomitant with the increase in older inmates is the greater cost of caring for them. Expenditures for the care of older inmates is, on the average, more than three times the cost of caring for younger inmates (Faiver, 1998:128).

Although the older person in the non-prison population is generally defined as being at least 60 years of age, the older prisoner may be defined as being at least 50 years of age. Experts agree that a number of factors, including chronologic age, are to be used in defining aging (Morton,1992:4). Moreover, the three categories of older inmates listed previously, may age at different rates. The more rapid aging of prisoners is due to a number of factors, including inadequate access to medical care, socioeconomic status, and lifestyle (Faiver, 1998:125; see also Marquart et al., 1996).

Long-term care may be needed by younger inmates, for instance those with AIDS, paraplegia or quadriplegia, and by older inmates. AIDS occurs among state and federal inmates at a rate greater than five times that in the free population (Maruschak, 1999: 1). Although long-term care is needed by people of any age, a higher percentage of older people than younger people in the free population need long-term care (Massie, 1993:79). In spite of the fact that the potential for needing long-term care increases as people age, nearly as many people who need long-term care are under 65-years of age as 65 or over (Feder et al., 2000: 41).

Long-term care involves the organizing, financing, and delivering of a range of goods and services to chronically ill or disabled individuals over a period of time (Friedland, 1990:3). The need for long-term care is based on the ability to perform activities of daily living (ADLs) which include bathing, eating, dressing, using the toilet, and transferring from a bed to a chair, as well as

the ability to perform instrumental activities of daily living (IADLs). IADLs include activities such as grocery shopping, cooking, and housekeeping (Massie, 1997:250-251).

Questions regarding the housing and care of prisoners who are in need of long-term care, therefore, are facing the various states. Should such prisoners be housed in general population cells or in infirmaries or special units within the various prisons or should special prison facilities be devoted to the housing and care of such individuals? Are other strategies or models available for providing long-term care to inmates? The need to address such issues is intensified by the overall growth in the inmate population and the resultant costs and overcrowding.

Before these questions can be answered, however, it is essential to identify the ways in which long-term care is actually being provided in the prison setting. As the need for long-term care has increased in prisons, what models or approaches have developed? Have these models evolved as the result of the formulation of related policies and/or on an ad hoc basis as inmates have developed long-term care needs? In this study, the models or approaches that currently exist in the Pennsylvania State Correctional Institutions (SCIs) are identified as are the issues that are key to related policymaking and planning.

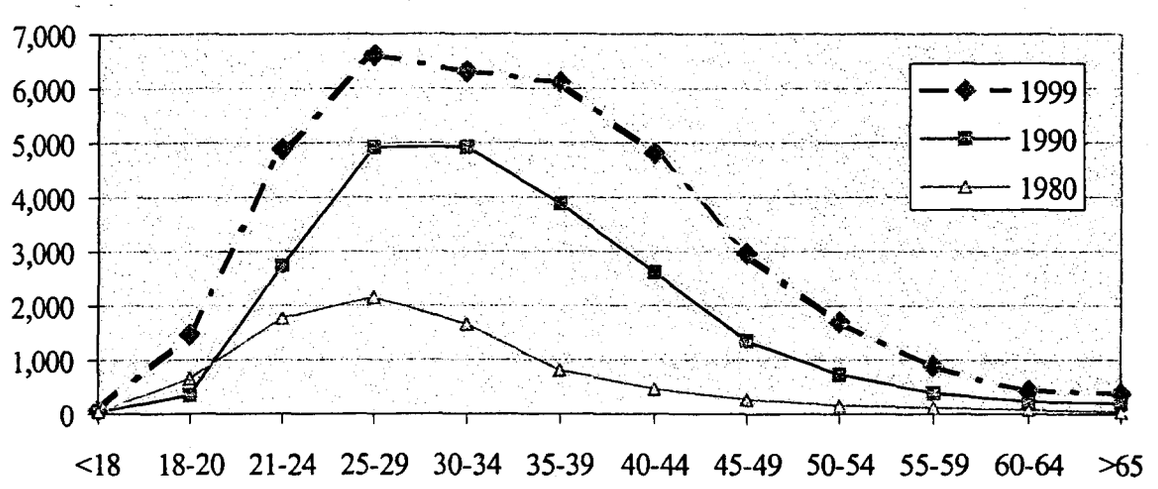
SECTION 2: PURPOSE OF THE STUDY

The national growth in the prison population, including the older prison population, is reflected in Pennsylvania. Although the incarceration rate for counties in Pennsylvania varies from one year to the next, the overall inmate population has constantly increased. Between December, 1987 and December, 1997, the Pennsylvania state inmate population increased from 16,301 to 34,964, a 46 percent increase in that ten-year period. From 1996 to 1997, the state prison incarceration rate increased by 1.4 percent or 286.5 per 100,000 state residents in 1996, to 290.6 per 100,000 in 1997 (PDOC, 1997). In that same time period, the number of inmates serving a minimum sentence over 10 and up to 20 years increased by 14.5 percent, and the number of inmates sentenced to life in prison increased by 5 percent from 1996 to 1997 (PDOC, 1997).

The increase in the state prison population has been attributed to several factors as reflected in the above statistics: (1) increases in court commitments; (2) longer sentences; and (3) increases in the number of inmates given life sentences. In addition, there has been a decline in the number of paroles granted. In 1987, 66.9 percent of parole eligible inmates were paroled, whereas in 1999, only 41.8 percent were paroled, a differential of 25.1 percent. In that same time period, there was an increase in the number of inmates who were returned to prison for parole violations (2,798 in 1987; 5,925 in 1997).

While the inmate population increased 350 percent from 1980 to 1999, (from 8,162 in 1980 to 36,564 in 1999), the inmate population age 40 and over increased 912 percent during that time and the prison population age 65 and over increased 1176 percent. As Figure 1 shows, the Pennsylvania state inmate population has increased both in number and age (Personal Communication, 1999).

FIGURE 1: NUMBER OF INMATES BY AGE GROUP



According to projections for the Pennsylvania Commission on Crime and Delinquency, the older prison population in Pennsylvania will reach 4,500 by the year 2005 (as cited in Bryce, 1996).

These statistics reveal what corrections officials in Pennsylvania have known for some time, the prison population has been increasing because:

- sentences are getting longer;
- fewer inmates are being paroled;
- more inmates are being returned to prison for parole violations; and
- the inmate population is getting older, with the percentage of inmates above 40,

above 50 and above 60 increasing.

Pennsylvania has already started to address this problem with the establishment of Laurel Highlands State Correctional Institution (SCI). Historically in Pennsylvania, long-term care has been provided to chronically ill and disabled inmates in infirmaries within each of the prison facilities. More recently, small numbers of inmates were housed in a state-run nursing home. Security guards were provided by PDOC. When that strategy proved inadequate to handle the growing number of inmates with long-term care needs, a minimum security prison for "infirm and elderly" inmates in Pennsylvania, Laurel Highlands SCI, was opened in Somerset County. The inmates at the state-run nursing home were transferred to this facility. (See Appendices H and I.) Laurel Highlands houses older prisoners, and both younger and older inmates with long-term care needs, as well as a work force of general inmates. Not all of the inmates with long-term care needs, however, are housed in this facility. The long-term care facility and programs at Laurel Highlands comprise one strategy or model through which the Pennsylvania Department of Corrections is addressing the long-term care needs of inmates. That inmates also receive some aspects of long-term care at prison facilities other than Laurel Highlands suggested that Pennsylvania and other states likely have multiple strategies for dealing with the problem (Mara & McKenna, 1998).

SECTION 3: DEFINITION OF TERMS

Long-term care terms may need explanation. In addition, certain long-term care phrases used in the free population need to be adapted for use in the prison setting. For these reasons, a definition of terms section is included.

"Long-term care" involves assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) over an extended period of time.

"Activities of daily living" (ADLs) include activities such as eating, bathing, dressing, using the toilet and transferring from the bed to a chair.

"Instrumental activities of daily living" (IADLs) in the free population include activities needed to maintain one's independence such as grocery (and other) shopping, cooking, house cleaning, maintaining one's finances and using the telephone.

"Functional impairment" indicates a limitation in one's ability to perform ADLs and IADLs.

"Home" in the prison context includes areas such as the inmate's cell, shower area and dining hall.

"Hospice" is a type of care provided to individuals with a life expectancy of six months or less. The focus is on relief of symptoms and interdisciplinary care.

"Personal care attendants" in the free population are paid individuals who provide assistance with ADLs and IADLs to people in their homes and communities. Inmates often provide similar but much more limited assistance to other inmates.

"Adult day services centers" provide care during the day for community-living, non-institutionalized individuals needing assistance with ADLs and/or IADLs.

An "assisted living facility" in the free population typically consists of apartments, a communal dining room and other shared spaces; assistance with ADLs and IADLs may be provided to residents, as needed.

A "continuing care retirement community" (CCRC) in the free population offers a range of housing options with varying levels of assistance with ADLs and IADLs. Options from the lowest to the highest level of care include home care, assisted living and skilled nursing care. The various housing alternatives are located on the CCRC campus.

"Institutional/non-institutional long-term care" reflects a distinction in the free population

between nursing home care and home-and-community-based long-term care. Because the prison is itself an institution, this distinction is not as useful for the inmate population.

"Long-term care model/strategy" means the approach used to provide long-term care.

"State Correctional Institution (SCI)" indicates a prison in the Pennsylvania Department of Corrections. SCIs that typically house inmates with sentences of at least two years.

SECTION 4: REVIEW OF THE LITERATURE

In the literature, little is written that specifically relates to long-term care for younger and older inmates. Much more is written that deals with needs related to older inmates in general. In this section the literature focusing on older inmates will be reviewed, as will literature associated with health care for older inmates and long-term care. The focus in this section is on older inmates rather than in inmates of any age because that is the focus of the literature. In addition, literature related to strategies or models concerned with where and how long-term care is provided in prison and non-prison environments will be addressed.

Challenges Associated with an Older, Infirm Inmate Population

Some of the challenges related to older, infirm inmates emerge from the need for 24-hour nursing care, special diets, a restructuring of activities, and new or redesigned prison facilities (Aday, 1994). Institutional activities require restructuring to fit the needs of an older population, including those who need assistance in carrying out ADLs. In addition, special therapies including physical, speech, or occupational therapies may be needed. Another factor that affects institutional activities is the heterogeneity of older people. Older Americans as a whole are becoming more racially and ethnically diverse, with changes expected to be more dramatic in future years (Treas, 1995:8). This increasing heterogeneity, including the range of functional ability of older people, calls for an added focus on individualized assessment, planning, and programming in order to meet the diverse needs of older inmates (Morton, 1992:4).

Problems emerge from the design of the prison facilities themselves. These physical plants were planned with neither the structural nor the programmatic needs of older prisoners in mind (Morton, 1992). They were designed for a young, active inmate population. Buildings may be

scattered throughout the prison complex, requiring inmates to walk a distance to access health care, meals and additional activities. Architectural impediments such as steps, doorways too narrow for the passage of a wheelchair, and absence of grab bars or handrails, present problems for inmates needing long-term care. Inadequate heating, cooling and ventilation can exacerbate chronic lung conditions (Faiver, 1998:130). Several studies have provided evidence that all of these problems need to be addressed (Merianos et al., 1997; Vito & Wilson, 1985; Cavan 1987).

Safety is also a concern related to older, infirm inmates. When the number of such inmates was lower, younger prisoners tended to assist them. With a growing number of older inmates, however, such treatment is no longer typical. Instead, predatory abuse of older, infirm inmates is more common than in the past (Faiver, 1998:130-131). In California, for instance, the increased presence of prison gangs, has decreased the safety of older inmates (Hunt et al., 1993).

Increasing cost is a major problem associated with an aging prison population. Older inmates, like older people in general, have greater health care needs and expenses. Although many jurisdictions do not collect data on medical costs by the age of inmates, sources indicate that the medical care expenditures for older inmates are almost triple the average cost of medical care per inmate. In 1994, for example, the average cost for inmate care was $21,000 in the state of Washington. However, the average cost of care for older inmates was $77,000, much of which was spent on medical care. A National Criminal Justice Commission report indicated that the average annual cost for a typical adult prisoner was $22,000, while the average cost for an older inmate was $69,000 (Faiver, 1998:128).

The cost of incarcerating an older inmate in California is also approximately three times that of incarcerating a younger inmate. Zimbardo (1994) predicted that, between 1994 and 1999, the

number of California inmates over 50 would increase by more than 300 percent, primarily due to the state's "three strikes" law. He concluded, taking into account recidivism costs among older offenders, that the crime savings predicted to have resulted from the law were questionable.

A portion of the increased cost of caring for older prisoners is due to long-term care costs. As one author wrote, "Our penitentiaries are turning into nursing homes. Can we afford it?" (Holman, 1997:30). Much of the research shows that there is a strong relationship between aging and the need for assistance with ADLs (Kart & Dunkle, 1989). Further, a self-report study of older prisoners in Iowa found a higher rate of lifetime substance use (smoking and drinking) than noninstitutionalized Iowans, which may contribute to heart conditions and cancer (Colsher et al., 1992:882). Merianos et al. (1997:229) suggest that "there is a need to understand how health trends in the noninstitutionalized population affect prison organizations." Estimates show that older prisoners have, on average, three chronic illnesses (Aday, 1994). Merianos et al. (1997:311) concluded that the trend to develop geriatric units will continue. Moreover, the associated increases in expenditures would continue (Anno, 1990).

Long-Term Care, Health Care, and Older Inmates

The Eighth Amendment to the U.S. Constitution prohibits cruel and unusual punishment. As such, the Eighth Amendment has been interpreted by the U.S. Supreme Court to include conduct by prison officials toward the inmate population. Included within that framework is the access to adequate medical attention and care. Although prison officials have a great deal of discretion when determining the degree of medical care needed by inmates, the U.S. Supreme Court, in *Estelle v. Gamble* (1976) created the "deliberate indifference" standard:

> Deliberate indifference to serious medical needs of prisoners constitutes the

kind of cruel and unusual punishment that is prohibited by the Eighth Amendment (*Estelle* v. *Gamble*, 429 U.S. 97, 1976).

In succeeding cases, the standard has been amplified, refined and modified (for example, see *Ruiz* v. *Estelle* (503 F. Supp 1265; 1980 U.S. Dist.). As a further example, the standard of deliberate indifference has been extended by the Court to include not only medical care, but psychiatric and dental care as well (Pollock, 1997: 370). Although there is no specific application of the deliberate indifference standard to long-term care, long-term care's inclusion in the category of medical care might be presumed. Even if long-term care would not be considered to be covered by the deliberate indifference standard, and thus by the Eighth Amendment, the increasing need for long-term care will remain a problem for the corrections population, and, therefore, must be addressed.

As noted earlier, little is available in the literature that deals in a specific way with strategies or models through which long-term care is provided to prison inmates.[3] More in the literature is available that addresses the needs of older inmates in general. The various identified strategies or models for addressing the needs of older prisoners generally do not specify which of these models provide for the long-term care needs of inmates, and which ones do not. Inmates become more vulnerable as they age. Therefore, older inmates may be placed in separate units, e.g., geriatric units, for safety reasons. At least some of these units house only inmates who are able to provide for their own self care. Thus, long-term care is not provided in those units.

An annual survey regarding inmate health care, conducted for Corrections Compendium (Wees, 1997), contains questions concerning special facilities or programs for inmates over the age

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[3]It is important to keep in mind that long-term care is needed by chronically ill and/or disabled people of any age. Therefore, the related needs of both younger and older inmates are to be considered.

of 55. Responses to these questions were received from 43 Departments of Corrections (DOCs) in 42 states (excluding Alaska, Arizona, California, Colorado, Montana, Nevada, North Carolina and Oklahoma) and the District of Columbia.[4] Twenty-six of the responding state DOCs were found to have some provision for older inmates. For the most part, the report did not specify if long-term care was provided. These findings, however, will be presented here in two categories: (1) provisions for health care or geriatric units; and, (2) provisions for long-term care. The provisions for health care or geriatric units include:

- annual physicals for inmates who are at least 50 years of age and follow-up care, as indicated, provided in Maryland;
- reality orientation and current events support group for older inmates provided at a facility in Maryland;
- handicapped accessible facility located in Massachusetts, Missouri (two such facilities), and South Dakota;
- chronic illness or chronic care clinics located in Kansas, Missouri, South Dakota and Wyoming;
- individual treatment plans provided for older inmates in North Dakota; and,
- a geriatric unit or separate housing unit or program for inmates who are at least 50 years of age located in Arkansas, Connecticut, Mississippi (convalescent care), Missouri (two such facilities), Ohio, Pennsylvania, Utah, Tennessee, West Virginia, Virginia (older prisoners who are starting to develop health-related problems; approximately 50 beds) and Texas.[5]

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[4]In addition, surveys were sent to the Federal Bureau of Prisons and to various Canadian systems. Because the focus of the current research is on state prisons in the U.S., the information presented here focuses on the results related to the state prison systems in the U.S.

[5]No long-term care services are indicated as being provided in any of these facilities, except as noted. In general, the survey results indicate that these facilities house older inmates who can perform their ADLs independently.

Long-term care services or related services appear to be provided[6] in at least one facility in 12 (27 percent) of the 43 United States DOCs that responded to the survey. These services reflect a range of intensity that includes:

- inmate helpers assigned to provide assistance to inmates in Florida (the type of assistance is not specified) and South Carolina (help with ADLs is provided);
- a special needs section[7] in Wyoming (unspecified as to the specific type of special need);
- an assisted living unit where assistance with ADLs is provided in Michigan;
- a nursing care facility in Kentucky and two such facilities in Texas;
- a hospice program or unit in Illinois, Pennsylvania and South Carolina (one was to have been opened in South Carolina in 1997);
- special programs or units for chronically ill or disabled inmates or inmates with special needs that may well include long-term care services in Alabama (for aged and infirm inmates deemed to be at risk in other prisons), Arkansas, Georgia, Illinois and New Mexico; and
- a long-term care facility in Pennsylvania.

A special-provision program for older inmates in Indiana was reported to be in the planning stages. Pennsylvania is the only state that is specified as having a long-term care facility or unit. As noted above, however, long-term care may be provided in other states' facilities even though such care is not specified in the survey results. In addition, the survey does not provide information regarding the number of inmates (or the percentage of older inmates or of the total number of

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[6]From the report, it cannot be determined with certainty if all of these strategies include the provision of long-term care or if they are programs for older inmates without long-term care needs.

[7]"Special needs" inmates are defined elsewhere to have at least one of the following: physical disability, emotional or mental health or developmental disability, a terminal illness or advanced age (Briscoe, 1994).

inmates in need of long-term care) who are housed in each of these facilities or receiving these programs. The percentages of inmates over 55 years of age, where reported, ranged from a low of 1.4 percent in Connecticut, to a high of 10 percent in Utah, with Pennsylvania reporting 3.8 percent. Twenty-seven of the responding DOCs reported the presence of laws that allow for the early release of certain inmates, primarily those who are terminally ill (Wees, 1997:16-19).

Further information from Corrections Compendium (November, 1998) reveals that the state of Maryland makes use of chronic care protocols for chronically ill inmates as well as hospice care and that the state of Wyoming houses chronically ill inmates in the infirmary.

In a 1991 study (National Institute of Corrections), state prison systems and the Federal Bureau of Prisons (BOP) were surveyed regarding the presence of special housing units or facilities for older inmates. Thirty-nine state agencies and the BOP responded. Some of the results of this study overlap those of the study described previously. However, additional information was provided and some of the states responding were different from those responding in the 1997 study. As in the report of the 1997 survey, the report of the 1991 survey did not often specify whether or not long-term care services were provided in the units. Seventeen state agencies and the BOP indicated the presence of some type of special unit or housing for older inmates. A six-month follow-up survey found that two of the units had been discontinued, and that two of the agencies did not offer the special units or programs for older prisoners that were requested in the survey.

Florida and South Carolina are the only two states reporting specific attention to older female inmates. Florida Correctional Institution has a unit for older female inmates, while older male inmates are provided special services at Hillsborough Correctional Institution and at Lawtey Correctional Institution. As exists at Laurel Highlands SCI in Pennsylvania, a work force of

younger inmates is also housed at these facilities. In South Carolina, maximum security older men are housed at Broad River Correctional Institution while similarly classified older women are placed at the Women's Correctional Center. Minimum security men and women are housed at State Park Correctional Center.

The information that follows (Morton, 1992) was either not provided in the 1997 survey or not provided in as much depth in that survey. At North Carolina's McCain Correctional Hospital, a minimum security facility for men (including older men) with certain health-related needs, skilled nursing and inpatient care are provided. The Kentucky facility, noted above, is a 50-bed medium security convalescent care unit for male inmates. During the day, a nurse is available. The Georgia facility, also noted earlier, is a medium security facility for older, ill, infirm and disabled male inmates. The 60-bed facility provides round-the-clock medical care. Special needs inmates, including those who are at least 55 years of age who have at least one chronic illness, are housed at the Health Care Unit of Illinois' Dixon Correctional Center.

Wisconsin offers a Self-Care Unit for male inmates who have medical problems, but who can, most of the time, provide for their own ADLs and an Infirmary Unit for male prisoners in need of continual medical attention. These units are located at Waupun Correctional Institution, a maximum security prison.

A 1998 report by the Massachusetts Department of Corrections details the process through which that state made its decision to add an assisted daily living unit to an existing medium-security facility in the Norfolk area. This alternative was viewed by the committee charged with the responsibility to review the housing situation for ADL inmates (29 identified within the Massachusetts prison population) as a mid-range cost alternative at $530,530. The more costly

solution would have been to construct a separate ADL facility at an average cost of $175 per square foot, with a total cost to exceed $2.6 million. The least costly solution, at a projected cost of $275,730, would have been to convert an existing facility to an ADL unit. The addition of the special ADL unit would provide the Massachusetts Department of Corrections with 45 beds and would occupy the first floor of the main housing unit of the facility (MA DOC, 1998).

The findings of a multi-year survey of 46 correctional systems in the U.S. and Canada, conducted by Flynn (1992), indicated that tracking and monitoring of older prisoners were not conducted by most of the systems. Flynn found no consensus definition of older inmate or long-term offender. As a result of the study, Flynn made five recommendations:

1) baseline data be maintained on older inmates;
2) current classification systems be changed to mainstream older inmates if doing so is consistent with their mental and physical health status;
3) prison facilities be modified to foster equitable treatment of both younger and older prisoners;
4) educational and work programs include preventive medicine, health care education and counseling aimed at the needs of older prisoners; and
5) geriatric units be developed for older prisoners who need special types of care.

Thus, the literature provides few specifics of strategies or models for providing long-term care to inmates with more studies being available in terms of the care of older inmates in general.

Long-Term Care Strategies or Models in the Free Population

Assisted living (or personal care) facilities consist of individual rooms or apartments, generally with a common dining area. Varying degrees of assistance with ADLs and instrumental

activities of daily living (IADLs) such as housekeeping are provided. Long-term care may also be provided in adult foster homes where care may be provided to a small number of residents. Continuing care retirement communities (CCRCs) are comprised of a range of housing and care options. An individual may live in his or her own home on the CCRC campus or in a room or apartment in an assisted living (or personal care) facility. Long-term care may be provided in either of these locations. In addition, nursing home care is provided on the CCRC campus. An individual may move from one level of care to another, as needed.

An increase in the number and types of community-based long-term care options has also taken place in recent years. For instance, adult day services centers (also called adult day care centers) have emerged. At these centers, various levels of care are provided, including assistance with ADLs and, at some centers, therapies including physical therapy, speech therapy and occupational therapy (Massie, 1998:228). Individuals who live in their own homes or apartments can spend one or more days a week at a day services center.

Care at home can be provided informally by relatives or friends or formally through for-profit or not-for-profit organizations. The majority of long-term care is provided by relatives and friends of the chronically ill or disabled individual (Wiener, Illston & Hanley, 1994:1).

Research conducted by Mara and McKenna (1998) indicated that certain of the free population long-term care strategies or models (included in Section 3: Definition of Terms) are reflected in the Pennsylvania DOC's strategies in addressing the long-term needs of inmates. Hospice services are provided to certain inmates at the V2[8] facility. The Laurel Highlands facility

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[8] In most instances Laurel Highlands has not been coded. SCIs other than Laurel Highlands have been coded. The same coding is used in the SCI profiles in Section 6. An

provides long-term care in a fashion similar to that of the CCRCs. At Laurel Highlands, as at the CCRCs, an individual can move, as needed, between a unit in which a lower level of care is provided, i.e., the geriatric unit, and one in which a higher level of care is provided, i.e., the long-term care unit or the wheelchair unit.

As earlier noted, prior to the opening of Laurel Highlands SCI, a small number of inmates with long-term care needs were housed at a state-run nursing home. Although this model is no longer employed by the Pennsylvania DOC, it is a strategy that reflects the nursing home model for the non-incarcerated population. One purpose of this study is to identify other models or strategies used in providing long-term care to prison inmates.

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explanation of the coding system can be found in that section.

SECTION 5: METHODOLOGY

Exploratory research conducted by Mara and McKenna (1998) relied on the review of material published by the Pennsylvania DOC and two focus groups, one with the correctional staff and health care staff of Laurel Highlands SCI, and one with program administrators within the PDOC. The overall purpose of this study was to begin to identify the strategies or models for providing inmate long-term care that actually exist in the PDOC. The models that were identified were noted in the previous section.

In order to explore further the issue of long-term care in the Pennsylvania prison population, the following research questions were developed for the current study:

1) How and where does each of the 25 SCIs in Pennsylvania provide long-term care to inmates?
2) If a facility does not provide any long-term care services, what is it about the facility or its population that does not require them?
3) If a facility does provide long-term care, how does it do so, and how did it come to the current way of providing such care?
4) What issues are important in the development of these models or strategies to address the long-term care needs of inmates?

Reasons for the Focus on the State Prison System Level

In this study, facilities within a state correctional system, as opposed to a local jail system or the federal prison system, are the focus. Jails, which are administered locally, typically hold individuals who have not been sentenced and prisoners with sentences of no more than a year. Prisons, on the other hand, generally incarcerate inmates with sentences longer than a year (Profile,

1996). In Pennsylvania, local jails, which are referred to as prisons, hold prisoners who are serving up to two-year sentences. Because local systems typically incarcerate inmates for relatively short periods of time, concerns regarding long-term care needs would not be felt as acutely in the local jail systems as in the state or federal correctional systems.

Additional reasons the state level was chosen as the focus of this study include the following:

1) the number of state prison inmates in the U.S., i.e., 1,178,978 in 1998, far exceeds the number of federal prison inmates, i.e., 123,041 (Beck & Mumola, 1999:1);

2) DOCs in the various states are looking for strategies to address the needs of the increasing number of older inmates, including those inmates in need of long-term care; and

3) state DOCs can learn from the strategies employed by other states.

Reasons for the Selection of the Pennsylvania Corrections System

The Pennsylvania correctional system was chosen for a number of reasons. A preliminary study of long-term care strategies employed in that system had already been conducted (Mara & McKenna, 1998). In addition, in Pennsylvania, the percentage of older people is the second highest in the nation. The state's older population has increased by 106 percent over the past four decades. During the same time frame, the increase in the under-65-year cohort has been less than five percent (Cornwell et al., 1993:1). Therefore, aging-related issues, including long-term care, are of particular concern in the state. More specifically, the Pennsylvania DOC has developed, and is continuing to

develop, strategies to address the increasing need for long-term care for its inmates. Those strategies have been discussed earlier.

An Advisory Committee was formed for the research project. (See Appendix A.) A meeting with the Committee members was conducted in December 1998. An overview of the research project was presented. Committee members underscored the value of the research undertaking. They recommended that the definitions of critical terms be clarified because of the variety of meanings that may be applied to them in corrections, health care and public welfare.

The research methodology draws on social science methods that are typically employed in research aimed at identifying models and key issues and that have been practiced to a considerable extent by the principal investigators on this project. Approval of the involvement of human subjects was granted by the Institutional Review Board of the Office of Regulatory Compliance at the Pennsylvania State University. (See Appendix E.)

The research made use of several social science methods of data collection:

1) a written quantitative and qualitative survey of Superintendents (or their designees) at all Pennsylvania State Correction Institutions (SCIs);
2) in-person, on-site interviews with the Corrections Health Care Administrator (CHCA) at three SCIs;
3) telephone interviews with the CHCA at each of the remaining 22 SCIs; and
4) separate group interviews (focus groups) with staff and with inmates at seven selected SCIs (two focus groups per institution).

Research Plan

The original research plan called for a written qualitative survey (Step 2 above), telephone interviews (Step 4 above), and two separate focus groups at each of six SCIs, chosen according to the "model" or approach to providing assistance with ADLs that those SCIs seemed to represent (Step 5 above). Although various circumstances led to the expansion of the research effort, the unit of analysis, the individual SCIs, remained the same. The following section describes the development of the five steps used in the study.

1) The Pennsylvania DOC played several key roles in this research. Needless to say, the Department's cooperation was vital to gaining entry into the SCIs. Forms and methods of data collection and inmate protection required PDOC's approval as well as the approval of Penn State University's Office of Regulatory Compliance. Beyond granting "permission to conduct research," however, PDOC displayed genuine interest in the project. In the early months of the current project, permission and approval held the attention of both the principal investigators and PDOC's highest levels of administration.

Close work with PDOC's Bureau of Health Care Services characterized the second stage of the research plan and culminated in a letter from Martin F. Horn, Secretary of the Pennsylvania Department of Corrections to the Superintendents of the SCIs. (See Appendix D.) The Bureau had planned to conduct its own quantitative survey to assess the general level of need for providing assistance with ADLs to aging and other inmates. Rather than burden staffs at the SCIs with two obviously related research efforts, and perhaps thereby reduce the response to this

project, the two efforts were combined. The resulting instrument had two components: 1) a quantitative component (Table A located in Appendix B) that mainly served PDOC's needs but also provided descriptive statistics for the current research and 2) a qualitative component ("Interviewer's Guide" found in Appendix B) that mainly served this research.

SCI Correctional Health Care Administrators provided survey data by completing the two parts of the survey instrument. The first part, referred to as Table A during the survey process, contained quantitative data and responses to closed-ended questions. These data elements include:

- an inmate identification number (that was used by PDOC to determine inmate ages but was not used by the researchers);
- the ADLs with which the inmate needed assistance (identifying the Level of Need as defined in Appendix B; the typical source of the assistance, whether nurse, security officer, other inmate, etc.; and the typical location in which the assistance was provided, such as the dining hall, cell, etc.);
- the inmate's primary impairment (as defined in Appendix B);
- the secondary impairment (also as defined in Appendix B); and
- the housing location of the inmate.

The second part contained open-ended questions. (See Appendix B.) Responses to these questions formed the starting point for the interviews and, together with the interviews, provided the data for the descriptions of the ways in which the SCIs provide inmates with assistance with ADLs.

The heightened interest of the Bureau of Health Care Services in the project led to a collaborative development of the survey instrument, requiring a longer time span than anticipated, but resulting in a well-accepted product. The collaboration resulted in a Bureau-sponsored telephone conference to review the survey instruments with all of the SCI superintendents and/or health care administrators (CHCAs), giving them the opportunity to ask questions and seek clarification. The telephone conference also provided an opportunity to ensure that June 1, 1999, 12:01 a.m., would be the agreed-upon time for counting inmates for the survey.

2) Following the review of the completed survey instruments, rather than commence the telephone interviews immediately, the principal investigators chose to conduct in-person interviews with CHCAs at three SCIs, and to request tours of those institutions. One older SCI, one newer SCI and one SCI that performs intake tasks and assessments of new inmates were selected. This enhancement was chosen in order to provide the principal investigators with a mental image of SCIs and thereby make the remaining telephone interviews more enlightening.

3) Both the in-person/on-site and telephone interviews, all conducted by the two principal investigators, followed the open-ended questions in the survey instrument. (See Appendix B.) The researchers also probed subject areas, according to the responses.

4) At the conclusion of the interviews, seven SCIs rather than the planned six became sites for focus groups and tours. The selection included:

- Laurel Highlands because PDOC established it specifically to provide assistance with ADLs for inmates;
- V2[9] because it has an "official" hospice program;
- V5 because it provides for inmates with a variety of infirmities, although not all of these inmates were necessarily listed on Table A as being in need of assistance with ADLs;
- V4 because it is one of two SCIs for women and it houses more inmates needing assistance with ADLs than does the second female institution;
- V7 because it is a so-called "prototype" institution, one of the newest in Pennsylvania;
- V6 because of the apparent emphasis on an explicit team approach to providing assistance and also the role played by inmates;
- V3 because of the variety of infirmities of its inmates, the diversity of housing options, and the age of the facility.

The original research plan called for the selection of SCIs according to the model or approach they represented. On the basis of the written survey responses and the interviews, there appeared to be a variety of practices at most institutions, rather than a discrete "set of practices" that could be categorized as a specific model. That is, two institutions are less likely to exhibit completely different (or completely similar) models than they are to have some differences and

[9]In most instances Laurel Highlands has not been coded. SCIs other than Laurel Highlands have been coded. The same coding is used in the SCI profiles in Section 6. An explanation of the coding system can be found in that section.

some similarities in practices. Thus the basis for selecting SCIs for focus groups became their variety in practices and their special characteristics. Selecting any one SCI as totally representative of additional SCIs became futile as well as arbitrary; SCIs forming a group on one characteristic might be quite disparate on others.

It was decided not to visit SCIs that represented one particular model. These were the SCIs that lack an infirmary and which would rarely, if ever, have an inmate who needs long-term care. In addition, the "boot camp" prison was not visited.

The Interviewer's Guide presented in Appendix C, with suitable follow-up questions was used at separate group interview with staff and inmates. The tour of each institution provided additional opportunities for the principal investigators to gain information regarding the components of that SCI's approach to providing assistance with ADLs.

Group Interviews

After completing the interviews with the CHCAs, seven SCIs were selected for site visits to include group interviews (focus groups) with staff and inmates. At those SCIs, the following staff members were included in the staff interviews (if they were available at the time of the interview):

1. nurse,
2. physician,
3. Unit Manager from the SNU or another cell block with inmates needing assistance with ADLs,
4. Security Officer from the SNU or another cell block that houses inmates needing assistance with ADLs,
5. counselor,

6. psychologist,
7. housing assigner,
8. assigner of inmate jobs and
9. other staff as appropriate.

For the inmate group interviews, the process of selecting inmates included several steps. First, based on the responses to Table A, inmates needing assistance were selected to represent a variety of ages, types of impairment, and kinds and levels of assistance needed. The groups also included inmates who provide assistance to other inmates, such as dining hall workers, infirmary workers, and cellmates of inmates needing assistance. The list of selected inmates was sent to the CHCA for review. Some inmates had been transferred from that SCI or would otherwise not be available on the day of the focus groups. In a telephone conference, the CHCA and the researchers together arrived at the final selection of inmates.

The Interviewer's Guide used in the in-person and telephone interviews during the initial part of the study is quite similar to the moderator's guides used in the later focus groups. Consequently, single descriptions were developed of each SCI's practices in providing assistance with ADLs, rather than separate descriptions based on each separate data source.

SECTION 6: FINDINGS

Quantitative Findings

There was a 100 percent response rate for the written survey and the telephone interviews. The quantitative component of the written survey revealed the number of inmates needing assistance with ADLs, by age, in each SCI. This number very likely represents an undercount because many of the SCIs reported not including inmates who need "only prompting" or "just occasional help that we provide." Based on the written responses, 1.8 percent of Pennsylvania's inmate population needs assistance with the ADLs. That estimate increases to 4.2 percent for inmates who are 40 and over, and to 23.8 percent for those 65 and over. The percentage of women inmates needing ADL assistance is 1.88 percent, almost identical to the overall percentage of inmates needing such assistance.

As Table 1 shows, the percent of inmates needing assistance with ADLs increases with age, and increases sharply for those past 55 years old. This expected result, together with the observation that the number of older inmates is increasing (see Figure 1 in Section 2 above), provides clear evidence that states will have to provide for an increasing number of inmates needing assistance with ADLs.

TABLE 1: NUMBER OF INMATES AND NUMBER OF INMATES NEEDING LONG-TERM CARE BY AGE (IN PENNSYLVANIA DEPARTMENT OF CORRECTIONS, 1999)

Age	Number of Inmates	Number of LTC Inmates	Percent of Inmates Needing LTC
<18	73	0	0.0
18-20	1,477	5	0.3
21-24	4,893	18	0.4
25-29	6,607	33	0.5
30-34	6,289	54	0.9
35-39	6,118	94	1.5
40-44	4,797	121	2.5
45-49	2,970	99	3.3
50-54	1,678	56	3.3
55-59	879	62	7.1
60-64	413	42	10.2
65-69	231	31	13.4
70-74	98	31	31.6
75-79	30	16	53.3
80-84	6	5	83.3
85-89	5	5	100.0
Total	36,564	672	1.8
40 & over	11,107	468	4.2
65 & over	370	88	23.8

Age distribution of all inmates needing assistance results from summing the distributions of the individual SCIs. (See Table 2.) The modal age category of inmates needing assistance is 40 – 44 years. The age distribution (see Table 2) of such inmates has fewer inmates in younger groups, due to the smaller percentage of younger inmates needing assistance. It also has fewer inmates in older groups needing assistance, due to the smaller number of older inmates.

TABLE 2: NUMBER OF INMATES REPORTED AS NEEDING ASSISTANCE WITH ADLs BY PENNSYLVANIA SCI BY AGE

Age Group	TOTAL	V1	V2	V3	V4	V5	V6	V7	P1	P2	P3	AA	BB	CC	DD	EE	FF	GG	HH	JJ	KK	LL	MM
Under 18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18-20	5	0	0	0	0	0	1	0	0	2	0	0	0	0	0	1	0	0	0	0	0	1	0
21-24	18	1	0	1	0	1	2	0	0	3	0	0	0	0	2	4	0	0	0	1	1	2	0
25-29	33	1	0	3	0	2	5	1	2	1	1	0	1	1	2	1	2	0	3	0	2	5	0
30-34	54	1	0	6	1	11	8	2	0	3	0	0	0	0	3	11	2	0	2	0	0	4	0
35-39	94	4	1	8	3	11	6	10	0	8	0	0	0	2	4	19	6	0	2	3	6	1	0
40-44	121	9	0	14	0	18	15	8	2	0	2	3	0	2	5	20	10	0	3	2	2	4	2
45-49	99	9	0	8	2	14	16	6	1	4	1	0	0	2	3	14	9	0	5	0	1	3	1
50-54	56	7	1	4	2	10	9	2	0	2	1	2	0	0	2	5	2	1	2	1	1	2	0
55-59	62	15	2	6	3	4	5	3	2	1	1	1	0	1	0	2	9	0	1	0	2	2	2
60-64	42	6	0	2	3	8	5	2	1	0	0	2	0	1	0	5	4	0	1	0	0	0	2
65-69	31	6	0	3	3	3	6	0	0	1	1	0	0	0	1	2	3	0	0	0	1	1	0
70-74	31	16	1	0	0	2	4	2	0	0	0	1	0	0	0	2	1	0	1	0	0	0	1
75-79	16	10	1	1	0	0	1	1	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0
80-84	5	2	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
85-89	5	3	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0
90-94	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
95 and Over	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	11	0	0	4	2	0	2	0	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0
Total	683	90	6	60	20	84	86	38	9	27	7	9	1	9	22	88	48	1	20	8	16	26	8

Number of Inmates needing assistance with Activities of Daily Living (ADLs), Response by CHCA, as of June 1, 1999.
Three SCIs reported no inmates needing assistance with ADLs.

The seven institutions in the sample selected for site visits demonstrate substantial variation in capacity, population, year opened as a State Correctional Institution, security level, geographic region and number of inmates requiring assistance with the activities of daily living. This variation is noted in these quantitative measures even though qualitative characteristics, not quantitative measures, served as the basis for selecting the sample. The site visit sample of seven SCIs provides a reasonable representation of all 25 SCIs as Table 3 demonstrates.

The qualitative characteristics that describe the ways in which institutions provide assistance with ADLs form the focus of this report and the basis for selecting institutions for site visits. Those characteristics include:

- physical plant,
- kinds of impairments that prompt a need for assistance,
- flexibility in housing inmates,
- special programs,
- training of staff beyond the DOC foundation training,
- role of inmates in providing assistance,
- link with community organizations,
- release planning,
- transfer practices and
- terminally ill inmates and hospice care.

TABLE 3: QUANTITATIVE CHARACTERISTICS OF SCIs IN SITE VISIT SAMPLE

SCI	Capacity	Population (5/31/99)	Year Opened	Security Level	Geographic Region	Number of Inmates Requiring ADL Assistance
V7	1,220	1,983	1993	3	Northwest	38
V6	1,087	1,798	1960	3	East	86
V5	2,482	3,374	1929	4	Southeast	84
V1	309	394	1996	2	Southwest	90
V4	596	901	1920	3	Central	20
V3	1,528	1,757	1882	4	Southwest	60
V2	1,179	1,130	1989	2	Northeast	6
Sample range	309 – 2,482	394 – 3,374	1882 – 1993	2 - 4	All regions	6 - 90
Population range	158 – 2,482	178 – 3,374	1882 - 1998	2 - 4	All regions	0 - 90

Qualitative Findings

Of the more than 36,000 inmates in the custody, control and care of Pennsylvania's SCIs, more than 683 require assistance with the activities of daily living, 297 of whom need only additional prompting. This section provides descriptions of the ways in which each institution provides such assistance and for whom they provide it.

The sources of these descriptions include documents from PDOC and the several data sources of this research: the written quantitative and closed-ended questions, the written open-ended questions, the on-site or telephone interviews with CHCAs, and the on-site focus groups with staff and inmates.

Data Sources

Information regarding the "Year Opened" and the "Security Level" were included on a list of SCIs provided by PDOC. The "Monthly Population Report: May 31, 1999" provided by PDOC included the "Capacity" and "Population" as of that date. The number and disposition of inmates needing assistance with ADLs were taken directly from Table A of the written survey instrument of this research. (See Appendix B.) Textual information comes from the open-ended questions of the survey instrument (also Appendix B), the interviews with the CHCAs, and the focus groups. (See Appendix C.)

Limitations of Sources

These sources sometimes provide inconsistent information. The most notable and understandable instance of this inconsistency lies in the "Number of inmates needing assistance with ADLs". The source of the reported number is Table A of the written survey. Interviews and site visits, however, regularly revealed that this number substantially understated the actual number

because staff members take for granted some of the assistance they provide, considering that they "are just doing what they have to do." In other instances, SCIs did not include blocks of inmates who "only need to be reminded to do things," even though that is precisely what is meant by a "Level 4" need for assistance. There is also a variety of understandings about what constitutes "long-term care" and "assistance with ADLs." In spite of these inconsistencies, these numbers represent the most precise information available regarding the number of inmates needing assistance in the Pennsylvania system. Moreover, we have encountered no other state corrections system whose estimates approach the precision of these numbers.

Focus groups or group interviews are always subject to within-group dynamics, and the moderators / researchers recognize these dynamics in listening to and learning from groups. Focus groups with inmate participants where staff were absent and where staff were present yield different potential limitations. At times, when staff were present (for reasons of security or other concerns), the principal investigators were quite conscious of at least some inmates exercising care in what they chose to say. Where staff were absent during the focus group interview, it appeared that at least some inmates were careful of what they said in front of their fellow inmates. In one particular instance, an inmate appeared ready to speak positively – even enthusiastically – of infirmary staff and then, perhaps sensing the body language of fellow inmates, spoke negatively of the services "that brought me back when I was dying." In spite of these limitations, the researchers were confident they had gathered information from inmates concerning the manner in which long-term care is provided. In future projects like this one, one-to-one interviews may prove to be a worthwhile component.

An inconsistency, not of a data source but of an understanding of allowable practice, exists in the role that inmates have in providing care. Where inmates do provide some sort of care to other inmates, both inmates and staff report being satisfied with the assignment, but often would prefer that the assignment be more explicit. Interviews revealed that in some SCIs, inmates do not push wheelchairs but may clean another inmate's cell under the supervision of a staff member. Other SCIs explicitly incorporate inmates in their care plans, including training and contracts for inmates who provide care under the supervision of staff. (See Appendix F.) Some SCIs provide selected inmates (especially inmate infirmary workers) with training for the handling of "blood and body fluids" in case of emergencies. Inmates have reported that the job "infirmary janitor" includes tasks that they would include in a job description of an "orderly." Some illustrations include shaving an impaired inmate, changing the soiled clothes and bed linens of an incontinent inmate, and helping an inmate to get dressed. These reports did not suggest that the inmates did not want to perform the functions, but rather that they thought a different job title was warranted.

Since this research focuses on "assistance with ADLs," the profiles of the SCIs reflect this focus. For example, "Caregivers and Training," does not reflect the general training provided to SCI staff, the professional training undertaken by general care providers (e.g., training in nursing undertaken by nurses), or specialized training undertaken for purposes not related to assisting with ADLs. Likewise, descriptions of "Release Planning" have as their focus release planning on behalf of inmates needing assistance with ADLs.

The term "capacity" refers to the total number of single beds for which an SCI was originally designed plus the results of subsequent additions or renovations resulting in beds being added or

deleted (Yates, 1997: 59). Committed "population" refers to the number of inmates who have legally been sentenced to confinement under PDOC's jurisdiction.

"Levels of Need" help to describe the intensity of assistance needed. "Level 4, " the lowest level of need, consists only of prompting or cueing. "Level 1" refers to assistance needed when one is unable to care for oneself. (See Appendix B for a full explanation of the levels of need.)

Commonly used abbreviations include: CHCA (Corrections Health Care Administrator); ADL (Activities of Daily Living); SNU (Special Needs Unit); and RHU (Restrictive Housing Unit).

Common Circumstances

Whether or not it is explicitly stated in the profile for each institution, it is common practice that SCIs provide inmates, upon release, with a 30-day supply of medications and with descriptive information on their medical conditions.

Inmates certified as medically unable to work are provided idle pay. The descriptions of only some SCIs refer to this circumstance, but it applies to all SCIs. Inmates vary in their willingness to take idle pay, with some preferring to work at some job.

SCI Codes

Consistent with confidentiality, the profiles appear with code names rather than with the SCI names themselves. We recognize that individuals familiar with Pennsylvania's SCIs will readily identify all or most SCIs. The codes represent four groups of SCIs as follows.

- SCIs at which on-site focus groups were conducted appear as V1 – V7;
- SCIs with on-site interviews with CHCAs appear as P1 – P3;
- SCIs reporting no inmates needing assistance: N1 – N3;
- Other SCIs appear as AA – MM (with no II).

Profiles of Pennsylvania State Correctional Institutions

Introduction to the SCI Profiles

Summarizing the qualitative profiles of 25 SCIs challenges us to capture the variety of ways in which SCIs provide long-term care. In the summary, the same dimensions (Physical Plant, Caregivers and Training, etc.) as the individual profiles are used. We choose these dimensions after conducting the survey, visits and interviews, because they seemed to distinguish the ways in which the SCIs provide long-term care.

THE NUMBER OF INMATES NEEDING ASSISTANCE WITH ADLs

At the various SCIs, the number of inmates needing assistance with ADLs varies from 0 to 90. Visits and interviews suggest that the reported number underestimates the actual number, with staff providing assistance "because that's what we need to do" without thinking of the assistance as providing long-term care.

PHYSICAL PLANT

SCIs of diverse age exhibit diverse designs. Some (not all) accommodate wheel chairs and walkers; some (not all) have special facilities such as mental health units and dialysis facilities. In some, the Special Needs Unit is within easy reach of the health care unit.

CAREGIVERS AND TRAINING

Staff

Some (not all) SCIs arrange for specialized training to allow staff to provide long-term care to inmates with special needs (e.g., training in signing so staff can communicate better with hearing impaired inmates).

Inmates

Some SCIs provide inmates with explicit training to assist other inmates. In other SCIs, inmates are "written up" for assisting other inmates; in such instances, training would be inconsistent. Where inmates provide assistance, it can vary from assigned and paid jobs, to volunteering openly to assist another inmate, to surreptitiously assisting a cellmate or other inmate. Inmates help other inmates with wheel chair pushing, getting food for them in the dining hall, accompanying them from place to place, putting on their clothes, and cleaning up after them in the infirmary.

ACCOMMODATION

Some SCIs provide wheel chairs temporarily in the winter to make it easier for inmates with mobility problems to get around outside the building; others move certain inmates to cellblocks (where outside walking is not required to access services such as the dining hall and the infirmary) or deliver some services (such as hair cuts or meals) to the cellblock. Security personnel and others

remind inmates who need prompting that it is time for the next activity. Some SCIs provide physical accommodations, such as special thresholds to allow wheel chairs or walkers to be maneuvered in and out of the showers.

JOBS

Inmates who cannot work because of medical reasons receive "idle pay". Many inmates would rather work at some job than not work at all. Some (not all) SCIs identify or develop jobs for inmates with limited capability.

TRANSFER

In some SCIs, if an inmate needs meals or medications brought to the cell, accommodation is made. In other SCIs, such needs indicate that it is time for the inmate to be housed in the infirmary. In SCIs without an infirmary, it is time to request that the inmate be transferred to another SCI.

SPECIAL PROGRAMMING

Some SCIs offer no programming specially designed for those inmates needing assistance with ADLs; others offer programming for older inmates, for HIV inmates, for inmates recovering from addictions, and/or for those dealing with mental health problems.

RELEASE PLANNING

It is common practice for SCIs to provide inmates with a 30-day supply of medications and written descriptive information on their medical conditions. In addition, SCIs typically contact social service agencies to facilitate continuing care. Release planning for inmates needing ADL assistance can be problematic. Long-term care facilities (in the community) may not want to admit individuals being released from prison. In addition, the inability of these individuals to pay privately

for LTC makes such admissions even less likely to occur. Family involvement can facilitate the process.

TERMINALLY ILL INMATES

Parole is not a ready option for terminally ill inmates, even for those whose death appears imminent. One SCI has a three-bed hospice unit formalized by the Department of Corrections. Some inmates from other SCIs are sent there. However, the bed capacity is limited. Also, women cannot be transferred to the SCI with the official hospice program. Moreover, some inmates would rather stay in the SCI where they are if the staff are able and willing to provide support. Therefore, some SCIs provide hospice-type care, while other SCIs request a transfer for a terminally ill inmate. Some SCIs invite and make use of community hospice resources, including training for corrections staff.

COMMUNITY LINKAGES

Outside agencies provide services at some SCIs and none at others. These services include training to work with the hearing and sight impaired; hospice support; chaplain services; training in addiction services; and adapting to aging in prison.

Profiles

V7 SCI

Opened: 1993

Security Level: 3

Capacity: 1,220 Population: 1,983

Table A reported 38 inmates needing assistance with ADLs, the vast majority due to skeletal/locomotor impairment.

PHYSICAL PLANT

SCI V7 has an 18-bed inpatient infirmary. Twelve beds are designated for medical care, convalescence care or postoperative care. Two beds are for respiratory isolation and four for psychiatric observation. The infirmary is seen by the inmates as a hospital. Inmates do not have visits from their friends when they are in the infirmary.

This SCI has a special needs unit (SNU). Inmates who have mental health or mental retardation problems and inmates with physical impairments are housed in the SNU.

The facility is handicapped accessible. However, there are distances that an inmate needs to travel from the housing units to the dining hall, commissary, infirmary, etc. The only stairs are to the second tier on a housing unit. Everywhere else, a wheelchair can be used without a problem.

The facility itself was intended to have been a rehabilitation site where inmates from other SCIs would go for rehabilitation after hip replacements, heart attacks, etc. However, V7 did not become a rehabilitation site.

CAREGIVERS and TRAINING

Staff

Staff members monitor the provision of assistance to an inmate by another inmate and if it appears that an inmate is taking advantage of an inmate needing assistance, the staff intervenes. Also, if inmates make fun of an inmate because he walks in a different way or acts in a different way, staff members give a written or unwritten message that such behavior is not acceptable, saying, "That is not the way we operate." A team approach in which staff members communicate with other staff members regarding inmate's needs for assistance with ADLs and IADLs appeared evident.

Staff receive 40 hours of off-site training and 40 hours of on-site training. All nurses are certified in a particular area. Some staff members are learning sign language.

Inmates

At times inmates provide help to other inmates, although training is not provided. It appears that the lack of training emerges from the requirement that inmates not provide certain types of help to other inmates. There would probably be a need for more infirmary care if it were not for cell mates and other inmates providing some assistance. Inmates also monitor the behavior of other inmates and notify the block officer, unit manager, or counselor that a particular inmate is not looking well or that he is not taking a shower or that he is not getting to meals. A staff member then checks on the inmate to determine the nature of the problem and may call health care personnel.

Some of the inmates are encouraged by the staff to walk with certain of the older inmates who want to retain their independence and stay in general population but need someone to accompany them from place to place. The inmates said that they would receive a misconduct if they do not help another inmate when a corrections officer asks them to provide help. They said they are

reluctant to providing help to other inmates who do not try to help themselves but rather depend upon other people to help them with things they could do themselves. They said that inmates who are willing to provide help generally have been in prison for a length of time or are older inmates. Younger inmates or shorter-term inmates are less likely to help.

The incline makes it necessary for wheelchair inmates to have someone push the wheelchair. Inmates may volunteer to be wheelchair pushers for another inmate. The helper inmates generally work as a network of helpers because they have other assignments.

The inmates being helped may give the helper inmate a pack of cigarettes or something else that they have obtained at the commissary as a thank you. Both the inmates who receive help and the inmates who provide help seem to be comfortable with this informal exchange. However, the helper inmates would prefer if it were a paid position. The inmates were aware that pushing a person's wheelchair is a paid position for inmates at other SCIs. One inmate who needs a wheelchair pusher said that if wheelchair pushers were paid, the inmates who are in wheelchairs would not have to ask volunteer inmates to cut into their recreation periods. Also, he pointed out that sometimes inmates are willing to volunteer at some times but not at other times, yet the inmate in the wheelchair needs to have help on a consistent basis. The inmate was saying that it would make it a lot easier on both the inmates needing help and the inmates providing help if there were an inmate job for wheelchair pushers.

Generally the volunteer wheelchair pushers are friends of the inmate needing assistance. However, at times an inmate who does not know the inmate in the wheelchair will push the wheelchair, but that does not happen often. The inmate said that inmates providing help to other

inmates who need assistance and to also try to do as much for themselves as they can. Such assistance is easier to find.

Another way that inmates provide assistance is to clean that inmate's cell. Some inmates who have a need for assistance, however, are able to clean their cell, perhaps except for the floor. At times, it is a matter of one inmate recognizing that another inmate needs assistance and providing that assistance. Inmates will also write letters for other inmates or read other inmates their mail.

As stated earlier, the inmates who provide help do not receive any formal training. The inmates they are helping probably provide some training of the inmate helpers to let the inmate helpers know how it is best to provide help to them.

ACCOMMODATION

In the winter time, there are more inmates who need help in the bad weather. For instance, inmates with asthma may be loaned wheelchairs for temporary use at that time. At the time of the interview, all the inmates who were permanently in wheelchairs were younger inmates.

Another accommodation would be for inmates who take longer getting from one place to another. There is no cane and crutch line at V7 but the corrections officers know the inmates who require a greater amount of time and they realize that the inmate is taking a greater amount of time because of a problem with mobility. There can be a problem, when there is a relief officer, e.g., when there is a standing count. Although the regular officer knows that he needs to go to the deaf inmate's cell to let him know that it is time for count, a relief officer might think that the inmate is not coming for the standing count for reasons other than deafness.

If an inmate has Alzheimer's Disease or another dementia, the COs know which inmates have these illnesses and they contact the nurses, the unit counselors, managers for help if there is

a problem. There seems to be an effort made to distinguish between behavior that emerges from Alzheimer's Disease or other dementia versus other behavioral problems in corrections. The security staff members try to work with these inmates rather than writing misconducts because of their behavior. Sometimes, though, when SNU inmates go to another part of the prison, the officers there may not be aware that the behavior is the result of a disease process and he may give them a misconduct. At that point, medical staff might work with the corrections staff to have the misconduct time decreased and have that inmate returned to the SNU. Consistency, the staff said, works very well. If the officers, unit managers, counselors, psychologists are aware of the needs of the inmates, especially in the SNU, and there is not much turnover in the staff, they get to know the inmates well. Consistency is very helpful especially for inmates who are often confused.

Another accommodation takes place in the dining hall. Some of the inmates who have a need for assistance with ADLs and IADLs sit at designated tables and someone comes to take their ID cards and identify the diets they need. Kitchen workers bring the trays to those inmates.

Another accommodation, the inmates said, was to have a special chair in the shower. A shower chair and a bar allow the inmate to transfer himself from his wheelchair to the shower chair and back to the wheelchair.

The goal at SCI V7 seems to be to encourage independence so it is seldom that meals are delivered to an inmate in his cell, although that has happened. Inmates are encouraged to be independent in being able to go to the dining hall on their own. If an inmate has difficulty in taking a shower, but can live in the general population, then that inmate might go to the infirmary for a shower but live in the general population. This is somewhat similar to the adult day services model in the free population.

One inmate cannot carry his tray because of non-union of the bone in his arm. However, he does not want anyone to carry it for him. His meals are delivered to his cell, as they are for an inmate with Huntington's Chorea who is at risk of falling. An inmate, particularly one with difficulty in mobility, may need to be assigned to a bottom bunk in a lower tier. Therefore, he would have no stairs to climb.

The key ability is the ability to transfer — from the bed to the wheelchair, from the wheelchair to the shower, etc. An inmate needs to be able to perform this key activity of daily living in order to be able to continue to live in general population.

JOBS

The staff developed 15 - 20 jobs that can be done by inmates who have some functional limitation, taking into account of the need for inmates who have weight restrictions or restrictions on how long they can stand.

Inmate workers in the SNU come from the SNU. They perform laundry, janitorial and clerical jobs and pull weeds. Inmates from other areas are not brought into the SNU to work. Although inmates from other areas do not come to the SNU to work, at times, SNU inmates work in other areas such as in the kitchen or the main laundry or in the medical area.

TRANSFER

Generally if an inmate needs meals and medications delivered to his cell, it is thought that it is time for the inmate to be admitted to the infirmary in order to assess his condition. Therefore, if an inmate cannot or will not function fairly independently, that inmate will be housed in the infirmary. If the inmate is not able to get to the medication line or the dining hall or to get into the shower on his own or if an inmate has had recent surgery, he may need to be in the infirmary. If an inmate has problems walking or transferring, for instance, from the bed to the wheelchair or from the wheelchair to the shower, that inmate might go to the infirmary. If an inmate is in a wheelchair for the first time, the inmate might go to the infirmary until he can get from place to place safely in the wheelchair. If an inmate is using a cane for the first time, he might be in the infirmary to learn to walk safely with the cane.

In identifying inmates who need care, the physician's assistants and the nurses work with the housing unit managers and the corrections officers, asking if meals in the cell are needed, if a cane is needed or if the inmate functioning less well than he is saying he is. These factors are triggers for moving an inmate from the general population into the infirmary. The physician makes the decision about transferring the inmate to the infirmary and from the infirmary back to general population.

SPECIAL PROGRAMMING

There is a STEP program for the older inmates. There is gait training in the infirmary. The physician's assistant helps inmates with strengthening exercises in their rehabilitation. There is peer education related to HIV. In the SNU there are Mental Health Education programs and Mental Health Management programs.

A program for inmate volunteers for hospice is in the planning stage. In this way, inmates who are terminally ill would be able to have visits from other inmates who have been specially trained.

RELEASE PLANNING

When an inmate is to be released, the staff tries to arrange for Social Security, getting the inmate started with his application and helping him obtain a prescription card. When the inmate leaves the facility, he is given a 30-day supply of medications with summary information about the medications, the complications the inmate has experienced and other information.

TERMINALLY ILL INMATES

Inmates are asked if they want to sign an advance directive regarding the use or non-use of life support efforts. When an inmate is dying, he might stay in general population as long as he can. When he needs more assistance than can be provided in general population, he goes to the infirmary. The inmates said that inmates who are dying resist going to the infirmary until they have to because of the isolation from the other inmates in the infirmary. There are hospice volunteers who come in from the outside and, as previously noted, there are plans being made for training inmate hospice volunteers.

COMMUNITY LINKAGES

An outside agency is helping staff members to learn sign language. Hospice volunteers come in from the outside and an association for the blind also provides some assistance.

JJ SCI

Opened: 1992

Security Level: 2

Capacity: 587 Women Population: 586 Women

Table A reported eight inmates in need of assistance with ADLs. All inmates needing assistance have a cognitive-intellectual impairment which may be due to low IQ or to the side effects of psychotropic medication. All but one of the inmates required Level 4 assistance and one required Level 3 assistance. One inmate not listed as needing assistance is blind and other than adaptation because of that impairment, no assistance is needed.

PHYSICAL PLANT

The buildings do not have ramps or elevators. Renovations are currently underway to address these problems. There is a "quasi SNU" with a capacity of 123.

CAREGIVERS and TRAINING

Staff

Caregiver training has included programs on suicide training, first aid, CPR, restricted housing unit (RHU) assessment, special needs of a female offender, and SNU training. Medical and security staff and inmates have been given sight training and have received training in adaptive equipment from the Keystone Blind Association.

IADLs

To take care of commissary needs, one inmate might accompany another to carry items; if the inmate cannot get there, a staff member will go to redeem the commissary items. Clothing exchange — trading in one's clothing for newer clothing — is another IADL.

ACCOMMODATION

Elevator passes, first floor housing, bottom bunk, delivering of medication and meals, golf cart pick up of inmates with medical needs and commissary delivery of items, as necessary, are examples of accommodation. For instance, one inmate who needs help getting from place to place because of a heart condition has a bottom bunk and an elevator pass. Another, with a problem with obesity is housed on the first floor, bottom bunk and uses a quad-cane.

JOBS

If inmates are unable to work or if there are no jobs available to fit their disabilities, they are put on "medical idle" status and receive pay.

TRANSFER

If an inmate needs much more help than prompting, the individual will go to the infirmary at JJ for short-term care or to V4 SCI for long-term needs.

SPECIAL PROGRAMMING

Department of Health staff provides inmates with individual counseling concerning specialized needs, especially regarding diabetics.

RELEASE PLANNING

The office of the CHCA contacts outside agencies to set up referrals upon discharge; unit managers and counselors make arrangements with the inmate's family if family members are available.

TERMINALLY ILL INMATES

The SCI staff members have not used services of a community hospice but have made arrangements with the hospice if an inmate fits hospice criteria. The hospice provides people to work with the inmate in the facility. Three inmates have been diagnosed with terminal illness. One was discharged to a hospice center with medical staff working closely with the family. The others were transported to V4 for long-term care.

COMMUNITY LINKAGES

The following have worked with the SCI: Blind Association and the Carnegie Library and College for the Blind.

P2 SCI

Opened: 1941

Security Level: 4

Capacity: 2,059 Population: 3,374

P2 is really two SCIs in one. About 1,300 are in the regular prison population with the remainder being in the diagnostic center. P2 processes 500 to 550 adults each month.

Table A identified only 15 inmates needing assistance with ADLs. This number is clearly an undercount but it suggests that some of the assistance that is provided is simply "taken for granted" by staff as something that they do because it is simply part of the job.

Staff interviews revealed that there were 64 inmates with mental illness and 16 with mental retardation. The vast majority of those inmates need assistance in one form or another. Other inmates had Tourette's syndrome, Klinefelter's syndrome, congestive heart failure, seizures or Alzheimer's disease. The number of inmates reported in the interviews as needing assistance far exceeds the number reported on Table A, again pointing to the staff's taking some of this assistance for granted.

PHYSICAL PLANT

P2 SCI consists of several buildings that have distinct functions. C Block is the special needs unit of the diagnostic center. L Block has a SNU and houses sex offenders. N Block houses inmates with drug and alcohol problems. The several general population blocks house either regular inmates or inmates in the diagnostic center, but not both.

CAREGIVERS and TRAINING

Staff

Healthcare staff, counselors, and security staff all seem to be involved in providing care in an integrated way. Corrections officers for the special needs units are specially selected. In addition to the regular DOC training programs, staff are given other training as needed. Security staff are included in the special training sessions or off-site training programs. For example, one security officer was preparing to attend signing school.

Inmates

Inmates provide considerable informal care to other inmates, as in the free population where informal care might be offered by friends and formal care might be provided by paid careworkers. Staff observed that, "It would be too costly if that care had to be provided by paid help."

In making a housing assignment for an inmate needing assistance with ADLs, the compatibility and the helpfulness of the cell mate is taken into account. One blind inmate was assigned a compatible cell mate. One large inmate would carry an inmate whose legs had been amputated out to the yard for yard time. Inmates signed for deaf inmates; a speaker at a DOC Sports Banquet noticed that an inmate was signing for deaf members of the audience. While inmates helping inmates is informal, it appears to be pervasive.

ACCOMMODATION

There are accommodations both in buildings and among staff providers. The SCI provided an inclined threshold over a concrete lip in front of a shower so that a wheelchair could be pushed into the shower. Security staff in the unit that houses deaf inmates flash the cell lights as schedule bells ring. Meals, barber, laundry pick-up and delivery are provided right at the cell block of the special needs unit. While there is some prompting for inmates needing that kind of assistance, much of the prompting is part of the routine; everyone moves together to meals, yard, programs and so on.

Much of the accommodation appears to be in response to needs as the arise. SCI P2 developed a special observation unit (SOU) and drafted a relevant policy so that an inmate could stay at P2 and not need to go to a psychiatric observation cell at a local Medical Center.

JOBS

Job placement staff consider the medical department's description of an inmate's functional limitations in placing the inmate. There is an attempt to mainstream inmates as much as possible.

TRANSFER

The inmates from the diagnostic center are routinely transferred to other SCIs. When an inmate's impairments become so severe that the SNU can no longer provide the care that he needs, he moves to the infirmary. When the infirmary can no longer provide the care, the institution applies to have him transferred to Laurel Highlands. Such a transfer depends on space at Laurel Highlands and the security level of the inmate.

COMMUNITY ORGANIZATIONS

Someone from the community provides HIV instruction for inmates. Community volunteers assist with and support chapel services. P2 SCI has a contract with a community association to provide signing for education programs.

RELEASE PLANNING

Some offenders are no longer eligible for their green card, that is, for approval to participate in Medicaid and other welfare programs. That situation compounds the work of corrections when an inmate is about to be released. The SCI provides as complete an after care program as possible including 30-days of medication. The counselor will review with the inmate his appointments, needed medications, interviews for SSI, etc. To the degree family members want to participate, they can be involved in discharge planning.

Staff mentioned that one counselor had made calls to every helping association he could identify to get help for an inmate who was about to be released who was mentally ill and going blind but who would not permit surgery. He could find no association to help him. The inmate went to a mission after he was released. The Department of Aging helped an individual who was only 27 but had multiple medical problems. If the SCI staff members are successful in arranging for an individual to go to a nursing home, they will transport the inmate to the nursing home with a 30-day supply of medication.

TERMINALLY ILL INMATES

The staff has worked with a local hospice organization which has provided training for the terminally ill inmate and the staff. The inmate was given the option to go to V2 but chose to stay with the nurses and the staff whom he knew. Staff arranged for extended visiting hours for the inmate, who stayed in a single cell in the infirmary.

N3 SCI

Opened: 1998

Security Level: 3

Capacity: 592 Population: 899

The survey reported no inmates in need of assistance with the activities of daily living. There is an infirmary with a capacity of 28 inmates; up to now the maximum number in the infirmary has been nine, with one exception after a false alarm gas leak when the infirmary was full for less than a day.

PHYSICAL PLANT

The physical arrangement of N3 is such that inmates in wheelchairs are able to live in the cell block.

CAREGIVERS and TRAINING

Staff

With no inmates needing assistance with ADLs, there is no special training in this regard.

Inmates

Inmates may help other inmates but this help is provided without the direct knowledge of the staff. Liability is one reason staff members do not approve of inmates assisting each other.

ACCOMMODATION

To date, few inmates at this SCI have needed assistance. Accommodations have been made for those inmates. For instance, one inmate was fitted with a special harness that helped him walk. In addition, when a Spanish speaking inmate was dying in the infirmary, contrary to the usual rules regarding visitors, his family and an interpreter were allowed to visit him in the infirmary. As time goes on, more inmates needing assistance are expected to be at the SCI and the SCI expects to make accommodation.

TRANSFER

Transfers related to ADLs have not been relevant to this date. Transfers to another prison for hospice care have arisen but the limitation and the size of the hospice center at V2 makes it hard to get inmates transferred there.

RELEASE PLANNING

The counselors arrange for continuity of care when an inmate is about to be released. Again, so far, this need has not been relevant specifically because there have been no inmates needing assistance with ADLs.

TERMINALLY ILL

There have been several terminally inmates. In two instances, family members took an active role in the disposition of the inmates. In those two cases, the inmates were transferred prior to dying; one to a nursing home for hospice care and the other to his family's home. A terminally ill current inmate is not likely to be transferred to either of those settings because of his offense. He will be cared for either at a community medical center under 24-hour guard or at the SCI in the infirmary.

HH SCI

Opened: 1993

Security Level: 3

Capacity: 964 Population: 1,765

The survey included 20 inmates needing assistance, most at Level 2 and most due to skeletal/locomotor impairment.

PHYSICAL PLANT

There has been a SNU for 2 ½ years. It houses mostly mental health inmates who need no assistance with ADLs. There are 28 handicapped cells. It is a prototypical SCI. HH has an infirmary.

CAREGIVERS and TRAINING

Staff

If an inmate needs help in transferring, for instance, from the bed to the wheelchair or from the wheelchair to the shower, that inmate would typically be housed in the infirmary and the nurses in the infirmary would assist the inmate in transferring.

Inmates

At HH, wheelchair pushers are employed inmates. The inmate who has a wheelchair is given specific guidelines to follow in operating the wheelchair. (See Appendix F.) At HH, there is also an orientation program for inmate wheelchair pushers. After a wheelchair pusher is given an orientation, the staff member witnesses his signing a wheelchair pusher's contract. (See Appendix F.)

The wheelchair pusher pushes the inmate to the dining hall, the commissary, the barber shop, to chapel, wherever that inmate needs to go. The inmate wheelchair pusher also carries the other inmate's meal tray to the table. The dining hall inmate workers clear the tables, so the wheelchair pusher does not need to clear the table for the inmate who is in the wheelchair. When the wheelchair pusher is unable, because of a scheduling conflict, e.g., due to another work assignment, to assist the inmate with the disability, another inmate provides assistance.

The wheelchair pusher might help with the inmate's shoes and socks if needed. If the disabled inmate and the wheelchair pusher do not get along, another wheelchair pusher is assigned.

In addition to the orientation provided by a staff member to the inmate wheelchair pusher, the inmate in the wheelchair may also share information with the wheelchair pusher about the

wheelchair — if there are any problems with the wheelchair that the wheelchair pusher needs to know.

The staff encourages the inmates to use a wheelchair assigned to them by the institution, rather than using their own wheelchairs. If an inmate uses his own wheelchair, he is responsible for the maintenance of that wheelchair. The wheelchair would then be sent out for repairs and the SCI would lend the inmate a wheelchair. There are five or six inmates who use their own personal wheelchairs in prison and their families help with the maintenance.

ACCOMMODATION

An inmate may be assigned to a bottom bunk, lower tier cell. Meals and medications are brought to individual inmates in their cells under certain medical conditions and also in bad weather and during lock-downs when there is no movement of inmates within the SCI except, perhaps, for emergencies.

The telephones are equipped so that inmates who have difficulty hearing can increase the volume. Also, AT&T has a special service, a bilingual service, to help in explaining medical or dental services to an inmate who might need them.

JOBS

Inmate disabilities are considered in making work assignments. The inmate might work in the library or as a clerk, for instance, making sure that the cells are clean, or doing paperwork as a block worker, cleaning the chapel or serving as a janitor elsewhere in the SCI.

RELEASE PLANNING

Only one inmate in a wheelchair has been released from HH. In that case, the counselor helped to arrange for a personal wheelchair for the inmate and also for a handicapped accessible place for the inmate to live. The inmate would go to a half-way house if he is paroled.

The family may be involved in the release planning if the family would like to be and if the inmate is in agreement. One nurse ensures that the inmate has all his shots and has a 30-day supply of medication.

TERMINALLY ILL INMATES

Six inmates have died at HH SCI, one by suicide and five of natural causes. One inmate with stomach cancer was pre-released in June and died 20 days later. That inmate would have been "up for parole" just six days after his actual release. His family was involved in obtaining his pre-release authorization.

Two terminally ill inmates have gone to V2. One of those inmates died recently. Another terminally ill inmate went to V5 because the infirmary there was near the yard. In addition, there is one inmate with AIDS who is living in general population. When his blood count goes down or he is unable to care for himself on the block, he goes to the infirmary, is stabilized in the infirmary and then goes back to the block. Eventually, he may go to V2, especially at a time when he is unable to care for himself for an extended period of time.

HH medical staff members do not like to keep inmates in the infirmary for a long time because infirmary inmates do not have access to various activities. When an inmate is dying in the infirmary, arrangements can be made for extended visiting hours. The family is called and

family members who would like to visit are identified and the times of the proposed visits are noted. If approval from security is obtained for the visits, these family members can visit the inmate in the infirmary because the inmate would be unlikely to be able to go to the visitor's room.

COMMUNITY LINKAGES

HH does not work with a local hospice. The SCI provides maintenance service for a military installation and for a local municipality.

EE SCI

Opened: 1987, built in the 1920s as a tuberculosis sanatarium.

Security Level: 3

Capacity: 936 Population: 1,293

The survey included 88 inmates needing assistance with ADLs, mostly for long-term mental health reasons and mostly at Level 4.

PHYSICAL PLANT

The SCI is in hilly terrain. There is a two-part SNU. One part (A Block) is geared toward inmates with medical diagnoses who need an elevator or a handicapped bathroom or who require delivery of medication, meals and commissary items due to skeletal, locomotor impairment. There is a dining hall in the basement of this block. The second part (S Block) houses inmates with psychiatric diagnoses. These inmates may need monitoring with their showers on the cell block and with grooming.

CAREGIVERS and TRAINING

Staff

Security staff members, especially in S Block, monitor showering and grooming. Verbal prompting is often necessary and sufficient.

Inmates

Wheelchair pushers are volunteers; they are not paid.

IADLs

Inmates may need assistance with telephone calls. In addition, inmates may need help with writing letters because they are illiterate or because they have poor vision.

Regarding taking medication, inmate noncompliance may be due to a lack of understanding of the need for medication because of intellectual problems. It may also be caused by not knowing English well enough to understand. In the latter case, the AT&T language line can be used. A speaker phone is used so that the inmate and staff person can speak with the help of an interpreter who speaks the inmate's primary language.

ACCOMMODATION

The (inmate) barber comes to the cell block but never to an individual cell. The barber also goes to the infirmary.

The Block Officer may bring a meal to an inmate in A Block if he is having an acute care problem. However, such an inmate would typically be in the infirmary.

Tutors will come to A Block for inmates who are unable to get to the bottom of the hill and back from the Education Building. The physician will write an order. This process is rare, however, probably because such inmates would likely be sent to Laurel Highlands.

"A" Block is similar to a personal care home in that inmates have access to the elevator, meals on the block, commissary items delivered and frequent visits from the nurse. Medication is delivered to A Block because these inmates would have difficulty getting to the pill line three times a day, especially in winter weather when walking could be dangerous for them.

JOBS

The Superintendent is committed to reducing idle inmate time. Work assignments depend on job availability. If there is a job available and an inmate can do the job, he is assigned to it. If he cannot do his current job, he may be assigned another job.

TRANSFER

The screening conducted upon the inmate's intake at the SCI determines the inmate's initial housing. The unit manager and the psychiatrist help the nurses and the physician in the decision as to transferring an inmate to or from the SNU. Admission to the SNU is ordered by the physician. Inmates in the SNU who need ADL assistance are housed in the infirmary.

The part of the SNU designated for inmates with psychiatric diagnoses may be used as a step-down unit from the inpatient mental health unit at the SCI. When inmates in this unit become stabilized, they can be moved into general population. An inmate might then be housed in a lower tier cell in a lower bunk if necessary.

Inmates using a wheelchair or who need nursing home care are housed in the infirmary and are give high priority for transfer to Laurel Highlands.

PDOC Health Bureau provides input as to whether an inmate needing dialysis is to be transferred to Laurel Highlands or V5. The need for assistance with ADLs is a factor.

RELEASE PLANNING

When an inmate needing nursing home care was about to be released, the SCI staff contacted six or seven nursing homes. A nursing home close to an inmate's hometown accepted him but only after his family intervened. Family involvement is key. Another inmate was released to a personal care home after the SCI staff had "begged" the personnel to do so. Admission to a nursing or personal care home is difficult because the personnel at the homes have concerns for security.

TERMINALLY ILL INMATES

A number of deaths have taken place at the SCI. If an inmate is terminally ill with a prognosis of weeks or months, the inmate is asked if he wants to stay at this SCI or be transferred. Thus far, none of these inmates has gone to V2. The inmate is kept in general population as long as he is able. There are no extended visiting hours for the inmate's family. However, the family may visit in the infirmary. The family of an inmate who died recently was with him in the infirmary at the time of his death.

On occasion, inmates who know the terminally ill inmate have been allowed to visit the dying inmate in the infirmary, one at a time. The custody staff must approve the inmates who can visit. If an inmate has a family member who is also an inmate at the facility, that family member may visit.

For terminally ill inmates in the infirmary, the nurse might help an inmate write letters because that may be the inmate's only means of communication with his family.

COMMUNITY LINKAGES

There is no affiliation with a local hospice. The Prison Society's STEP Program assists older pre-release inmates in informing them of available services in the community and in release planning.

V6 SCI

Opened: 1960.

Security Level: 3

Capacity: 1,039 Population: 1,798

Table A included 86 inmates requiring assistance with ADLs. Most of these inmates need assistance with multiple ADLs at Levels varying from 1 to 4. Need for assistance arises from skeletal-locomotive and cognitive-intellectual impairment for the most part. Such inmates are housed in the infirmary or in single cells in the personal care unit.

PHYSICAL PLANT

V6 is a sprawling SCI. Halls are wide and long with much movement of inmates from place to place. Therefore, some inmates with a need for assistance with moving from place to place have a particularly difficult time at V6. Because of this problem, the role of the infirmary unit is comprehensive.

The infirmary houses inmates with acute care needs. Other inmates are housed in the infirmary because moving in a general block would be problematic, given the layout of the SCI.

CAREGIVERS and TRAINING

Staff

Beyond the DOC-required training, many staff members have participated in programs such as HIV/AIDS education, infectious disease seminars offered by DOC, pharmaceutical companies, Department of Health and others.

Inmates

Some inmate workers are on the "blood and body fluid" detail. This job requires training by the infection control nurse. Infirmary inmate workers also undergo an orientation by the infirmary officer at which time they are informed of the services to be provided. The infirmary workers are technically infirmary janitors. Staff and inmates took advantage of a training program in sign language that was offered by an inmate.

IADLs

Inmates may require assistance with carrying and sorting laundry, with making their commissary purchases, picking up mail, procuring clothing, reading, keeping track of their commissary account (the special education teacher teaches the latter skill, "taking care of your finances"), writing letters, and housekeeping (cleaning one's cell).

ACCOMMODATION

Effort is made to provide accommodation to an inmate's needs in the least restrictive environment. This endeavor includes having an inmate housed on L Block (an inside block not far from medical staff and dining hall) rather than admission to the infirmary. Housing in an outside block necessitates frequent long walks for meals and medication which would provide a hardship or medical risk.

A cell block is set aside for inmates with chronic and age-related conditions who require medication monitoring. This personal care unit is next to the infirmary. Security staff in this unit are attentive to recognizing health-related concerns which they then pass on to medical staff. Because shower facilities are located in the basement of this unit, many inmates in the personal care unit are permitted to shower in the infirmary area.

JOBS

Inmates work but are not employed as wheelchair pushers. (Inmate) relatives or friends of a wheelchair inmate may provide assistance on a volunteer basis as the inmate ages.

Inmates working in the infirmary receive an orientation session with the infirmary officer. An inmate in infirmary housing (not formally admitted into the infirmary) may need an escort to get to yard or chapel and so forth. An inmate worker provides such assistance.

Inmates are paid for helping other inmates in delivering trays in L block and in bringing food to the infirmary patients and to the SNU inmates. Otherwise the help inmates provide each other is a neighborly kind of help, sometimes with a reward of a token of appreciation, such as a pack of cigarettes.

TRANSFER

Transfers from V6 to another institution are triggered by major medical events such as a need for kidney dialysis (transfer to V5), need for sophisticated surgery (temporary transfer to an SCI near the hospital) and more intensive long-term care (transfer to Laurel Highlands as space permits). Typically space does not permit transfer to Laurel Highlands so V6 provides the long-term care.

Transfer within the institution is part of the accommodation that V6 provides. Such transfer may involve moving an inmate from an outside to an inside unit or temporarily housing the inmate at the infirmary.

SPECIAL PROGRAMMING

Nursing staff provides classes on such topics as nutrition, hygiene and simple preventive measures to the SNU inmates. The medical department offers a broad list of health education classes to the general inmate population.

The special needs unit is located next to the infirmary. Many of the SNU inmates require psychotropic medication. Because of the side effects of these medications, inmates need ongoing direction to facilitate their ADLs. Security officers support medical staff in their administering medication on the unit, helping to ensure that the inmates actually take the medication.

There is a therapeutic community for those recovering from drug and alcohol abuse. If inmates stay in the program for two years, their chances for parole are increased. The assigned job for these inmates is to participate in the therapeutic community.

RELEASE PLANNING

The Unit Management Team has responsibility for release planning.

TERMINALLY ILL INMATES

When an inmate has signed a living will — a policy that went into effect in 1996 — and that inmate is getting very sick, he goes to the infirmary. Many such inmates at V6 are beyond the security level for Laurel Highlands or V2.

Two of the psychiatric observation cells have been converted into medical observation rooms which are reserved for terminally ill inmates. These cells afford privacy and increased access from the nurses station. On-site family visits are coordinated with the security personnel.

COMMUNITY LINKAGES

Efforts are underway to establish a link with a community hospice organization for no-cost training.

OTHER

The approach here seems to be one of integration where all the resources work together. The security officer in L block, who knows the inmates well, can tell if something is wrong with the inmate and he will inform the nurse. It is easy for security officers to communicate with the nurse because the nurse goes out to the cell blocks to check on the health care needs of the inmates. Officers specifically said that in some instances a condition might not appear to be grave enough for them to bring to the attention of the nursing staff or medical staff but when the nurse happens to be in the cell block area, they will mention it to him. As an LPN distributed medications in the SNU, the security officer standing by ensured that the inmate had taken the medication.

Staff members also reported working together in convincing inmates with serious problems to maintain a clean cell and personal hygiene. They noted that the nurse is very good at this task. They said that the medical department supports their judgement when they see that something needs to be done and they take action with the intent of doing the right thing. They say that this flexibility and authority enable them to do their job well.

N2 SCI

Opened: 1987

Security Level: 4

Capacity: 705 Population: 998

N2 reported no inmates in need of assistance with the activities of daily living. The interview revealed, however, that some SNU inmates need prompting from staff and security officers.

N2 has no infirmary; that is, it shares an infirmary with CC as it has done since 1997. There are no health care cells, but there have been inmates in need of some assistance: long-term care, short-term care, ill with AIDS, cancer, etc. There are no infirmary beds, not even for 23-hour observation.

PHYSICAL PLANT

SCI N2 is on a hill. Inmates who need help go to CC SCI.

ACCOMMODATION

Inmates stay as long as they can function and can perform their own ADLs; after that they go to CC. When inmates cannot come for medications and so forth, they go to CC. If CC staff members decide when the inmate needs to go to Laurel Highlands. They make the decision and the N2 staff members do the paperwork for the transfer.

SPECIAL PROGRAMMING

There is an on-site forensic, licensed, mental health unit to which inmates can be committed.

V5 SCI

Opened: 1929

Security Level: 4

Capacity: 2,482 Population: 3,374

The survey included 84 inmates needing assistance with ADLs. Most need assistance because of cognitive-intellectual impairment, but some need assistance because of skeletal/locomotor impairment, insulin dependency, need for dialysis and other life sustaining support. One inmate who is hearing impaired and speech impaired (in the drug and alcohol unit) is specified as not needing assistance; that inmate uses sign language and reads lips. The inmates needing assistance are variously housed: general population including the SNU, mental health unit, infirmary, infirmary housing (living in the infirmary but not officially assigned to the infirmary), drug and alcohol unit, therapeutic housing unit and restricted housing unit. The Level of assistance is mostly 4 with a small number of 3s, smaller yet of Level 2s and only a few Level 1s. Inmates who are insulin dependant

or who need dialysis are classified as having a Level 4 need (prompting) because the inmate needs only minimal assistance with the ADLs. The survey table itself was completed by several different staff members, each reporting on his or her area of responsibility.

PHYSICAL PLANT

V5 is characterized by long distances from place to place within the institution. Corridors are long, cell blocks are long, cell blocks are multi-tiered, stairwells are narrow and cell blocks are not necessarily on the same level as the corridor. Even in the infirmary where wheelchair inmates live, spaces are so small that wheelchairs cannot be maneuvered. Many cell blocks are not accessible from the hall without going up or down stairs. The SCI has two elevators, neither of which is particularly accessible. When an inmate has to be moved from one level to another he may be carried on a litter with the litter being maneuvered around the stairwell banister.

Infirmary showers are not large enough to allow a person in a wheelchair to approach the shower stall. The infirmary contains a single raised tub; the inmate must be lifted up and into the tub. The mechanical lift that is available and could be used for lifting a person into a tub is too large to fit through the door to get inside the bathroom.

Space that had been set aside as a worship area for followers of Islam had to be vacated because of flooding in the area. There were two inches of water in the lower level of the space on the day of our visit after two days of severe rain fall. Inmates told us that their space had been moved, but either they did not know the reason or did not share with us that they knew the reason.

CAREGIVERS and TRAINING

Staff

The staff is faced with the need to provide care for inmates with a great variety of needs, including health care needs, mental health care needs, and assistance with ADLs. There is no special long-term care training beyond the training required by DOC and the various professions. Security officers are the first line of staff typically responding to the assistance needs of an inmate, particularly in the SNU. The needed response generally relies on "common sense and a knowledge of a particular inmate." In some instances, the assistance takes the form only of prompting an inmate to take a shower or to perform other ADLs; in other instances the security staff accompany the inmate to the shower and give him soap and shampoo; and in other instances staff help the inmate wash himself.

There are no formal programs for teaching the inmates about ADLs other than for some hygiene programs. Nursing staff members have attempted to teach inmates about hygiene and grooming, and they said it was a very frustrating task that required much patience. Staff reported an instance of an inmate who was belligerent and violent and unresponsive to the staff and guards, but who responded to female guards and nurses who used a rewards-based process to get him to take care of his own ADLs. In time, his behavior improved sufficiently that he was able to go to one of the other specialized housing units and leave the SNU. Staff said it would be helpful if some outside agencies who provide services in the free population would be willing to teach the staff how to provide such care at V5.

Another instance of staff learning or wanting to learn is seen in the response to a number of deaf inmates arriving at V5. Staff members learned sign language in order to be able to communicate with them. They suggested that it would be helpful if P2 would notify them before sending inmates with a particular disability so that V5 staff could better prepare rather than adapt after the arrival of the inmates.

There is a kind of team approach or at least an interactive approach among the staff. This effort is typified in the counselor's relying on information from medical staff, and working with a family and outside agencies in preparing for an inmate's release. Staff indicated that inmates are often the first to recognize another inmate's need for assistance; they notify security staff who in turn notify health care and other staff.

Inmates

Inmates are often the first to notice the need for assistance by another inmate. Some of the inmate-to-inmate care takes place informally in the cell blocks. One inmate has trouble buttoning his clothes and must wait for the cell doors to open so that another inmate can help him with his buttons.

An inmate might push a wheelchair inmate although this task is not included in his job. For instance, infirmary workers are technically infirmary janitors. One inmate explained that he does more than janitorial work in the infirmary. He knows that he can get a misconduct and lose his job in the infirmary if he is caught providing direct care. If an inmate needs a blanket, for example, the inmate worker is not supposed to go and get it for him. If an inmate needs help getting to the bathroom, even if there is no staff person around to help, the inmate worker is not supposed to help.

The inmate worker said he will do either if an inmate needs that help even though he runs a risk of getting caught.

Inmates reported — both inmates needing assistance and inmates who provide assistance — that, in the past, inmates were more willing to help inmates needing assistance. An older infirmary worker said that he, for one, "looks out for" the older inmates on his block but that younger inmates do not do the same.

Staff stated that inmates should not provide services that could be provided by the staff. Inmates provide the care as the need arises out of a sense of comradeship but not because they are part of a formal system of care in any way.

TRANSFER

The staff reported that it seems to be easier for an inmate to be transferred from another SCI to V5 than from V5 to another SCI. Only one inmate has been transferred from V5 to Laurel Highlands in the last three years. Reasons include lack of space at Laurel Highlands and custody level of the inmate. The difficulty in moving inmates with long-term care needs to other SCIs results in their staying in the V5 infirmary. While this approach has not yet caused a problem, there is concern that eventually there will be so many infirmary inmates who need long-term care, that there will be insufficient infirmary space for inmates with acute medical needs.

Staff also reported resistance from other SCI staffs in accepting a transfer from V5. Reasons included lack of space in the handicapped block or the inmate being a security risk by being

too close to family members. However, inmates have been transferred to V5 so that the inmate could be closer to family members.

There have been some transfers to V2's special assessment unit and V2's intermediate care unit. The latter transfer would be for inmates who are not committable but are more difficult to manage in V5 than they might be in an ICU. Consequently, if an inmate has long-term care needs and is unable to go to Laurel Highlands it is difficult to transfer that inmate to any other SCI. An inmate in a wheelchair could be transferred from the infirmary to a prototypical institution, but such transfers apparently do not happen very often.

Staff noted that it could be helpful for them to know ahead of time when they would be getting transfers from P2 who would have unusual special needs.

V5 is a reception center for inmates in the eastern region. These inmates come to V5 before going to P2 and include inmates in wheelchairs who arrive without any prior notice. Staff members keep some beds in the infirmary open for this eventuality. V5 also gets just over half of the state's parole violators who go through the assessment unit. Consequently, there are approximately 5,000 parole violators going in and out of this SCI each year.

RELEASE PLANNING

When an inmate "maxes out," he is provided 30 days of medications and "whatever else he might need." Upon release, the inmate might be escorted to the Social Security Office to apply for assistance that might be needed to support his continuing medical needs.

Staff reported that knowing someone in an outside agency or nursing home is essential in arranging a successful release to such an agency. Other outside agencies are explicitly not interested in taking someone who has committed the kind of offense common to the inmates at V5.

TERMINALLY ILL INMATES

It is not easy to get an early release for a terminally ill inmate and, generally the process requires a long time period. There is a professional law clinic at V5 that has helped inmates and their families to have an inmate released. The success of this effort seems to depend on family involvement.

There are only three hospice beds at V2 and those beds are usually full. Custody level also influences transfers to V2. The consequence of these situations is that terminally ill individuals tend to stay where they are.

Staff and inmates prefer that a terminal inmate stay in the general population as long as he can. Once the inmate is no longer able to live in the general population, he goes to the infirmary. The staff has worked to have a terminally ill inmate released to a hospice or nursing home but without much success. There was no indication that hospice-like care is provided at V5. Staff members do not work with a local hospice. Special family visits are approved by the Deputy for a terminally ill inmate.

One inmate was transferred to a hospital or the long-term care facility attached to the hospital and had a guard there with him. A guard would stay with the inmate. An inmate who formally had an early release, however, would not have a guard with him.

DD SCI

Opened: 1993

Security Level: 4

Capacity: 1,204 Population: 1,585

Table A included 16 inmates as needing assistance. Only one of these inmates does not live in a single cell either in the SNU or the RHU (restricted housing unit). Only two inmates have needs other than Level 4 (verbal prompting). All but two of the inmates needing assistance had a cognitive/intellectual impairment as their primary impairment. None of the inmates with HIV/AIDS needs assistance with ADLs at this time.

PHYSICAL PLANT

DD has an infirmary. Because nearby SCI-MM lacks an infirmary (and also lacks a SNU and is not handicapped accessible), MM inmates who need more than 24 hours of care in an infirmary-type setting are sent to DD. Very rarely does an inmate return to MM once he has been sent to DD. CAREGIVERS and TRAINING

Staff

SNU staff, security staff and counselors receive SNU training. There is no training regarding medical issues. A team effort is used. More staff is employed in the SNU than in general population units because of the SNU inmates' decreased ability to function as inmate workers and because of their greater need for specialized supervision. SNU security staff members are "hand picked".

Many of the SNU inmates have very low mental functioning. Without the structured routine of the SNU, fewer inmates would eat or bathe adequately. SNU security officers need to let inmates know when it is time to take showers. More than a routine announcement is needed. The security officers are more aware of the inmates' needs in the SNU. If an inmate is not cleaning his cell, the security officer might bring cleaning materials to the cell and show the inmate how to clean or another inmate might help. Many SNU inmates also need direction in taking their medications.

Inmates

Each inmate cleans his own cell. Other inmates provide assistance with cleaning the cell if an inmate is unable to do so himself. There are no paid wheelchair pushers. However, an inmate may voluntarily push the wheelchair of another inmate if the inmate is unable to propel himself in his wheelchair, e.g., the inmate has a broken wrist.

IADLs

Inmates with mobility problems requiring the use of canes or wheelchairs may need assistance in carrying their laundry, carrying their property or going to the commissary.

ACCOMMODATION

There are inmates who need no human assistance with ADLs but who need devices such as a wheelchair, cane and/or braces. One inmate in RHU has an amputation but provides self-care. There are showers that are handicapped accessible with a bench inside.

One inmate who is unable to sit while eating eats in the infirmary where he can stand during meals. For an inmate with a gastronomy tube (who is in RHU), Ensure (a liquid food supplement) is brought to the inmate by the nursing staff. Food that has been pureed in the dietary department

is delivered to the inmate when the food trays are delivered to RHU. The inmate himself pours the liquid into the tube.

The use of a wheelchair by an inmate does not mean that he will automatically be housed in a particular housing unit. For instance, a 21-year old inmate with paralysis as a result of a gunshot wound could receive more intensive physical therapy and have the strength to go longer distances in the wheelchair than could a 65-year old inmate with congestive heart failure who needs a wheelchair. The older inmate would be housed closer to the dining hall and other specialized areas. Therefore, a younger inmate is more likely to be able to function in the general population than is an older inmate with a similar impairment.

JOBS

SNU inmates may work as block workers (janitors) in the SNU. All inmates in general population work if jobs are available.

TRANSFER

Referrals to SCI-Laurel Highlands are made for inmates who need skilled nursing care. Typically, an inmate awaiting transfer to Laurel Highlands will be housed in the infirmary. Referrals are also made to SCI-Laurel Highlands or SCI-V5 when an inmate requires dialysis. Inmates needing dialysis are typically housed in general population until being transferred. They are transported to a dialysis center in the community while awaiting transfer. SPECIAL PROGRAMMING

Groups dealing with anger, stress and depression are held in the SNU.

RELEASE PLANNING

Community referrals are made, for instance, by Psychology Department personnel when an inmate who is being released needs follow-up care. Medical department personnel send the inmate's medical records to the inmate's family doctor whom they may contact, as needed, to ensure continuity of medical care.

TERMINALLY ILL INMATES

Terminally ill inmates may be transferred to the hospice unit at V2 SCI. If an inmate is dying at DD, he is housed in the infirmary. There is no association with a local hospice.

AA SCI

Opened: 1969

Security Level: 3

Capacity: 566 Population: 830

The survey included nine inmates who need assistance with ADLs; this represents an undercount as SCI staff explicitly did not include inmates who need assistance only at Level 4, prompting and reminding. Most inmates needed care because of a skeletal/locomotor impairment.

All of these inmates listed on the survey have been included in a request for transfer to Laurel Highlands. They do not yet need skilled care for the most part, but rather personal care. None of them is currently in a wheelchair.

AA has no infirmary, with inmates who need infirmary housing being transferred, typically to LL SCI. The infirmary was closed, officially, in 1998; it was not within sight or sound of the medical department which necessarily created some challenges.

PHYSICAL PLANT

The physical plant is sufficiently challenging that AA was unable to accept one inmate from another SCI specifically because of the physical plant. The institution has two main levels with an elevator but it is a problem to have large numbers of inmates go from one level to the other for drills and other activities.

GAREGIVERS and TRAINING

Staff

Staff members provide whatever special care is given. Nursing staff provides care, instruction, applying lotion or salve, as needed. Security officers might make sure a pathway is clear and assist an inmate who is very weak. Security has called the medical office when an inmate was too weak to walk the full length of the hallway. The medical office then responded with a wheelchair. Rarely has this situation occurred.

Security staff receive some training in assisting those inmates with needs. The Huntington's Disease Society has provided much information and some specialized instruction for one inmate who is in the early stages of Huntingdon's Disease.

Inmates

The staff reported that inmates provide no assistance to other inmates.

IADLs

Inmates listed on Table A have their laundry picked up at their cells, while all other inmates carry it to the laundry.

ACCOMMODATION

Inmates housed in the SNU have their own yard.

JOBS

Inmates with special needs generally do not work, although, if they want to, they can. Regular inmates generally do work.

TRANSFER

Inmates with special needs or who need assistance with ADLs are generally targeted for transfer to Laurel Highlands, but some have been transferred to LL. Transfer occurs when the institution, without an infirmary, is unable to provide care for an inmate on a long-term basis.

SPECIAL PROGRAMMING

There are special activities for inmates who need assistance. They include non-competitive activities in the yard. The institution provides an instructional program for inmates who are part of a self-medicating group.

COMMUNITY LINKAGES

The Huntington's Disease Society has provided instructional material to the staff.

P1 SCI

Opened: 1996

Security Level: 3

Capacity: 1,220

Population: 1,820 including 190 juvenile inmates who have adult sentences. P1 is the only SCI with a juvenile unit.

The survey included nine inmates needing assistance. One inmate who is housed in the infirmary has Level 1 needs in all of the ADLs except for toileting (Level 2 need). Eight inmates have Level 3 ADL needs. Of these inmates, two also have one Level 2 ADL need. Seven additional inmates have a skeletal/locomotor impairment and use a cane or walker and/or need a bottom bunk assignment. These latter inmates require little assistance. Additional inmates are listed as having some type of impairment but not as needing assistance with ADLs. AIDS and Hepatitis C are projected to be the two main disabling illnesses associated with the need for assistance with ADLs and IADLs.

PHYSICAL PLANT

There is a SNU which houses mainly inmates with psychiatric problems. No one in the SNU at the time of the interview needed prompting or other assistance in performing ADLs. Some of the SNU inmates, however, were using canes or crutches.

CAREGIVERS and TRAINING

Staff

Nurses instruct the inmates in using crutches and canes. The medical/nursing staff members are pro-active in teaching inmates what to anticipate from their illnesses or disabilities. The health

of older inmates is monitored through the medication lines. An interdisciplinary approach is used. When correctional officers are first employed, the CHCA speaks with them about the interface and needed communication between corrections and health care. Corrections officers alert the health care personnel to inmate needs. A pro-active approach is also thought to be needed in order to prevent litigation.

Inmates

In the dining hall, inmate workers bring meal trays to those inmates unable to carry their own trays. An inmate may walk with another inmate who has problems with balance. In addition, inmates let the staff know when an inmate needs assistance with ADLs and/or IADLs.

Inmate training is ad hoc, as needed. For instance, if an inmate begins to use a wheelchair while at this SCI, the nursing staff instructs the inmate as to use of the wheelchair. That inmate might instruct another inmate who would help him. This approach resembles consumer-directed personal care in the free population.

Training for both staff and inmates was provided by the Blind Association regarding care of an inmate who was losing his sight. The Association also helped the inmate prepare for being blind. The inmate was housed in the infirmary until he adjusted to the blindness and was able to ambulate and care for himself. An inmate buddy system was developed to provide assistance. The staff members assigned to his care were assigned with continuity of care in mind. The inmate was able to be transferred to general population housing. IADLs

Laundry is picked up at the cell block by inmate laundry workers. If an inmate cannot carry his laundry to his cell, it will be delivered to him. For inmates who are unable to go to the

commissary, a commissary list is brought to them to complete. If an inmate is unable to go to the barber shop, the barber can go to that inmate's cellblock.

ACCOMMODATION

There is a crutch-and-cane line for inmates who have difficulty with ambulation and, therefore, walk more slowly than other inmates. In addition, gloves were provided for an inmate with paraplegia in order to prevent sores on his hands that could result from propelling himself in his wheelchair. This inmate carries out his catheter care himself.

JOBS

Inmates with disabilities may have a job in the library or as a tailor or block janitor.

TRANSFER

One inmate who was on a ventilator and who had a tracheostomy was in a community health care facility where he was being weaned off the ventilator. He is on the list for transfer to Laurel Highlands.

SPECIAL PROGRAMMING

There are no formal programs that are specific to inmates who need assistance with ADLs and/or IADLs. General programs are offered separately for the SNU population and take into account the slower mental capacity of this group of inmates.

RELEASE PLANNING

One program at the SCI was presented by an inmate who had been released. The presentation focused on finding and continuing care after release and obtaining SSI and access to drug and alcohol treatment programs.

TERMINALLY ILL INMATES

When an inmate is found to have a terminal illness, the health care staff talks with the inmate, if possible, about the disease and about facing death. The inmate is involved in the decision making process regarding his illness as much as possible. Advanced directives are discussed. The staff contacts the inmate's family if the inmate agrees. The Dietary Department may be included in care planning. If the inmate wants to stay in general population, medication and other health-related items/services will be brought to the cell.

Generally, the inmate decides when to be transferred to the infirmary. However, if the inmate's needs become too great for the health care personnel to meet in his cell, he will be transferred to the infirmary even if he wants to remain in general population. An intermediate step is also used. In this case, the inmate remains housed in general population but goes to the infirmary for needed care. The inmate, therefore, has general population privileges and is not isolated in the infirmary. When he is unable to get to and from the infirmary even with someone accompanying him, he is then housed in the infirmary. A similar strategy is also used for non-terminally ill inmates who have high levels of need.

No dying inmates at this SCI have been transferred to V2. So far inmates have preferred to stay at this SCI with inmates and staff with whom they were familiar. The CHCA previously worked at V2, however, and learned about hospice care there.

BB SCI

Opened: 1889

Security Level: 4

Capacity: 1,274 Population: 1,807

The survey included one inmate needing assistance.

PHYSICAL PLANT

There is no infirmary at this SCI. Inmates needing an infirmary are sent to KK. There is a SNU. Most of the inmates in the SNU have a mental illness or have mental retardation.

CAREGIVERS and TRAINING

Inmates

An inmate may carry a meal tray for another inmate who has difficulty doing so, e.g., because of using crutches.

ACCOMMODATION

Inmates who are slow in the showers may go to the infirmary. They bring their soap, etc. with them. They do not need assistance giving themselves a shower but are unable to keep up with the pace in the regular showers.

Currently there is an inmate who has had a leg amputated but does not want to be transferred. Staff members are working with him. They realize that he will eventually have to be transferred if he loses his other leg.

TRANSFER

Because there is no infirmary at this SCI, most of the inmates who need assistance with ADLs have been transferred to KK or Laurel Highlands. If an inmate cannot function in general population, he is transferred to another facility. Generally, such inmates are not transferred to this SCI.

TERMINALLY ILL INMATES

It is rare that an inmate dies at this SCI because sick inmates are transferred.

SCI Laurel Highlands

Opened: 1996

Security Level: 2

Capacity: 309 Population: 394

Prior to the opening of Laurel Highlands, inmates needing skilled nursing care were sent to a state-run nursing facility. Guards were provided by PDOC. Approximately ten inmates were housed there. A change was deemed necessary because of the high cost and the realization that the need for such care would far exceed ten inmates.

Four groups of inmates are housed at Laurel Highlands: those needing skilled nursing care, those needing personal care, nearly 20 inmates receiving dialysis and a group of inmates not in need of care who serve as a worker cadre for the prison. As of December 1999, there were 85 inmates in skilled nursing, 82 in personal care and 246 worker inmates. All of the inmates except the worker

inmates are included as needing assistance with ADLs. Inmates with higher custody levels and inmates with severe psychiatric problems are not housed at Laurel Highlands.

Prior to the use of the four groups listed above, inmates were categorized as being: in need of skilled nursing care (similar to inmates in infirmaries in other SCIs), geriatric (Laurel Highlands offers a less threatening environment for older inmates), wheelchair use and worker inmates.

A diagnostic tool is used to determine the level of care an inmate needs. The tool includes an assessment of the inmate's proficiency in life skills (including ADLs).

PHYSICAL PLANT

On July 1, 1996, Laurel Highlands became a prison. It was originally a state mental hospital. Therefore, inmates are housed in ward rooms (although there are a small number of single rooms/cells in the long-term care area) or in dorm-type rooms. Because this facility was originally built as a hospital, it lends itself better to accommodating the long-term care needs of inmates than do other SCIs, especially the older ones.

There is no SNU at Laurel Highlands. Inmates with severe psychiatric illness would likely be sent to an SCI with a MHU or to the state forensic unit at SCI V2. However, because the majority of the former state mental hospital staff became SCI staff, the staff has an awareness of mental health needs.

CAREGIVERS and TRAINING

Staff

When the state mental hospital became an SCI, 251 of the Department of Public Welfare (DPW) staff became DOC employees. Because of the large number of new staff, the Corrections

Academy conducted training on site. Some of the current Laurel Highlands' corrections officers had been psychiatric aides in the state hospital.

Laurel Highlands is the only SCI with certified nurse aides (CNAs). This job classification was created for Laurel Highlands and, as nurses resigned or retired, some were replaced with CNAs. Aides' tasks include bathing, dressing, feeding, lifting, turning and repositioning inmates.

The Life Skills Committee deals with topics such as nursing needs, nutrition needs and drug and alcohol abuse. The treatment team develops a plan of care for the inmate. The plan includes attention to ADLs and, as needed, to anger control, drug, alcohol and sex offender programs. Every three months, the plan of care is reevaluated and the inmate's progress or lack of progress is assessed.

Staff members receive the regular DOC training. In addition, a video tape was used to instruct staff about Tourette's syndrome when an inmate had the illness. Staff members indicated that additional education on the aging process and geriatrics, in general, would be helpful.

Inmates

At this SCI, inmates can be employed as wheelchair pushers. Additional information is provided in the section, "Jobs".

Inmates may help other inmates on a volunteer basis with their class assignments. A number of the older inmates have very limited education. Inmates may also help other inmates with their commissary slips, especially adding figures for inmates who are unable to do so.

In skilled nursing care, more of the assistance is provided by the nursing staff. In personal care, inmates provide more assistance for other inmates, for instance in getting from place to place, help with laundry and writing letters for inmates who cannot read or write.

One inmate, who picks up the laundry weekly, encourages other inmates to shower, as needed. If they do not know how to make their beds, he teaches them.

IADLs

The section, "Inmates", contains information about IADLs including doing laundry, writing letters and ordering items from the commissary. Currently, getting into the dental chair can be difficult for certain inmates with impairments, especially for heavy inmates. However, this problem is being addressed in renovation plans that will allow for more space around the chair. This change will facilitate the transfer of an inmate from a wheelchair to the dental chair. In addition, a lift is needed in assisting inmates who are overweight.

ACCOMMODATION

Five satellite medication units exist at this SCI rather than a single central unit for dispensing medications. This system was developed after staff faced the security problems of taking medications to the inmates in different locations versus the problems surrounding getting the inmates, especially the more infirm inmates, to and from a single medication line.

Staff members tend to be more aware of behaviors that stem from illness, for instance Alzheimer's Disease, as opposed to disruptive behaviors that are not based in a disease process.

The physician may write a paper for the guards to know, for instance, that an inmate is unable to hear and should have someone wake him for the inmate count. Otherwise, the inmate could be "written up" for not responding.

Bowling is provided for inmates in wheelchairs.

JOBS

Finding a sufficient number of jobs for inmates who need assistance presents a problem. Some jobs are modified to address inmates' limitations. For instance, two older inmates from personal care are assigned to the Activities Department to take care of athletic equipment. They distribute the equipment, take the IDs, take inventory and, in the winter months, they maintain the equipment. Wheelchair pushing is a job; inmates who cannot work in maintenance or other more physically demanding jobs assist other inmates in getting from place to place. For instance, 21 of the inmates attending the sex offender classes are blind or use a wheelchair, walker or cane or have significant cognitive impairment. These inmates are given assistance in getting to and from the program. Sometimes an inmate is unable to push a wheelchair up the hill and, therefore, only pushes wheelchairs down the hill and another inmate pushes the wheelchair back up the hill.

A blind inmate has a number of other inmates who help him get from place to place. For some of this assistance, inmates are paid; some is volunteer. If an inmate is unable to clean his cell, inmate block workers are assigned to help.

The Life Skills Program is connected to the work program in that inmates receive some pay for their participation in Life Skills by cooperating with their plan of care. The care plan is aimed

at increasing self sufficiency on the part of the inmate and includes participation in various programs. TRANSFER

Between SCIs

A formal application and assignment process exists for transferring an inmate to Laurel Highlands. An informal exchange of information augments that process. Prior to establishment of the formal process, a number of approaches were used and the need for a standardized approach was recognized because there were more inmates needing to be transferred to Laurel Highlands than there were beds at the SCI. An estimated 90 percent of inmates coming to Laurel Highlands were previously housed in the infirmary of another SCI. In personal care at Laurel Highlands, an inmate can go, for instance, to yard and the library. When housed in an SCI infirmary, an inmate would not have these privileges. An additional reason for transfer of an infirm inmate to Laurel Highlands can be the need for safety from predatory behavior on the part of other inmates.

Within the SCI

There is considerable movement between the skilled nursing floors as inmates improve or become more infirm. If an inmate is unable to get to the dining hall (approximately 400 or 500 yards from the personal care unit) even with assistance, he goes to skilled care where the dining area is less than 50 yards from the room. In skilled care, an inmate does not need to leave the unit except for a visit or for religious services. An inmate in personal care at this SCI who needs skilled care has priority for transfer to skilled care over an inmate in another SCI who needs skilled care.

An inmate in personal care would be moved to skilled nursing care if he has a major weight loss, medical deterioration, increased confusion, increased difficulty in getting from place to place.

A "shuffling gait" can be a factor in being transferred. If it takes an inmate 45 minutes to get to the dining hall, he is likely to be moved to skilled care where the dining area is on the unit.

On occasion, an inmate moves from personal care to general population. For instance, an inmate with a CPAP (breathing machine) was found to be able to function in general population and will likely to transferred to another SCI. In addition, an inmate who has suffered a stroke may recover well enough to be moved to lesser levels of care and, eventually, to general population. Improvement in functional level and corresponding decreases in the need for staff time in meeting needs are factors in movement to more independent units. For instance, if an inmate can transfer himself to and from his wheelchair and needs the staff only to help him with his shoes and socks, he can be moved from skilled care. Ability to transfer oneself (for instance, from the bed to the wheelchair or the wheelchair to the shower seat), feed oneself and follow directions are all factors. Mental status is also a consideration.

SPECIAL PROGRAMMING

Because this SCI is dedicated to the care, housing, and security of inmates with needs for assistance, all of its programming (except that for the worker inmate cadre) is focused on their needs.

RELEASE PLANNING

The Area Agency on Aging assists SCI staff in placing older inmates who are being released. Arrangements for funding, e.g., Medicare or Medical Assistance is begun. When there are family members and they are willing to be involved in aftercare planning, they are included. For inmates receiving dialysis, arrangements are made with the dialysis unit closest to the area where the inmate is going. The Public Health Department may be involved.

In the past six months, a Release Planning Committee has been formed with representation from various departments. The Committee focuses on inmates to be released in the next six to nine months as a result of parole or maxing out. A staff member is assigned to work with each of these inmates. For hard-to-place inmates, a committee is assigned. One such inmate has been paroled for over a year but is still waiting for a placement. One nursing home run by a church organization has taken inmates needing assistance, including inmates with mental health needs.

At times, an inmate declines community placement (which might be a county nursing home) and insists on going home. However, the inmate's mother may be widowed and ill and infirm herself and unable to provide care.

The STEP program staff person works with inmates who are age 50 or older, helping them with release planning. This person, who is not a DOC employee, is aware of resources on the outside. He assists inmates with getting a driver's license.

The SCI's oldest inmate, who was 91, went to a personal care home. Staff at the home helped him get a Social Security appointment.

The inmates said that obtaining medications on the outside is difficult. One inmate who said he had mental (as well as obvious physical problems) said he could not get medication when he had been released previously.

TERMINALLY ILL INMATES

Inmates who are in the last stages of dying may be moved to a single cell/room on the unit for privacy. Family members may visit. After the inmate's death, a memorial service is held in the chapel. When an inmate dies in a housing unit, a staff member from the medical area and one from the psychology department hold a session for inmates (who are dealing with the death of the

inmate) on the housing unit, giving the inmates an opportunity to talk. The Chaplaincy Department offers a program on Death and Dying to help inmates with the death of another inmate or the death or terminal illness of a family member. There are plans to have a hospice at Laurel Highlands.

CC SCI

Opened: 1993

Security Level: 3

Capacity: 1,220 Population: 1,963

Table A included nine inmates needing help with ADLs. Seven of them live in the infirmary with a Level 2 need for assistance because of skeletal/locomotor impairment; two have a Level 3 need by reason of cognitive-intellectual impairment and live in the SNU.

PHYSICAL PLANT

All units are handicapped accessible and have handicapped cells. The SNU is located closest to the medical department and to the inmate dining rooms.

CAREGIVERS and TRAINING

Inmates

There is a job description for wheelchair attendants. Wheelchair attendants are trained, perhaps informally, to provide this service which may include helping the inmate to get into the wheelchair and to put on his shoes and socks.

ACCOMMODATION

Wheelchair inmates are assigned a wheelchair attendant and are assigned jobs that fit their infirmity.

JOBS

With thirteen apprentice programs at CC, individuals in wheelchairs can be assigned to shoe repair (a sitting-down job) if they are able to do that job.

TRANSFER

As the staff members become aware of an inmate's needs, transfer or other accommodation is triggered.

SPECIAL PROGRAMMING

There is no special programming for inmates with a need for assistance with ADLs, but they are welcome to participate in all events. Having all handicapped accessible units facilitates participation.

RELEASE PLANNING

Planning includes contact with the family, if they are available, initiation of medical assistance enrollment and the involvement of special groups for inmates with special needs. Wheelchair inmates have to arrange to acquire a wheelchair after they have been released.

TERMINALLY ILL INMATES

Staff members work with a hospice group. Nurses provide care with the involvement of the Chaplain, Psychology Department, and Superintendent — in keeping with the Superintendent's philosophy of interdisciplinary approaches. They have been able to have one terminally ill parole

violator who had committed a non-violent crime released with the intervention of the Deputy Superintendent. The individual did go home to die. Not all terminally ill inmates or those for whom death is apparently imminent are released as this depends on whether they are considered to be a threat to the community.

OTHER

The organization appears to be run with a philosophy that includes an interdisciplinary perspective. This approach seems evident in the hospice care and also in the goals orientation in the restricted housing unit where an interdisciplinary behavioral modification plan is used. The CHCA expressed concern at the future burdens on DOC because of chronic illnesses such as HIV and Hepatitis C.

FF SCI

Opened: 1978

Security Level: 2

Capacity: 579 Population: 1,049

The survey included 48 inmates needing assistance, most at Level 3 and most due to skeletal/locomotor impairment.

PHYSICAL PLANT

The SCI has an infirmary with five beds that are located together in one area and an additional bed that is not with the five beds. Therefore, security concerns arise when the sixth bed is needed.

CAREGIVERS and TRAINING

Staff

One inmate is provided assistance with bathing in the infirmary even though the inmate is housed in general population. Assistance is needed to prevent cross contamination due to blisters on his skin. This approach is similar to an adult day services model in the free population. However, this inmate, if not for the blisters, would be able to provide for his own bathing.

Inmates

Wheelchair pushing is a paid job. The nursing staff shows the inmate helper about using the brakes, etc. One inmate helps a cell mate (in the cell) with getting a sponge bath, dressing and grooming. Inmates also deliver meals to the cell blocks when there is a need. Inmates also help other inmates to write letters.

IADLs

Writing letters is an IADL.

ACCOMMODATION

There is one unit that is close to both the dining hall and the infirmary. A number of inmates with a need for ADL assistance are housed there. There is a covered walkway to the pill line and to the dining hall from that unit.

JOBS

There are few jobs, especially light jobs, at this SCI. Disabled inmates are not able to work in the sign shop because of the use of heavy machinery. Sitting jobs, however, have been found for inmates in wheelchairs.

TRANSFER

The need for nursing care triggers a move to the infirmary. One inmate stayed in the infirmary while getting ready for his prosthesis. He had a post-operative infection following a leg amputation. There was concern about his getting around safely using a walker. It is difficult to be in general population with one leg, using a walker to ambulate. He could go to general population only if he could ambulate safely there, which is unlikely. He is on the waiting list for Laurel Highlands.

RELEASE PLANNING

Appointments are made, as needed, for follow-up medical care after release. As appropriate, SCI staff members talk to the inmate's family to explain what has been done and what the family will need to do. If release to a nursing home is needed, nursing home staff members want to know the crime(s) the inmate has committed. They do not want inmates with a record of assaults. One inmate who needed nursing home care had a central line for feeding and no nursing home could be found that would accept him because the cost of caring for him would exceed Medicaid reimbursement. He went to live with his sister who was a nurse.

TERMINALLY ILL INMATES

For one inmate who was dying, a local hospice came in "quite a few times" to help the inmate and the SCI staff members. Bereavement care also was provided. The inmate had no family and wanted to stay at this SCI. Another inmate who was his friend helped him in the infirmary.

Some years ago, a dying inmate was transferred to V2 in order to be closer to family members. There have been no early releases because an inmate is dying.

V4 SCI

Opened: 1920

Security Level: 3

Capacity: 596 Women

Population: 901 Women (41 additional inmates assigned to V4 are housed in the Bedford County Prison)

The survey included 20 inmates needing assistance with ADLs, about three quarters of them because of cognitive-intellectual impairment. Most of the inmates listed on the survey need Level 4 assistance (prompting). A few have skeletal/locomotor impairments and one is blind. Several other inmates with seeing impairments do not need assistance with ADLs. Those numbers are supported by conversation with staff and inmates. Aside from inmates with mental health impairment, there is not much need among inmates for assistance with ADLs.

That there would be a broad need for assistance with ADLs seems to be foreign to the staff. Up to now, the capacity of their infirmary has been sufficient to serve the needs of inmates who need assistance with ADLs beyond Level 4, but as the female segment of the inmate population increases and ages, V4 is expected to have the same experience as the other institutions; namely, their infirmary spaces will be taken by inmates needing assistance with ADLs and eventually there may be insufficient bed space for acute medical care. The staff expressed the belief that there are more inmates with mental problems in the state prison system than in previous times because such inmates no longer are sent to state mental hospitals.

PHYSICAL PLANT

Except for the fence around the perimeter, this SCI appears like a college campus. SCI V4 consists of many relatively small multi-level buildings. There has not been much need for

wheelchairs but there is a wheelchair accessible shower (made accessible by removing the lip on the floor).

CAREGIVERS

Staff

Most of the inmates at this SCI who need assistance with ADLs have mental health challenges and are housed in the SNU. Their corrections staff and other staff provide prompting. Prompting represents the most frequent level of need. Without a regular SCI schedule, the staff claims that some inmates would sleep all day and probably all night.

Some staff members have participated in special training that DOC provides, but they report that if there were more spaces available, more of the staff could get special training. Other staff have taken advantage of correspondence courses in SNU training provided by the American Corrections Association. There is a certification process involving 40 credits of course work.

Staff members report that some inmates need intense reminding because they are not accustomed to taking care of their ADLs. One inmate had lived under a bridge and was not interested in taking care of herself. Others have come from home situations in which survival was a far greater concern than taking care of their ADLs.

A team approach was apparent during the tour of this facility when a psychiatrist and other staff members were participating in a planning session with an inmate. Although mental health needs, not ADL needs, were being addressed, a team approach was evident.

Inmates

Some inmates received informal directions from the nurse and are given blood and body fluid training. Inmates report that as infirmary workers, they do much more than janitorial tasks, providing some hands-on care. Inmates reported that new inmate workers in the infirmary have an orientation session and that other inmates provide part of that orientation.

Wheelchair pushing, not a great need at present, has not been classified as a job. The staff learned just recently that other SCIs have such a job and they are developing a program and seeking to have wheelchair pushing classified as a job.

IADLs

Inmates sew and wash their own clothes and hang them on the line. These activities represent IADLs.

ACCOMMODATION

Making a shower accessible by removing the lip is an example of a physical accommodation. Inmates who are deaf are fitted with hearing aids; one inmate kept breaking hers. In the past, staff members enlisted the aid of someone from one of the Commonwealth agencies to help them learn sign language to be able to communicate with a deaf inmate.

TRANSFER

There is nowhere for inmates from V4 to be transferred. Some inmates come to V4 from JJ. Potential candidates are not accepted at the all-male V2 hospice or Laurel Highlands personal care or skilled nursing units.

If transfer to Laurel Highlands were to be approved for women, a non-ADL-related experience at V4 might provide some help. Some women — not needing assistance with ADLs — have participated in the Boot Camp Program. At first, when just a few female inmates were sent, they quickly dropped out of the program and returned to V4. Later, a number of female inmates went as a group from V4 to the Boot Camp Program. They were more successful in staying in the boot camp program. If female inmates would ever be permitted to be transferred to Laurel Highlands because of their need for assistance with ADLs, it could be advisable to transfer them as a group of more than a few inmates.

RELEASE PLANNING

Staff members indicated that, when appropriate, they start release planning two or three months before an inmate is to be released. With the inmate's permission, the staff members communicate with those organizations, sending medical information that the community organization will be able to use to initiate services for the recently released inmate. They have had some success in having an inmate's family involved in planning for release, with the family sometimes taking responsibility for contacting community helper agencies. Some inmates have used community services prior to their incarceration and have returned to them after their release.

When an inmate with considerable ADL needs is about to "max out," staff members contact personal care homes and similar facilities. These efforts, however, have not met with much success.

TERMINALLY ILL INMATES

Staff spoke of the early release of a terminally ill inmate who went to a hospice program. The inmate died there. Another inmate in advanced stages of AIDS was released to a community

program. There she got better, was married, assaulted her husband, and returned to the institution where she was housed not in the infirmary but in general population. Such a case highlights the dilemmas surrounding early release.

V3 SCI

Opened: 1882

Security Level: 4

Capacity: 1,528 Population: 1,757

This SCI is the initial reception center for all inmates in the county. Data entry, TB testing, immunizations, x-rays and lab work are completed before these inmates are sent to P2 for further processing. Many of the inmates have life or other long-term sentences.

Most of the 60 inmates listed on Table A have Level 3 or 4 needs for assistance as a result of cognitive/intellectual impairment. There are some inmates who, because of blindness, for example, need someone to be with them as they go from place to place but otherwise need no assistance. Some inmates, because of partial paralysis, have particular difficulty using steps and ambulating on snow and ice and if they fall, they are unable to get up without assistance.

PHYSICAL PLANT

The terrain poses difficulties for inmates who have difficulty in getting from place to place. Parts of the facility are ADA compliant. This SCI is expected to be replaced by a new SCI in approximately three to four years. A smaller number of inmates and staff is expected to remain at this SCI. It may serve as a regional facility to house inmates awaiting treatment in nearby health

facilities in the community and/or awaiting transfer to Laurel Highlands. In the past, this facility had operating rooms. Currently, however, community facilities are used for such services. Now, the infirmary offers subacute care and also serves as a kind of nursing home while inmates await transfer to Laurel Highlands.

There is a SNU, a THU (transitional housing unit) and a MHU (mental health unit). There is a combination of older and newer buildings. For instance, the SNU and THU are located in a newer building. A general population cellblock is located in an older building and has five tiers of cells.

CAREGIVERS and TRAINING

Staff

In the SNU, staff members provide assistance to inmates in performing ADLs. For instance, in addition to prompting inmates to shower, the staff may have to turn the water on for the inmates and may have to tell the inmates to use the soap and shampoo. The inmates in the SNU function, on average, at the third-grade level. Some have mental retardation. Staff members said that there have been more mentally ill inmates since the closing of state mental hospitals. A treatment plan is formulated for SNU inmates. Adequate hygiene may be one goal of the plan.

Staff may see an inmate bringing food (against regulations) to another inmate on the fifth (top) range of a housing unit and realize that the inmate has not been able to get to meals because he cannot safely use the stairs. An inmate may go directly to the staff about his own ADL needs, saying, for instance, that he can no longer see well enough to navigate the stairs. Corrections officers communicate health-related problems to the health care staff.

Staff members may provide special assistance to an inmate. For instance, an inmate in RHU maintained that he could not walk although the staff thought that he could. Over time, with muscle atrophy, he could not walk. The inmate was placed in a cell near the shower. Each week, the staff member would take the time to be with the inmate as the inmate would "half walk, half crawl" to the shower. In another case, an officer took an interest in a reclusive inmate who reminded him of his father. Eventually, the inmate got a job in the RHU and was able to be transferred to the SNU.

One officer took an interest in an inmate who is deaf and mute and has schizophrenia and mobility problems. Over a period of years, the two worked out a series of hand signals for communication. Now the inmate has a job picking up trash. In general, however, when inmates needing assistance are in general population, the officers and the unit managers have very limited time to help because of their other duties.

Inmates

Inmates help other inmates on a volunteer basis. At times, a staff member will ask an inmate who is housed near the inmate needing assistance if he will help, for instance, push the inmate in his wheelchair. At other times, an inmate who is a friend of the inmate needing assistance will volunteer to help. Several inmates might take turns pushing the wheelchair of an inmate who is in general population. One inmate might assist the inmate to get to a particular activity and another inmate (whose schedule allows) will come to assist the inmate to his next assignment.

A network of inmates provides assistance to a blind inmate, helping him to get to the pill line, the dietary line, the clothing room, etc. Winter weather, particularly with snow and ice, poses a further problem for inmates with mobility problems in getting from place to place, including to the

dining hall. Because there is no formal system for inmates to help other inmates, i.e., no job description, the helper inmates are sometimes cited by security staff because they are doing something they are not authorized to do. Inmates are not allowed to be in another inmate's cell and can be "written up" for being in the cell while providing assistance. The health care staff members are beginning to provide these inmates with passes and are communicating with the security staff, asking that the helper inmates not be cited. Although there is no paid job for wheelchair pushers, the health care personnel are developing a job description for wheelchair pushers. If an inmate is unable to clean his own cell, block workers can be assigned to clean the cell.

Inmates help other inmates for a variety of reasons: friendship or wanting to help another person; not wanting a cell mate to be transferred and another cell mate to be assigned; being paid "two packs" (of cigarettes) by the inmate being helped; having something to do to keep from being bored; and getting to go to the head of the "chow line" to get a meal for the disabled inmate and for himself.

Inmates alert the staff to problems other inmates are having such as the need to shower or that an inmate is behaving in an unusual manner. Inmates may provide additional help to cell mates. At times, though rarely, they do such an effective job of providing assistance that staff members are unaware of the problem, e.g., Alzheimer's disease, until it has progressed to a more obvious stage.

IADLs

Some inmates do not have the strength in their hands to push the buttons that are used instead of faucets at the sinks. Some inmates, like one inmate who is paralyzed from the waist down, can get down on the floor to clean their cells but cannot get back up without assistance. Waiting/standing in line outside the commissary in the winter can be a problem for inmates with

nerve damage and sensitivity to the cold. As inmates gain independence in IADLs, for instance in taking their medication, (as well as in ADLs) they may progress from the MHU to the SNU to the THU and to general population.

An inmate who can see nothing in one eye and only minimally in the other asks another inmate in the line or a kitchen inmate who is serving the food what food items are being served and says which items he would like. At times, the inmate workers include items the inmate does not want.

ACCOMMODATION

Inmates who need assistance with ADLs who are in general population may be assisted by the unit manager. They may be assigned to a lower tier of cells and to a lower bunk. An inmate who is unable to go to the commissary can complete a commissary slip and the items will be delivered to him. The physician and a nurse speak Spanish and are able to serve as interpreters for Spanish speaking inmates.

JOBS

Inmates who need ADL assistance may also work. For instance, one inmate who was functioning at a level that would have allowed him to go to Laurel Highlands worked in the tailor shop. Sitting jobs are available there. One inmate who could not get to a job was brought parts of the job that he could do. One inmate who needs assistance takes care of the laundry in the SNU or THU and has memorized the inmate numbers (that are on the inmates' clothing). The majority of inmates at this SCI work.

TRANSFER

The primary reason for being housed in the SNU is psychological need on the part of the inmate. Many of the SNU inmates also need assistance with ADLs and IADLs. The basis for transfer among the various units includes both psychological and functional improvement or decline. A SNU inmate whose mental condition declines may be transferred to the MHU at this SCI and, if further decline occurs, be transferred to the forensic treatment center after completion of a commitment process. Upon improvement, the inmate can be transferred back to the SNU at this SCI. The routine of carrying out ADLs in the SNU helps some inmates to assume more responsibility in carrying out their ADLs more on their own. In this event, the inmate may be transferred to the THU where he will receive some prompting to perform ADLs but less assistance than in the SNU. Inmates gain more independence in performing ADLs while in the THU. Also, while in the THU, the inmate may begin to go to the pill line rather than having medication delivered to him. When the inmate is able to carry out his ADLs independently and is functioning adequately psychologically, he can be transferred to general population.

In the past year, several inmates have been transferred to Laurel Highlands. Two inmates currently in the infirmary and two in general population are waiting for transfer there. Custody level is one problem in transferring inmates to Laurel Highlands. If the inmate's custody Level is 4 or 5, the inmate will not be transferred to Laurel Highlands which takes inmates only with lower security levels. In very select cases, an inmate's custody level has been reclassified in order to allow for a transfer. In such a case, the efforts of healthcare, administration and corrections staff are needed.

A number of inmates have, however, returned from Laurel Highlands. When an inmate's psychiatric needs become greater than his physical limitations, for instance if the inmate becomes assaultive, he may be transferred back to an institution like SCI V3 which has a mental health unit.

One inmate who qualified to go to Laurel Highlands decided to stay at this SCI. He said that this SCI was his home, where his friends lived.

The ability of an inmate to transfer from the bed to a wheelchair or from the wheelchair to the shower, is a key ADL. If an inmate is able to transfer himself to and from his wheelchair, he is much more likely to be able to stay in general population rather than being housed in the infirmary.

In general, higher security inmates who need dialysis are transferred to V5 while similar lower security inmates go to Laurel Highlands. In one case, an (exemplary) inmate was reclassified in order to go to Laurel Highlands because he had an elderly mother who would be able to visit him more easily at Laurel Highlands.

SPECIAL PROGRAMMING

Health and hygiene programs are among the numerous programs offered in the SNU. In the SNU, cell inspections are held. Inmates can earn points that they can use to make commissary purchases. If an inmate takes a shower when told to do so, points are added. If an inmate has problems carrying out ADLs, one-on-one teaching takes place. Inmates in the SNU (or anywhere in the SCI) can be ordered, under threat of misconduct, to shower.

The STEP program, conducted by non-SCI personnel, works with older inmates. STEP serves as an advocate for older inmates both as individuals and as a group. STEP personnel may work with SCI staff to identify problems older inmates are experiencing.

Older inmates in the restricted housing unit (RHU), cannot participate in the special programming group because RHU inmates are housed in single cells. Some RHU inmates, especially the older inmates, do not choose to go to the yard. Some do not shower.

RELEASE PLANNING

One inmate with Alzheimer's disease was sent to a personal care home. Such a placement is difficult and rare. Inmates are more likely to go to a particular mission in the area. The mission is open for night-time stay only. Check in is about 5:00 p.m. Each morning after breakfast, everyone must leave. There are several other organizations in the area that can accept a released inmate on a temporary basis.

A team works with inmates who are to be released. The team has worked with the Welfare Department and Social Security, identifying a contact person and initiating the paper work. For older inmates who reach their maximum sentence, there is insufficient placement on the outside. Technically, when an inmate "maxes out," DOC's responsibility ceases to exist. The inmate is given a 30-day supply of medications and, even if the inmate has no money in his account, he is given a bus ticket and about $8-10. The SCI staff completes the Medical Assistance application and provides the inmate with the telephone number for SSI.

When an inmate is paroled, the situation differs. A home plan must be approved prior to release on parole. A personal care home or geriatric home may be needed. If the inmate goes to a Community Corrections Center (CCC) he receives PDOC assistance such as medical care.

Inmates, especially those who have been incarcerated for an extended period of time, may have lost all of their connections on the outside and have no housing or finances when they leave. For one older inmate with diabetes, another inmate located lodging for him with his aunt who provided lodging to people and who was, herself, a diabetic and could give insulin injections. The SCI staff arranged for a visiting nurse to provide education and assistance. This inmate used a wheelchair. Therefore, providing him a bus ticket was insufficient. Transportation was arranged.

The thought of release is frightening to some inmates. One older inmate who had no family or connections on the outside was about to "max out" and feared release. When it was discovered that a 10 to 20 year detainer existed and the inmate would not "max out," the inmate was pleased. A similar inmate who was about to be paroled to a halfway house expressed relief when he received a misconduct and had to remain in prison. Various barriers exist to finding lodging and care for inmates who need assistance with ADLs, whether the inmate is paroled or has maxed out, especially when no family is available. They include the needs associated with physical and/or mental illness (especially when both exist) and insufficient financial resources. The greatest barrier to placement, however, is the fact that the person has served time in a prison. The message that is communicated by the outside facilities is that their clients/residents would not want to be housed in the same facility with a convicted criminal; neither would the residents' families want to be paying for care in a facility where such a person is living.

TERMINALLY ILL INMATES

Several deaths have taken place at the SCI. If an inmate cannot be transferred to Laurel Highlands, the inmate remains at this SCI. In at least one instance, the inmate's family lived nearby and had to rely on public transportation to visit. Therefore, the inmate asked not to be transferred from this SCI.

In general, as long as the inmate is mobile, he can remain in general population. Other inmates are not allowed to visit an inmate in the infirmary.

A terminally ill inmate may apply for commutation of his sentence. However, the process is lengthy and the inmate is likely to have died prior to completion of the paperwork. Intervention by the inmate's family is a key factor in early release. In one case, the court action took only a day for an inmate dying of cancer. The SCI staff made the needed arrangements and the inmate went home. The inmate was able to die at home and the DOC was released of financial responsibility for his care.

N1

Opened: 1992

Security Level: 2

Capacity: 158 Population: 178

No inmates were reported as needing assistance with the activities of daily living. There has been one deaf inmate who could read lips. The only accommodation he required was to have people face him when speaking to him so that he could read their lips.

No other inmate has needed assistance with ADLs on a long-term basis. No one has ever needed a wheelchair. An inmate might need a shower chair or might be on crutches for a short-term need such as a fractured leg. An inmate with a fractured leg would be transferred out of the program. If he chose to return after recovery, he would have to begin the six-month program again.

Inmates go to N1 only upon qualifying for the 16 hour-a-day rigorous training program. Inmates must be able to run two miles and do push-ups and sit-ups. Inmates completing the program are paroled.

GG SCI

Opened: 1988

Security Level: 3

Capacity: 458 Population: 828

Table A reported one inmate needing assistance with the activities of daily living. This is probably an undercount as the interview revealed that some other inmates, especially older inmates, sometimes need reminding but otherwise function well in the general population.

PHYSICAL PLANT

SCI GG is set among hills and has multi-storied buildings. It would be difficult or impossible for a wheelchair-bound inmate to reside at GG.

CAREGIVERS

Staff

Staff provide whatever minimal care has been needed thus far. There has been no special training beyond the program DOC provides.

Inmates

Inmates are not involved in providing assistance to other inmates.

ACCOMMODATION

Up to now, the only accommodation necessary and provided is to remind inmates to go to meals, programs, activities, and so on. Given the physical layout of the institution, an inmate unable to maneuver hills and stairs is placed in infirmary housing; if his condition becomes chronic, he is housed in the infirmary until a transfer can be arranged. The only inmate listed as needing assistance with ADLs was an inmate awaiting transfer to Laurel Highlands. He needed assistance only in getting necessary equipment from the security officer and he then provided his own colostomy care. The SCI makes accommodation for inmates, for example, after surgery or a stroke. They stay in the infirmary until they regain their mobility and ability to provide for their own ADLs. The objective of care for these inmates is that they be rehabilitated and returned to the general population.

An inmate who had suffered seizures lived in the cell block. When he suffered a seizure, health care staff would go to the block and bring him to the infirmary where he stayed until a doctor could examine him. While this was an accommodation to the patient, staff reported that such a time could be used by other inmates as a distraction so that security would become an issue.

TRANSFER

When an inmate is unable to handle the challenges of the hilly terrain and flights of stairs to go to the medical services and to educational services, the inmate is designated for transfer to another SCI that can accommodate his difficulties.

RELEASE PLANNING

When an inmate is about to be released after serving his sentence, social service referrals are made on his behalf by the SCI staff. A medical records staff member educates the inmate concerning his care and concerning having his records forwarded to a new care provider. With the inmate's permission and according to his wishes, medical information may be released to his family.

P3 SCI

Opened: 1912

Security Level: 3

Capacity: 1,054 Population: 2,115

The survey included seven inmates needing assistance with ADLs. Six of them have intellectual-cognitive impairment and need Level 4 prompting. They are housed in the SNU. One inmate with a partially amputated foot is in infirmary housing awaiting transfer to Laurel Highlands.

The visit to the SNU revealed that there were more inmates than the seven reported on the survey who were receiving assistance, mostly cueing (Level 4 - verbal prompting). The cueing is provided by staff, including security, or by other inmates.

PHYSICAL PLANT

The physical layout would require that inmates in the SNU walk by the main entrance on their way to the health care unit for medications. To avoid the related security risks, health care staff deliver medications to the SNU. The general population buildings have five tiers of cells with upper and lower bunks in each. Five hundred inmates are housed in each unit. In addition, there are modular units with 50 inmate beds in a dormitory arrangement.

CAREGIVERS

Staff

Housing and medical personnel work together to assign an inmate to employment, education programs, therapeutic programs, medical needs, and housing. The SNU staff works together as a team. With the assistance of the staff, inmates participate in self-help programs, in which they help other inmates in areas in which they themselves need help. Staff members receive special training from DOC for work in this program.

Inmates

There are inmate janitors who help push litters and wheelchairs under medical staff supervision. Because of this close supervision, no special training is needed. Inmates do assist in prompting and cueing other inmates in the SNU.

IADLs

Various IADLs were identified at P3. Purchasing commissary items is an IADL. If an inmate is unable to go to the commissary, the Unit Manager is the only person authorized to do it for him. Cleaning out one's cell prior to being transferred is another IADL. An inmate unable to

do so would necessarily have to have someone else do it for him. Doing at least some part of one's laundry seems to be a practice at P3 and perhaps elsewhere.

ACCOMMODATION

Some residents of the SNU are unable to go to the dining hall (typically for mental health reasons); their meals are brought to the common area — a corridor between two rows of cells — within the SNU. Newcomers to the SNU are assigned a current inmate as a buddy to ease the transition during the first 90 days in the unit. Inmates with problems with mobility are assigned to a lower bunk on a lower tier. Job assignment and cell assignment, as well as assignments for education, therapeutic and medical programs, are made to accommodate the educational level and other characteristics of the inmate. Inmates without a fifth grade education are assigned to education as their work assignment. Inmates who have an infirmity that requires the use of a cane, crutch, brace, etc., are assigned a job they can do sitting down.

The CHCA reported that transfer to another SCI is used as a last option. Instead, accommodation is made for the impaired inmate. The inmates become accustomed to being at P3 and the staff can work to keep them there if possible. Transfer to Laurel Highlands is based on the person's needing more care on a permanent basis than the SNU or infirmary is able to provide.

TRANSFER

When an inmate's infirmity reaches a point where SCI P3 is unable to care for him, he becomes a candidate for Laurel Highlands. Because of the shortage of space at Laurel Highlands, not many inmates are transferred. One inmate currently in the infirmary is awaiting transfer. One

inmate was transferred to Laurel Highlands, but was so accustomed to being a P3 that he requested and was granted a transfer back to P3. Some inmates are transferred from P3 to one of the newer prototypical SCIs because of health conditions.

An inmate with severe mental problems can be housed in a special mental health unit within one of the SCIs having such a unit, but this step can be taken only after the inmate has been evaluated in the same way that someone in the free population is evaluated for commitment.

RELEASE PLANNING

Family members are involved in release planning if they are available and wish to be involved. Health care personnel are required to provide a 30-day supply of medication.

Some inmates who function reasonably well in the structured environment of the SNU revert to disruptive behaviors after their parole or release into the free population. People in the free population are often afraid of such behaviors. Also the behaviors may be illegal, resulting in the former inmate's return to prison.

The health care staff makes arrangements with the home or community agency to ensure continuity of care for inmates with special medical needs after their release. For instance, for an inmate with HIV, the infection control nurse will contact health department personnel in the area where the inmate is going so they may be able to assist in making doctor's appointments and so on. In one instance an appointment was made to initiate the process of lung transplantation.

TERMINALLY ILL INMATES

In the past five years, there has been little use of compassionate release. The staff said that judges ask if an inmate, who may be dying, e.g., from an advanced case of HIV, is capable of

committing a crime. No one may be able to guarantee that the inmate is incapable of criminal behavior.

Hospice placement requires a person to have a life expectancy of six months or less — which is sometimes difficult to judge — and the inmate's consent. Inmates are often hesitant to opt for hospice placement at V2 because they are accustomed to being at P3.

Deaths in the SCI generally take place in the infirmary. They occur in general population only as a result of something unanticipated such as a heart attack. There is a contract with the local emergency corps which is to arrive within 20 minutes of being notified of an emergency.

COMMUNITY LINKAGES

"Volunteers in prison" conduct weekly groups for the self-help program in the SNU. (See Appendix J.)

KK SCI

Opened: 1988

Security Level: 4

Capacity: 652 Population: 1,183

Table A included 16 inmates needing assistance, mostly at Levels 3 and 4 and mostly due to skeletal/locomotor impairment. Two of these inmates live in the infirmary, three in the SNU and one in a single cell and the rest in general population.

PHYSICAL PLANT

KK is a pre-prototypical SCI. It has an infirmary where subacute care is provided. An effort is made to provide LTC, rather than sending these inmates to Laurel Highlands. If an inmate, however, needs more than verbal reminders to perform ADLs and is unable to function in general population, he is moved to the infirmary. KK's infirmary also serves inmates from BB where there is no infirmary. There is also a SNU at KK SCI. Both the infirmary and the SNU have been in existence since the opening of the SCI. The distances at KK are shorter than those at some of the older SCIs. Most of the cell doors are sufficiently wide to accommodate a wheelchair.

CAREGIVERS and TRAINING

Staff

No specialized training is provided to the security guards unless they work in the SNU. The amount of help, even verbal prompting, the officers can provide is limited; there may be four officers for a block of 200 to 300 inmates.

Inmates

No inmates provide hands-on care and therefore no training is provided. However, one inmate was assigned to help a wheelchair-bound inmate for whom the bed was modified and a device was used that helped the inmate transfer himself independently. The block worker assisted the inmate to the shower. The inmate could shower himself. In the yard, another inmate would place the weights into this inmate's hands.

IADLs

Activities include purchasing items at the commissary, getting books at the library, and activities such as card playing.

ACCOMMODATION

The SCI modified a cell to accommodate a wheelchair inmate.

JOBS

There are more inmates than there are jobs. An inmate in a wheelchair can do a job that can be done from his cell.

SPECIAL PROGRAMMING

At team meetings with the unit manager, counselor, security officer and psychological staff, an individual plan is developed for each inmate with special needs.

RELEASE PLANNING

Planning is conducted on a case-by-case basis, tapping into community resources as needed. At times, only two or three days notice of release is given, limiting the amount of planning.

TERMINALLY ILL INMATES

Inmates dying at KK may be given a few extra commissary privileges and have extended visits from family members in the infirmary. One terminally ill inmate went to V2. Most are likely to stay at KK, however. Some inmates do not accept hospice care. In the care of a terminally ill inmate who is being released, it is difficult to find a nursing home or boarding home that will accept the inmate. First, the SCI personnel lack the time and the contacts to arrange

such care. Second, there is the problem of payment for the facility. Third, the process to obtain a pre-release is lengthy and may well extend beyond the lifetime of the inmate.

LL SCI

Opened: 1993

Security Level: 3

Capacity: 964 Population: 1,775

Table A included 26 inmates needing assistance with ADLs. The vast majority need prompting assistance only for reasons of cognitive/intellectual impairment. The CHCA reported that everyone in the SNU (Population: 84) needs some minimal level of prompting from the staff, even if the Table A response does not indicate such.

Several inmates are in wheelchairs and live in the general population. Others using wheelchairs have less tolerance for distances and live in the SNU. Inmates using a walker are not housed in general population.

PHYSICAL PLANT

LL SCI is a prototypical institution. This SCI has an infirmary.

CAREGIVERS and TRAINING

Staff

A weekly meeting of the staff results in the determination of whether or not an inmate from the SNU is ready to go back into the general population. These meetings suggest a level of staff integration or teamwork.

Security officers bid to work in the SNU. Therefore, those officers who work in the SNU have asked to work there. A nurse gives a weekly class in the SNU on various health-related topics.

Inmates

Inmates assist other inmates by pushing wheelchairs. They do not receive any formal training from the medical department, but maybe or maybe not some training within the unit. Wheelchair pushing is a job.

ACCOMMODATION

Inmates with low tolerance for distances are housed in the SNU to be closer to the medical unit, the dining hall and the library. If inmates cannot get to the dining hall from the SNU, meals are delivered to them.

One stroke victim inmate needed physical therapy, occupational therapy, etc. He went to the hospital and then to a rehabilitation unit (at a cost of about $800.00 per day) where he received round-the-clock care. That inmate improved remarkably. After recovery, the inmate went to Laurel Highlands rather than require LL to continue incurring such high costs.

There is a special treatment line providing basic treatments (stretching, foot care, blood pressure). An inmate unable to get to the special treatment line would be housed in the infirmary.

JOBS

Most inmates work and there appears to be an emphasis on getting a job for an inmate if he is at all able to work.

TRANSFER

Some inmates have been transferred from LL to Laurel Highlands because they need the kind of medical care available at Laurel Highlands. Usually such transfers do not occur because either Laurel Highlands does not have space or the inmate's security level (level 3 or 4) would disallow him from going to Laurel Highlands without first obtaining a re-classification. For these reasons, LL reports being accustomed to dealing with inmates needing considerable care.

SPECIAL PROGRAMMING

The nurse provides weekly sessions on health-related topics while counselors provide classes for SNU inmates.

RELEASE PLANNING

If an inmate is going to a Community Corrections Center, then with the inmate's approval, relevant medical information would provided to that CCC. LL arranges for follow-up appointments through public health for individuals with communicable diseases. Counselors work with inmates to obtain SSI, etc., so they have funding at the time of release. No one has gone to a nursing home upon release.

When an inmate "maxes out," DOC has not further responsibility for the inmate. No one who has maxed out from this SCI has had need of assistance with ADLs. If so, counselors would have helped plan for that assistance.

TERMINALLY ILL INMATES

Some terminally ill inmates have been transferred to V2. LL does not work with a local hospice. If inmates are terminally ill, they stay in the infirmary and may receive extra visits

from their families. There have been no instances of inmates coming to visit a terminal inmate in the infirmary. The staff informs family members that they can seek a court order for commutation of sentence but no such commutation has ever happened at LL.

OTHER

The medical contractor is resistant to the SCI's taking inmates from another region who will need medical care.

V2 SCI

Opened: 1989

Security Level: 2

Capacity: 1,052 Population: 1,024

Six inmates are listed on Table A as needing assistance with the activities of daily living. The on-site visit indicates this number is an understatement.

V2, together with a forensic treatment center, is actually a collection of institutions. V2 includes a forensic treatment center for inmates committed for reasons of mental health. Commitment is preceded by a special assessment program to determine if inmates are committable. The population of the forensic treatment center is not counted in SCI V2.

PHYSICAL PLANT

Within the multi-story structure, three blocks (L1, L2, and M) provide ready access to the infirmary. The L Blocks and M Block are like dormitories. Within the infirmary, three beds provide a hospice area.

A state forensic program occupies one multi-story section of the building. Inmates live on the third floor (and perhaps higher floors) and treatment and activity rooms are on the second floor. An inmate who needs to be committed for reasons of mental capacity and who needs a high level of assistance with ADLs — especially getting from place to place — would not be transferred to the forensic treatment center.

The blocks close to the infirmary allow inmates in wheelchairs to stay on one level. There are elevators if they need to go to another level. Inmates say they do not use the elevator.

The recent escapes from two other SCIs have prompted the removal of such things as mirrors from cells, a reduction in the items inmates may have in their cells, and increased security.

CAREGIVERS and TRAINING

Staff

The staff includes medical staff, psychologist, clergy (employed by the institution) and security. The staff provides training for the inmates. V2's SNU is really an intermediate care unit for use as a step-up or step-down program for inmates with mental health problems. Aside from inmates housed in the SNU, there are few inmates needing assistance with ADLs.

Staff members appear to work as a team in both mental health services and in the hospice program. During the researchers' tour of the institution, a team (a nurse, a psychologist and a psychiatrist) was participating in a telephone conference with staff from another SCI, conferring about an inmate about to be transferred from V2 back to the other SCI. A tour of the facility provided an opportunity to see the building and the almost constant exchange between the CHCA and security staff, counselors, medical staff and others.

Inmates

Inmates work as wheelchair pushers; wheelchair pushers reside in the same block, close to the infirmary, as the wheelchair inmates. The wheelchair pushers provide assistance mainly to one inmate but cooperate with each other when other work duties create a schedule conflict. Wheelchair pushers have training in blood and body fluid cleanup and are trained by the nurses on how to push the wheelchair and help the rider in and out of the chair.

Inmates pointed out that as far as they know some of their work and the work of inmate janitors is not unlike the tasks of a hospital orderly. The wheelchair pushers themselves decide who is responsible for a rider (wheelchair inmate) with the objective of better learning the person's needs and of developing a relationship.

Inmates said that other inmates are usually the first line of action in recognizing when an inmate needs emergency medical care and who alerts the corrections officer to trigger a response to the need.

The inmates get training from the health care staff in the mechanics of wheelchair pushing, lifting a patient inmate and helping someone in and out of the chair. To some extent such inmates are like personal care assistants. There is no job classification called "wheelchair pusher." Block janitors are assigned to be wheelchair pushers. Inmates also report other informal help such as assisting a man with one leg into and out of the shower. The CHCA is seeking to get approval for inmates to do some hands-on care within the hospice unit.

ACCOMMODATION

The major accommodation is in locating inmates with trouble getting from place to place in a block that minimizes their need to walk or ride great distances. The special toilet and the shower supports accommodate the needs of those who have trouble using conventional facilities.

TRANSFER

Inmates come from other SCIs for the Special Assessment Program and perhaps then to stay in the forensic treatment center or the intermediate care unit of V2. Inmates also come from other SCIs to the hospice unit at V2. Because it is small, with three beds, and for other reasons, many potential candidates for V2's hospice unit stay in their own SCIs. When such inmates come from other SCIs, they first go to the infirmary. Depending on their condition they may return to the general population. Most prefer to stay in the general population as long as they can and return to it from the infirmary as soon as they can.

An inmate is transferred out of V2, excluding the hospice unit, when his condition reaches the point that V2 can no longer provide needed care. Examples include a need for dialysis, not available at V2.

SPECIAL PROGRAMMING

The mental health services generate their own special programs. The hospice unit is a special program to be discussed later.

RELEASE PLANNING

There have been two instances of inmates going home to die. The SCI made arrangements with local hospice units to provide support for the terminal inmates.

TERMINALLY ILL INMATES

V2 has a formal hospice unit, consisting of three beds in the infirmary area. The program seems to have a strong spiritual content. It provides services on an in-patient and out-patient basis. Both the staff and the inmate prefer that the inmate stay as independent as possible as long as possible. A wheelchair inmate recently was diagnosed with tumors throughout his body and given six months to live. He is commencing the hospice program but will continue to live in general population on the L Block. He may stay there as long as he is able to function.

The start of V2's hospice unit grew out of the CHCA's interest, an increase in AIDS and other afflictions, and a smaller likelihood for compassionate release. The SCI accommodates the family of the dying inmate, permitting them to visit when they are able to get there. Most but not all such inmates maintain a connection to family. A local hospice program entered into a three-year contract to provide training and to share expertise with V2's staff. The trained hospice staff provide training for newer staff. The SCI no longer has that kind of contract and does not use community volunteers in its hospice program. Inmates have been allowed to visit death-bed inmates in the hospice unit.

MM SCI

Opened: 1984

Security Level: 2

Capacity: 483 Population: 482

The survey reported eight inmates needing assistance, all at Levels 3 or 4. Five have skeletal/locomotor impairment and one each has cognitive/intellectual, hearing, and seeing impairments.

PHYSICAL PLANT

MM does not have an infirmary. If an inmate needs care for more than 24 hours, he is sent to nearby DD SCI. Such an inmate would typically stay at DD which is a prototypical SCI that can accommodate an inmate with mobility problems. If the inmate has greater ADL needs or if the inmate needs dialysis, he might be sent to Laurel Highlands SCI.

A housing unit close to the dining hall was selected for conversion to a handicapped/wheelchair accessible housing unit. Inmates who are temporarily using a wheelchair can be housed there.

There is no SNU at MM.

CAREGIVERS and TRAINING

Staff

The staff is informed of the type of assistance an inmate needs. Security staff may provide verbal prompting, e.g., for bathing, grooming and getting from place to place. The chaplain may go to the housing unit if an inmate is unable to go to the regular services. Barber services are

provided in the housing units. The activities manager may arrange for activities in the housing unit of an inmate who cannot go to regular activities.

Inmates

Inmates may help other inmates by accompanying them from place to place or carrying a meal tray for them. If an inmate is unable to go to the commissary, he completes his request and sends it through the mail system. A commissary inmate delivers the items to the inmate. Inmates "watch out" for each other, as, for an inmate with a seizure disorder who walks with a cane and for an inmate with narcolepsy.

ACCOMMODATION

The telephone system is not equipped for hearing impaired or deaf inmates. A deaf inmate would likely be assigned to another SCI. Some inmates, however, use hearing aids. Staff members are aware of the need to ensure that those inmates hear prompts. Bottom bunks are assigned to inmates, as needed, mostly for chronic back problems that could be aggravated by climbing to the top bunk.

JOBS

MM inmates generally have jobs which include an assignment of "medically idle". Inmates with disabilities or chronic illnesses may have light duty block work, like emptying ashtrays, dusting, etc.

RELEASE PLANNING

Discharge planning includes informing the inmate of recommended medical care and medical items for which he will need to arrange The Infection Control Nurse talks with HIV

positive inmates regarding discharge plans. They are provided a contact agency and/or person to contact for follow-up care.

TERMINALLY ILL INMATES

No inmate has been terminally ill at MM SCI.

Models/Strategies

The models or strategies employed in the prison system to provide long-term care are similar to those used in the free population. The implementation of the models, however, as one might anticipate, is quite different in the prison setting. The models, as existing in the free population, are: home care, personal care attendant, assisted living, adult day center, continuing care retirement community and hospice care. The term, transfer model, is used here to denote the model used in prisons that generally do not house inmates needing assistance. It is important to note again that an SCI (except for those with the transfer model) typically uses more than model in providing assistance to inmates.

Transfer Model

As a cost-saving measure, the PDOC consolidated the infirmaries in certain SCIs which are located in close geographic proximity to each other. Thus, not every SCI has an infirmary. Inmates who need more than approximately 23 hours of observation or care who are housed in SCIs without an infirmary are transferred to a nearby SCI that has an infirmary. If the inmate is found to have greater needs for assistance than can be provided at the SCI with an infirmary, he typically would be transferred to another SCI, for instance a prototypical SCI (with "handicapped cells") or Laurel

Highlands. It is rare that an inmate needing assistance with ADLs and IADLs would be housed at an SCI without an infirmary.

Home Care Model

In the implementation in the prison of the home care model, as noted in the "Definition of Terms" section, "home" is the prisoner's cell, extended to include areas for showering, eating, etc. Like people in the free population, inmates with needs for assistance typically prefer to remain in the familiar environment of their home and community with needed services being provided there. However, because of factors more typical of the prison setting, such as fear of predatory behavior, inmates with more severe functional impairments may have a need to be transferred to a prison facility (or unit within a facility) that selectively houses inmates with long-term care needs.

To a more limited degree than might be available to individuals in the free population, assistance with ADLs and IADLs is provided in the inmate's "home". A certain amount of prompting related to ADLs and IADLs is provided to all inmates by the security staff, e.g., by announcing that it is time to go to the dining hall. Because of the small size of the cells, inmates with assistance needs may require less help inside the cell than outside. In select instances, a cell may be modified for use by an inmate with disabilities. For instance, grab bars may be placed near the toilet in the cell. When inmates with assistance needs are unable to clean their cells, other inmates may be assigned to perform that task. Such inmates may be paid block workers who normally clean the cellblock area.

The presence of a commode and a sink in most cells helps inmates who need assistance with toileting (as well as other inmates). In addition, an inmate needing assistance may be assigned to a bottom bunk in a lower tier or to a "handicapped" cell.

In some instances, for instance when an inmate is going blind, an outside agency may be called upon to provide training for that inmate to prepare him or her for dealing with blindness in the prison setting. Staff members also receive related training as may the inmate's cell mate who may be specially selected based on the staff's thinking that the inmate will be compatible with an inmate with diminishing vision.

More care than is officially sanctioned is not infrequently provided by one inmate to another, especially if the inmates are cell mates. Without the awareness of the staff and perhaps only very rarely, an inmate may provide a great deal of ADL assistance to a cell mate. Such assistance may be provided for a variety of reasons, including a wish on the part of the inmate care provider to be helpful and/or a wish to avoid having his current inmate moved to the infirmary and having another, perhaps less compatible, inmate be housed with him.

The reason that such care is sometimes hidden from the staff is that American Correctional Association rules, as stated earlier, state that inmates may not provide direct patient care to other inmates. Various SCIs interpret this rule differently; some do not allow inmates to provide any assistance to other inmates, including pushing the wheelchair of another inmate. In other SCIs, inmates may push wheelchairs, help the inmate with his shoes and socks, assist the inmate in and out of the wheelchair, and perform help with other daily activities.

At times, assistance is provided by one inmate to a cell mate with the knowledge of the staff. In at least one instance, the inmate being helped is the parent of the cell mate. In addition, an inmate who is deaf might be assigned to the cell of a prisoner who is thought able and willing to work with a deaf cell mate (and not prey on him).

Nursing Home Model

This model, as described earlier, was previously used in the PDOC system. Inmates, with PDOC guards, were housed in a state-run nursing home. That model is no longer used. However, some inmates live for lengths of time in the infirmary of an SCI. The infirmary, in these cases, serves in the capacity of a nursing home. At times, these are inmates who are on the waiting list for the "long-term care prison".

Personal Care Attendant Model

The personal care attendant model is generally quite different in the prison setting than in the free population. In the free population, personal care attendants may help a person in his or her home with various ADLs and IADLs. In addition, the attendant may help the individual get to work or school or other location and may stay with the individual, continuing to provide assistance in those settings. In a prison, as stated earlier, one inmate may assist another with certain ADLs and IADLs. For various reasons, networks of inmates may provide assistance. An inmate may help another inmate in a wheelchair to get to a location but may be unable to assist him to the next assignment because he has to go to school or to work himself. Inmates may work together to plan a schedule for getting the inmate needing assistance to his various assignments. Hills provide another reason for having more than one inmate involved in pushing wheelchairs. In at least one

SCI located on a hill, certain inmates are able to push a wheelchair down the hill but are physically unable to push it back up the hill. Therefore, a second set of inmates assists the inmates in wheelchairs back up the hill. The amount of assistance, as noted earlier, varies from one SCI to another. In cases where the inmate needing assistance provides some training to the helper inmate, the consumer-directed approach to personal care (in the free population) is reflected, at least, in part.

Adult Day Services Model

In the SCIs where such care is provided, the adult-day-services facility is the infirmary. An inmate may come to the infirmary in order to receive assistance with a number of ADLs but still be housed in general population, i.e., "home". Such a situation may occur with a terminally ill inmate who prefers to remain as independent as possible and to stay in general population as long as s/he can. In addition, an inmate may come to the infirmary for only one need. For instance, some inmates move too slowly for the regular shower line. They may shower or bathe in the infirmary instead.

Inmates with mobility problems may not be able to get to the shower area which is located on another floor and is accessible only by stairs. They may go to the infirmary for showers. Also, an inmate needing a tub bath because of a medical condition may go to the infirmary for a bath.

Assisted Living Facility Model

The Special Needs Units (SNUs) comprise a specialized type of assisted living. Inmates in most of the SNUs are there primarily because of psychiatric illness and also, to a lesser degree, because of mental retardation. Some SNUs, however, house inmates primarily because of their physical limitations. Regardless of the reason for assignment to the SNU, many of the inmates

housed there require assistance with ADLs and IADLs. Programs focusing on health and hygiene are provided there.

It is in the SNU that the convergence of mental-illness-related and physical-illness and disability-related ADL and IADL needs are most evident. Whether the underlying cause of functional impairment (i.e., need for assistance with daily activities) is mental illness, the side effects of psychotropic medications, mental retardation, or chronic physical illness or disability, the need for assistance is a common factor. (See Appendix I.)

The way in which assistance is provided, however, may vary depending on the underlying factor. Depending upon the underlying cause, the inmate may or may not be aware of or in touch with the process of or need for performing ADLs and IADLs. In this case–which may be associated with mental retardation, mental illness or the side effects of psychotropic drugs–the way in which care is provided takes into account the detachment of the inmate from the process. The security guards in the SNU may need not only to give verbal prompts to inmates that it is time, for instance, for showers but they may have to turn on the water, tell the inmates it is time to undress, tell them to use the soap and shampoo and tell them to use the towel and to dress.

Another variation of the assisted living model is a transitional housing unit (THU) that is found in some prisons. In these units, less assistance with ADLs and IADLs is provided than in the SNUs. THU inmates who become able to perform their own ADLs and IADLs may be moved to general population.

A third adaptation of the model is found in prisons where inmates who have difficulty getting from place to place are housed in a general population unit near the infirmary, dining hall and commissary. This model is particularly useful in prisons that are located on hills and/or in areas

with extended periods of snow and ice and/or that have extended distances among buildings. Each of these factors increases the difficulty of cane, crutch or wheelchair assisted mobility.

Hospice Model

There is just one prison with a designated hospice unit. However, a number of SCIs provide informal hospice care to inmates who are dying. The prison with the hospice unit has three beds designated for inmates receiving hospice care. Terminally ill inmates may be housed in general population until they require more assistance than can be provided in a cell. Family members are allowed to visit the dying inmate in the hospice unit. The SCI entered into a three-year contract with a local hospice to assist in the formation and implementation of the hospice program.

Other SCIs offer informal hospice care. Programs were developed as a result of health personnel interest and previous hospice experience and/or because of inmate need. The SCI with the hospice unit is located in the northeastern part of the state. Terminally ill inmates in other SCIs may not want to transfer there for a variety of reasons: distance from family; desire not to sign an advanced directive form, which is required for admission to the hospice program; and/or desire to remain at the inmate's "home" facility where he knows the inmates and staff. In addition, if the terminally ill inmate is female, she cannot be transferred to the hospice unit because it is in a male-only prison.

The hospice-like approaches range from allowing the inmate's family to visit in the infirmary (rather than in the designated visiting area) to considering having a hospice training program for selected inmates to serve as hospice volunteers.

The presence of an interdisciplinary approach in an SCI appears to lend itself to the formation of hospice-like care for dying inmates. In the prison setting, the term *interdisciplinary* is used to denote special cooperation among the various health care and corrections personnel.

The Continuing Care Retirement Community Model

The Continuing Care Retirement Community (CCRC) model is also reflected in the SCIs. In a CCRC in the free population, people live in various housing arrangements. Individuals may live in their own home (or "cottage") on the CCRC campus where they can receive ADL and IADL assistance as needed. A person may live in an assisted living (or personal care) facility also on the campus. In the facility, the individual lives in his or her own apartment or rooms and can receive assistance there. Two or three meals a day are provided in the dining hall. Also on the campus is a skilled nursing facility. A person may reside in the nursing home or may live in another part of the CCRC and stay for fairly brief periods of time in the nursing home, as needed, for instance after being discharged from a hospital.

Laurel Highlands presents a type of CCRC. Some inmates live in skilled care units. Inmates are housed and receive care on the unit. Each unit is fairly self-contained. Inmates need to leave the unit only for visits and for chapel. Inmates, who are less functionally impaired, live in a type of assisted living facility where a lower level of assistance is provided. Some of these inmates are able to hold inmate jobs, for instance wiping tables.

The SCI system as a whole can be seen as an adapted continuing care retirement center model. CCRCs in the free population do not consist of a "campus" as large as a state and therein lies the adaptation of the model.

Issues

The study revealed a number of issues that need to be addressed by corrections policymakers and planners when they are examining care-related needs of older inmates and also disabled and/or chronically ill younger inmates. Included are: 1) the physical facilities with regard especially to inmates who have difficulty getting from place to place; 2) medical care and long-term care, including the cost of care; 3) staff, including related training; 4) inmates helping inmates, including training; 5) the tension between custody and control, on one hand, and care, on the other; 6) safety of infirm inmates; 7) the housing and care of female inmates who need assistance; 8) modification of inmate jobs to accommodate inmates' functional impairments; 9) release planning and 10) the care of dying inmates. These issues need to be addressed by any prison system planning for the health and long-term care needs of older inmates and of disabled and/or chronically ill younger inmates.

Physical Facilities

Many prisons were built in a time when few older people were inmates. Some were built on hills. Multilevel buildings lacked elevators. Buildings to which inmates need access were built at a distance from one another (Morton, 1992). In planning to meet long-term care needs, officials will address a number of questions, including: How accessible are the parts of current facilities that are used by inmates? Can facilities that are not accessible be made to accommodate the needs of infirm inmates? Can needed renovations be made cost effectively? Are separate facilities needed to accommodate the growing numbers of inmates who need assistance with ADLs? What are effective ways to address the needs of these inmates when new prison facilities are being planned?

Medical Care, Long-Term Care, Special Programs and the Cost of Care

The cost of caring for older inmates is, on average, more than triple the cost of caring for inmates who are younger. The annual expenditure for the care of older state inmates can be $70,000 or more (Faiver, 1998:128). Medical and long-term care expenses contribute to this higher cost.

Older persons are more likely than younger individuals to have at least one chronic illness. Estimates indicate that older inmates, on average, have three chronic illnesses (Aday, 1994). Chronic care clinics offer one means of focusing on prevention of complications (and the costs they entail). Inmates are charged a co-payment of between $2 and $15 when they receive medical care. The purpose of co-payments is to discourage frivolous use of medical services.

Co-payments typically are waived for provider-initiated care such as the care of chronic illnesses. If not, inmates could seldom afford the cost of follow-up care. In addition, the system can be saved the expense of costly complications that could be prevented (Faiver, 1998:118). Special programs may be offered to older inmates and disabled younger inmates with the aim of teaching the inmates how to reduce the risk of medical complications.

Questions arise. How and where should long-term care be provided to inmates? Should a long-term care program be implemented regionally throughout a state or should all such care be provided in one, specially designated facility? If one facility is designated, will that facility be able to house all the inmates in the system who need assistance? Should all prisons have the capability to provide care? Who should provide long-term care? What training should they receive?

Staff

Security staff provide a great deal of verbal prompting regarding ADLs and IADLs. They may be aware of physical limitations, for instance deafness, in an inmate and make adaptations, as needed. In this case, they might go to the inmate's cell to let him know it is time to be ready to go to the dining hall. Relief officers need the same awareness of inmates' limitations.

Security guards may tell inmates it is time, for instance, to shower. They may turn on the water for inmates unable to do so for themselves (whether because of physical and/or mental limitations) and tell the inmates to undress and get under the shower. They may tell them to use the soap and shampoo and to dry off and dress. However, they cannot bathe the inmates. As there are more and more inmates who need such help, an increasing need for nurse aides can be anticipated.

Medical care in prisons is increasingly being provided through contracted care. The goals associated with privatization include cost reduction and improved quality of and access to health care services. The training needs of contracted as well as directly-employed staff must be considered,

including the need for education regarding the medical and long-term care needs of older inmates. Security staff members, including relief staff, also need education regarding the aging process.

As discussed later under "Release Planning", a need may exist for social workers in the prison setting. These employees would assist in the planning for release of inmates with long-term care needs.

Inmates Helping Inmates

As previously stated, inmates provide assistance to other inmates, including serving as wheelchair pushers. An issue in planning for the provision of long-term care in a prison system

entails ACA rules concerning the ways in which inmates may help other inmates. The "American Correctional Association (ACA) Public Correctional Policy on Correctional Health Care" states that:

> [i]nmates. . .shall never be used in the provision of direct patient care. . . . Treatment shall be provided and/or supervised by competent, appropriately credentialed health care professionals (In Faiver, 1998:225)

What happens when an inmate wheelchair pusher goes to the cell of the inmate needing assistance and that inmate needs help putting on his shoes and socks? Is the inmate allowed to go into the other inmate's cell to provide the needed help? If he is not allowed to do so, who will provide the needed assistance? Will such an inmate necessarily be transferred to the infirmary? What happens when an inmate using crutches falls outside the cell block and cannot get up and no staff members are available to provide assistance? Can another inmate provide assistance? If not, who will help the inmate who has fallen?

Tension Between the Concepts of Security (Custody and Control) and Care

Security staff in prisons that house inmates who need assistance with activities of daily living (ADLs) such as bathing, dressing, eating, using the toilet and transferring from the bed to a chair, often are presented with dilemmas. They face situations in which accommodation to the functional impairments of inmates can conflict with the need for security. They are on the "frontlines". They are, so to speak, the "street level bureaucrats" who translate policy into action (Lipsky, 1980). Policies are needed that are sensitive to this tension, along with related training.

Safety of Older Inmates

Another issue is the safety of older, infirm inmates who tend to be susceptible to predatory abuse from younger inmates. As noted earlier, the incidence of such abuse has been increasing (Faiver, 1998:130-131). Policy and program questions arise regarding housing of such inmates.

Should they be housed together in a facility or unit of a facility set aside for older inmates or should they be "mainstreamed" and be placed throughout a facility? Older inmates are thought to have a stabilizing influence in the prison environment. Segregation of older inmates would eliminate this effect. If older inmates are housed together, can inmates who prefer to remain with younger inmates do so? If older inmates are mainstreamed, what oversight is needed to protect them from abuse?

Female Inmates

Attention to the needs of older female inmates will increasingly be needed. Although females comprise a small portion of the total inmate population, the number of incarcerated females is growing (Conly,1998: 2). They tend to have more health-related needs than do male prisoners (Faiver, 1998:134). In Pennsylvania, the prison designated for long-term care is a male facility. Female inmates who need assistance with ADLs or IADLs must be housed in one of the two female facilities. Related questions for policymakers and planners include the following. How is long-term care currently being provided to women? Is the number of women needing assistance expected to increase over time?

The percentage of state female inmates with AIDS (3.5) exceeds that of male inmates (2.2) (Maruschak, 1999: 1) What impact does this higher percentage have on the long-term care needs of female inmates? What is the current number of older female offenders? Of these, how many need long-term care? How many women have long (or life) sentences without the possibility of parole? If a decision is made to provide long-term care in a selected prison facility, should women as well as men be housed there? Should a unit in a female prison be designated for the provision of long-term care?

Job Modification

"Idle inmates" pose a concern for prison officials. To what degree can jobs be modified to accommodate the medical and functional impairments of older inmates? To what degree can chronically ill and/or disabled inmates be assigned to existing jobs that they are able to perform? What happens if there is an insufficient number of jobs even for non-disabled inmates? Should the work-related needs of chronically ill or disabled inmates be a factor in the selection of corrections industries? Should industries that include a number of "sit down" jobs be selected? If a reduction in "idle inmates" is a goal of a prison system, policymakers and planners will need to address these questions.

Release Planning

Increasingly, older inmates with functional impairments are being released as they complete their sentences. Where are these inmates going to be placed? The personnel at long-term care facilities may have a declining interest when they hear that the person is being released from prison after finishing a long sentence. A growing need for social workers to perform the job of discharge/release planning can be anticipated. Otherwise, already overworked counselors and other prison personnel will be increasingly called upon to undertake this time-intensive task. Not only is such planning needed for infirm inmates who have served their full sentence but also for those infirm inmates who have been granted parole.

Terminally Ill Inmates

The aging of inmates and the higher rates of HIV infection have combined to effect an increase in the number of dying prisoners. A decrease in the granting of compassionate releases means that most of these inmates will die in prison or in a medical facility that provides care to inmates. The hospice concept of care is increasingly being applied in prison settings. Of the 824 dying inmates in the U.S. in 1989, 152 were part of hospice programs. In 1987, the Federal Bureau of Prisons established the first prison hospice. Since that time, hospices have been developed in eleven state prison systems. Approximately 25 additional hospices are being planned (Shelton, 1999).

In some programs, specially-selected inmates are trained to be hospice volunteers. Related policy questions concern security and care. Can these volunteers visit dying inmates in parts of the prison to which other inmates are denied access? How much and what type of care can they provide?

Additional Issues

In addition to the issues discussed in the previous section, there exist other, more intangible factors that appear to have a significant impact on the model(s) developed by an SCI. One factor is the philosophy of the Superintendent, i.e., the warden, and the SCI as a whole. This philosophy appears to have an influence on the degree to which personnel of the various units work together in an interdisciplinary fashion as well as the degree to which staff members feel able to respond innovatively to inmates' needs regarding long-term care. In turn, the degree to which an interdisciplinary approach is present and to which personnel respond in an innovative way to inmates' needs has an impact on the model used in an SCI.

Associated with the degree of innovativeness is the manner in which regulations are interpreted. In SCIs where regulations are more narrowly interpreted, less innovation occurs; in those where a broader interpretation is employed, more innovation appears to take place. A case in point is the interpretation of the American Correctional Association guideline, presented earlier, that states that inmates are not to provide "direct patient care" to other inmates. At some SCIs, the guideline is interpreted to mean that no inmate can serve as a wheelchair pusher for another inmate. At other SCIs, using a broader interpretation, inmates provide some types of ADL assistance to other inmates.

A further factor that was found to influence the model used in an SCI is the prior work experience of the staff members. For instance, a CHCA with prior experience working in a hospice setting (who works with a Superintendent whose philosophy allows for innovation) may start a hospice-like approach in addressing the needs of terminally ill inmates who are not transferred to the SCI with the official three-bed hospice unit. An inmate may choose not to be transferred for a variety of reasons, including wanting to remain near family members who live near the SCI, not wanting to sign an advanced directive, and not wanting to leave the SCI staff and inmates with which the inmate is familiar.

Another determinant in the evolution of a model is a willingness on the part of the staff to enlist the services of community organizations in the care of inmates who need assistance. For instance, some SCIs have involved associations for the blind or the deaf when inmates with these impairments are housed there. At other SCIs, local hospice organizations have been involved, for instance, in providing hospice training.

A potential influence (although not one identified in this study of a single system) on the models developed in a correctional system could be the primary cause for the long-term care need in the given system. For instance, the majority of the need for long-term care in one system may arise from an increasing number of younger inmates with AIDS. In another system, the inmate population needing long-term care might be older. The models developed in the two systems may differ.

This discussion certainly does not exhaust the program and policy issues related to the medical and long-term care needs of older inmates. The potential for early release of infirm or dying inmates is another issue. As more attention is paid to the long-term care needs of inmates, additional issues will surface.

SECTION 7: SUMMARY, RECOMMENDATIONS AND CONCLUSION

Summary

In summary, a number of findings contributed answers to the research questions. Question one: How and where does each of the 25 SCIs in Pennsylvania provide long-term care to inmates? In general, a variety of approaches, rather than a single model, is employed in individual SCIs in the PDOC. For instance, in an SCI, some inmates with assistance needs may be housed in a general population cell which may be in a bottom bunk in a lower-tier cell and which may be located in a cell block near the infirmary and other services. Other inmates, with more extensive long-term care needs, may be housed in the infirmary or transferred to an SCI with "handicapped cells" or to the prison facility that focuses on providing long-term care.

Question two asked: If a facility does not provide any long-term care services, what is it about the facility or its population that does not require them? The SCIs that typically do not provide long-term care to inmates are the "boot camp" prison and facilities that lack an infirmary. Inmates at facilities without an infirmary are transferred to a nearby SCI with an infirmary if they need more than 23 hours of care.

Question three was: If a facility does provide long-term care, how does it do so, and how did it come to the current way of providing such care? This question, in terms of the way in which care is provided, overlaps question one. The approaches used by facilities where long-term care is provided were developed as a result of policies and/or as a result of ad hoc efforts to address the needs of inmates needing long-term care.

Recommendations

This research project has explicitly had as its objectives neither the assessment of the effectiveness of Pennsylvania DOC's overall efforts at providing assistance with ADLs nor an evaluation of the performance of any SCI. Consequently, recommendations will not address the relative effectiveness of the various models. Rather, this descriptive research has led to several recommendations for SCI practice and for future research.

Policymakers and planners in the various state Departments of Corrections would be well advised to plan for the needs of inmates with functional impairments. Studies of state systems in terms of long-term care, similar to the one reported here, can provide information upon which to base decisions. Such efforts should include not only group interviews with staff and inmates but also individual interviews. Group interviews will continue to provide useful descriptions of processes; individual interviews will enhance the details of the descriptions. Identification of inmates who currently need long-term care as well as inmates who are likely to need long-term care in the future (for instance, current older inmates and younger inmates with long, mandatory sentences) will provide information basic to the planning process.

In addition, with regard to future research, continuing attention should be paid to respondents' understanding of the related terms. With a more uniform understanding of the terms, respondents' related answers will provide more precise approximations of the extent of the long-term-care-related needs and, in turn, the resources required to address those needs.

Although the current study did not include an evaluation component, a recommended focus of future research efforts is the identification of the relative merits of the various models through which long-term care is provided, including the circumstances under which one model might be the preferred strategy. In addition, this study did not address the Americans with Disabilities Act. It

is recommended that future research address the impact of the Act on prison operations. Additional recommended research efforts involve the specific long-term care needs of female inmates and the impact of AIDS and hepatitis C on long-term care needs.

Departments of Corrections, lacking a compelling reason to do otherwise (such as a decision to house all inmates who need assistance in one facility), might do well to allow considerable variation in the ways in which long-term care is provided to inmates. Given the differences among the various prisons within a system, in terms, for instance, of age and condition of the facilities, the imposition of a uniform model could prove ineffective. In prison systems, however, where great similarity among facilities exists, a more uniform approach would have more likelihood of success. Opportunities could be provided for SCIs to share their successful (and less-than-successful) efforts with each other.

A reassessment is needed of the role of inmates in assisting other inmates with ADLs. Wide variation exists in the interpretation of ACA guidelines regarding the type of care one inmate can provide to another. If inmate-to-inmate care (whether paid or unpaid) is limited, other issues arise, such as the need for additional prison staff.

The training needs of individuals, staff and inmates, providing ADL assistance should be identified. Related training programs should be developed and implemented.

The role of community organizations in supporting efforts to assist inmates should also be considered. In the current study, it is not clear that SCIs without community linkages have explicitly chosen not to have them. Either SCI staff members may not have thought of such connections or have known how to establish them. In addition, they may not know if such linkages are permitted, encouraged and valued.

Conclusion

Much remains unknown about the ways in which long-term care is provided to inmates throughout the United States. Further research is needed to provide policy-makers and planners with the information they need to address this growing challenge.

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APPENDIX A: ADVISORY COMMITTEE MEMBERS

ADVISORY COMMITTEE MEMBERS
NIJ PROJECT

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APPENDIX B: SURVEY INSTRUMENT AND ATTACHMENTS

Interviewers' Guide and Survey Instrument for SCI Superintendents

Please record your answers to Question A below on the attached Table A entitled *List of Inmates by Assistance, Impairment and Housing.*

A. Some inmates, especially older inmates but also some younger inmates, need help with one or more of the following ordinary activities: bathing, dressing, grooming, eating, using the toilet (elimination), getting from the bed to a chair and getting from place to place. In addition, various levels of assistance may be needed.

To the best of your knowledge, list the inmates (by inmate number) who need any such assistance and record five pieces of information as follow:

1. **What level of assistance** is needed (level 1 represents the highest level of care; level 4 represents the lowest level, i.e., verbal prompting only)? Leave blank those activities with which the inmate needs no assistance. Attachment I, *Types and Levels of Assistance*, provides descriptions of the levels of assistance. Please use it as a guide in providing this answer.

2. **Who**, if anyone, provides such help (including verbal prompting) to these inmates? nurse, nurses aide, security staff, other inmate, volunteer, others?

3. **Where** is the assistance provided? Inmate's cell, infirmary, dining hall, dispensary, yard and other/as needed?

4. **What** is (are) the underlying **impairment(s)** of each of these inmates? cognitive / intellectual, speaking, hearing, seeing, skeletal / locomotor, impairment requiring life-sustaining machine? See Attachment II Inmate Impairments for further guidance.

   If other inmates have impairments but do not currently receive assistance with activities of daily living, please list them by number and answer only items # 5 & 6 on the table.

5. **Where** are these inmates **housed?** general population, infirmary, infirmary housing, hospice, handicap cell, single cell, long term care unit, personal care unit?

B. If you have specialized housing, e.g., infirmary, hospice, etc., what prompted your institution to establish them?

C. What specialized DOC training, if any, do the individuals in Question A 2 receive? How are they trained? For example, do the inmates, volunteers and/or security staff who provide any support (such as wheel chair pushing, verbal prompting, etc.) receive any training?

D. With what other activities (excluding those in Question A) might inmates need help? e.g., carrying laundry? purchasing commissary items?

E. In what ways, if any, do health care services (such as dispensary, infirmary, pill line, other) for the inmates in Question A. differ from those services for general population inmates?

1. Are there special accommodations/methods for providing the aforementioned services to inmates with specialized health care needs?

F. What medical and/or social programs (not including education programs for the general population) are there for inmates who need special help?

G. Are there special work assignments for the inmates listed in the answer to Question A? If so, please provide examples of such assignments.

H. What triggers an inmate with health care needs to move within the institution or system.

I. When an inmate who needs assistance (such as that described in Question A.) is about to be released, what process is followed?

1. How is Discharge Planning implemented?
2. What is the involvement, if any, of the inmate's family in the planning?

J. If you were the researcher, what other questions would you ask of the SCI Superintendent?

List of Inmates by Assistance, Impairments and Housing

Table A.

SCI: Date:

Completed by:

Components of Assistance in order of:
(Level of Assistance, Who will be assisting, Where assistance is provided)

1. Level of Assistance	Using Attachment I Levels of Assistance, Which one best describes the situation.	**4. Type of Impairment(s)** List one code as Primary. If inmate has other impairments list other code(s) as Secondary. (See Attachment 2 "Inmate Impairments") Codes: A. Cognitive-Intellectual B. Speaking C. Hearing D. Seeing E. Skeletal / Locomotor F. Impairment requiring life-sustaining equipment.	**5. Housing Location** G=General population In=Infirmary IH=Infirmary Housing H=Hospice HC-Handicap cell Z=Single Cell L=Long Term Care Unit P=Personal Care Unit
2. Who is to assist?	N-Nurse, A-Nurse's Aide, S-Security Staff, I-Other Inmate, V-Volunteer, O-Other		
3. Where is care to be provided	C-Inmate's cell, IN-Infirmary, DH-Dining Hall, DI-Dispensary, Y-Yard, O-Other/as needed		

Examples:

Inmate ZZ-6218 needs assistance with Bathing (Level 2, Nurse provides the assistance, in the Infirmary) and with Getting from place to place (Level 3, other Inmate provides the assistance as needed).

Inmate ZZ-9520 needs assistance by a nurse aide with Bathing, Dressing, Grooming, Eating, Using the Toilet, and Getting from place to place in the Infirmary.

Inmate Number	Bathing 1 2 3	Dressing 1 2 3	Grooming 1 2 3	Eating 1 2 3	Using the toilet 1 2 3	Getting from bed to chair 1 2 3	Getting from place to place 1 2 3	Primary	Secondary	Housing Location
ZZ-6218	2 N In						3 I O	E	D	G
ZZ-9520	2 A In	3 A In	3 A In	2 A In	4 A In		4 A In	A		In

Inmate Number	Bathing	Dressing	Grooming	Eating	Using the toilet	Getting from bed to chair	Getting from place to place	Primary	Secondary	Housing Location
	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3			

Attachment

TYPES AND LEVELS OF ASSISTANCE

TYPES OF ASSISTANCE	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
	Unable to care for self.	**Frequent intervention and/or monitoring required.**	**Minimal intervention and/or supervision required.**	**Only verbal prompting is needed.**
Bathing	Requires complete bathing or extensive assistance.	Requires some assistance with bathing. May complete some steps with supervision and assistance.	Bathes self independently, however, may need assistance to get in bath or shower chair. Requires minimal supervision / assistance.	Needs verbal prompting to bathe.
Dressing	Requires complete care with dressing or extensive assistance.	Requires assistance with obtaining clothing. Requires some assistance and supervision with dressing.	Dresses self. Needs minimal supervision / assistance with dressing.	Needs verbal prompting to dress.
Grooming	Requires complete care with brushing teeth, shaving, combing hair or extensive assistance.	Requires assistance with obtaining equipment for grooming. Requires some supervision.	Grooms self. Needs minimal supervision / assistance with grooming.	Needs verbal prompting to groom.
Eating	Requires feeding/hydration.	Requires assistance with setting up meal tray. Able to feed self with some assistance and supervision.	Sets up tray and feeds self. Requires minimal supervision/ assistance.	Needs verbal prompting to eat.
Using Toilet	Incontinent of urine/feces three or more times per shift.	Continent of urine/feces. Has a Foley/Texas catheter. May be incontinent of urine/feces during the night.	Continent of urine/feces. Catheter care, if needed, is independent. Requires minimal supervision/assistance.	Needs verbal prompting to use the toilet.
Getting from Bed to Chair	Requires complete help.	Can stand but needs some support getting to a standing position and sitting.	Requires minimal assistance/supervision to get from the bed to a chair safely.	Needs verbal prompting to get from the bed to a chair.
Getting from Place to Place	Requires complete help.	Can sit in wheelchair but needs a wheelchair pusher. Can use a walker with assistance.	Requires minimal assistance/ supervision.	Needs verbal prompting to go from one place to another.

Attachment II

INMATE IMPAIRMENTS

An impairment is either primary or secondary, and may be of several types.

PRIMARY This refers to a **PROGRESSED** inmate impairment. An inmate would have only one impairment that would be considered "primary".

SECONDARY One inmate may possess multiple medical impairments. All impairments other than the primary are considered secondary.

Type of Impairment

Cognitive / Intellectual Impairments are disturbances of development of cognitive functions, such as perception, attention, memory, and thinking, and their deterioration as a result of pathological processes. They include those of intelligence, memory, thought, consciousness, wakefulness, perception and attention. This may be related to retardation, dementia (e.g. Alzheimer's Disease).

Speaking / Language Impairments relate to the comprehension and use of language and its associated functions, which may include the inability to learn, communicate, comprehend, and speak as related to a CVA, cleft palate, etc.

Hearing Impairments relate not only to the ear, but also to its associated structures and functions. The most important subclass of hearing includes whose hearing impairment is so severe that they are unable to benefit from any amplification.

Seeing Impairments relate not only to the eye, but also to its associated structures and functions, including the eyelids. The most important subclass of ocular impairment is made up of impairments relating to the function of blindness. To be considered legally blind an inmate would be tested as best corrected at 20/200.

Skeletal/Locomotor Impairments include mechanical and motor disturbances of the face, head, neck, trunk, and limbs, including paralysis, dwarfism, gigantism, and obesity as related to quadriplegia, paraplegia, etc.

Impairments Requiring Life Sustaining machines include dependence on any form of external life-saving machine, such as a respirator, a kidney (dialysis) machine, or any form of electromechanical device for the sustenance or extension of activity potential.

APPENDIX C: SITE VISIT AND FOCUS GROUP PLAN AND FORMS

Site Visits to SCIs and Conduct of Focus Groups
As part of the Penn State Research Study on Long – Term Care in SCIs

Purpose

General purpose: To describe the approaches or models to providing assistance with activities of daily living in Pennsylvania's SCIs, and to describe the factors that influence these approaches;
Specific purpose for this phase: To gain information from service providers and recipients in the SCIs in order to describe the approaches.

Plan for Each Visit

- Tour of the SCI (about 1 hour)
- Group Interview (Focus Group) with Staff Members (1½ - 2 hours)
- Group Interview (Focus Group) with Inmates (1 - 1½ hours)

Participants in Staff groups:

- General Health care provider – nurse
- Physician
- Unit Managers of SNU and from another block on which inmates reside
- Security Officers from SNU and from another block on which inmates reside
- Counselor
- Psychologist
- Whoever has the responsibility of assigning housing
- Whoever has the responsibility of assigning jobs
- Teacher
- Other Staff as appropriate, given the purpose of the group interview

Participants in Inmate groups:

Inmates who provide assistance and
Inmates who get assistance -- Variety of

- Ages
- Type of Impairment
- Activities of Daily Living with which help is needed
- Level of Assistance needed

Inmates who provide assistance

- Barbers
- Dining Hall workers
- Wheel chair pushers
- Infirmary workers who provide some help
- Cell mate of an inmate who needs assistance

Consent to Participate

Staff will indicate their consent by signing a form at the session.
Inmates will indicate their consent by signing a form provided by the CHCA or designee prior to the session.

Focus Group #1 - Staff:

Thank you for taking the time to meet today to share your experiences and perceptions. As you may know, our research is focusing on inmates who assistance with Activities of Daily Living, things such as bathing or going to the shower, getting dressed, grooming, getting to the toilet, eating or getting one's tray, getting from bed to chair, and getting from place to place. In all of our questions we will refer to inmates who need assistance with these activities; if we want to refer to the general inmate population, we will say so explicitly.

Our purpose is to gather information and experiences from you as providers so we will be better able to describe how assistance with activities of daily living is actually provided. Our questions will focus on your experience in providing assistance. Our purpose is specifically not to evaluate what is done or how it is done, or to assess how effective any aspect of the assistance might be.

Focus Group Questions

1. How long have you worked here?
2. Where did you work or what did you do before coming here?
3. Where are inmates who need assistance housed?
4. What is your role in making special housing assignments?
5. What specialized housing units are there in this SCI?
6. Where was care provided before it was established?
7. What specialized training, related to providing assistance, have you received?
8. What specialized training, related to providing assistance, have other nurses, security staff, counselors, etc. received?
9. What triggered your – and their -- getting that training?
10. What is your role in providing assistance to inmates who need help with bathing, dressing, grooming, eating, using the toilet, getting from bed to chair, getting from place to place?
11. Where do you provide the assistance?
12. How do you know who needs assistance?
13. What has been your experience in providing the help? – things that made it easier and things that made it harder?
14. What are the roles of others in providing this assistance?
15. Where is that assistance provided?
16. What experience have you had with special programs for such inmates?
17. What prompted the initiation of such programs?
18. Have you worked with groups from the community in providing programs?
19. What – if any -- special work assignments are there for such inmates?
20. What is your role – if any --in making special work assignments?
21. If you have known of inmates who have moved from one block to another, what were the reasons for the move?
22. If you have known of inmates who have move from one SCI to another, what were the reasons for the move?
23. What is your role when such an inmate is about to be released?
24. How – if at all -- does an inmate's need affect housing, medical care, cell mate, programs, jobs?
25. What other activities -- besides bathing or going to the shower, getting dressed, grooming, getting to the toilet, eating or getting one's tray, getting from bed to chair, and getting from place to place -- might an inmate need help with?

Focus Group #2 - Inmates who get or provide assistance

Focus Group Questions

Inmates who get assistance

You have been invited to this group interview today because at least sometimes you get help with such things as bathing or going to the shower, getting dressed, grooming, getting to the toilet, eating or getting your tray, getting from bed to chair, and getting from place to place.

For inmates who get help:

1. What kinds of assistance have you received, whether from staff or from other inmates?
2. Who provides that assistance?
3. Where is that assistance provided?
4. What has been your experience in providing the help? – things that made it easier and things that made it harder?
5. What assistance has helped you to become more independent in taking care of yourself?
6. How did the staff know that you needed help?
7. Have you moved from one cell block to another at this SCI?
8. What prompted the move?
9. Were you at another SCI before coming here?
10. What prompted the transfer to this SCI?
11. What is your job assignment – if any?
12. What other activities -- besides bathing or going to the shower, getting dressed, grooming, getting to the toilet, eating or getting one's tray, getting from bed to chair, and getting from place to place -- might an inmate need help with?

Inmates who provide assistance

You have been invited to this group interview today because at least sometimes you provide help to other inmates, who need assistance with such things as bathing or going to the shower, getting dressed, grooming, getting to the toilet, eating or getting the food tray, getting from bed to chair, and getting from place to place.

We are interested in knowing about your experience in providing this help.

13. What assistance do you provide?
14. Is the assistance tied to a task or is it tied to a particular inmate?
15. How did you decide to provide this assistance?
16. Have you received any special training to provide this assistance?
17. How do you provide the assistance?
18. What has been your experience in providing the help? – things that made it easier and things that made it harder?
19. Do you get paid for helping?

Penn State Research Project on Long Term Care in Pennsylvania's SCIs

Staff Consent to Participate in Group Interview

This form will be distributed and explained, and signatures obtained, before the start of the group interview.

Project Principals and Group Moderators:
Dr. Cynthia Massie Mara
Dr. Christopher K. McKenna

Purpose

General purpose: To describe the approaches or models for providing assistance with activities of daily living in Pennsylvania's SCIs, and to describe the factors that influence these approaches;
Specific purpose for the group interviews : To gain information from service providers and recipients in the SCIs in order to describe the approaches.

Description of group interviews of staff

Staff will assemble and discuss the issues raised and respond to questions offered by the Penn State group moderator(s). The interviews will be audio recorded as a source of notes for later analysis by the moderator. The tape will not be made available to anyone other than the moderator. Comments will not be attributed to individual group members, whether in the Research Report or in any communication, written or oral. The group interview will last between 1 1/2 and 2 hours.

Consent to participate

I have read the purpose of this group interview. I am aware that it will be audio taped, with the tape made available only to the Penn State moderator. I agree to participate in the group interview, knowing that I may decline to answer any question and that I may withdraw from the interview at any time.

Name	Date
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Penn State Research Project on Long Term Care in Pennsylvania's SCIs

Inmate Consent to Participate in Group Interview

This form will be distributed and explained, and signatures obtained, by the Corrections Health Care Administrator prior to the group interview.

Research Purpose

General purpose: To describe the approaches or models for providing assistance with activities of daily living in Pennsylvania's SCIs, and to describe the factors that influence these approaches;
Specific purpose for the group interviews : To gain information from service providers and recipients in the SCIs in order to describe the approaches.

Description of group interviews of inmates

Inmates will assemble and discuss the issues raised and respond to questions offered by the Penn State group moderator(s). The interviews will be audio recorded as a source of notes for later analysis by the moderator. The tape will not be made available to anyone other than the moderator. Comments will not be attributed to individual group members, whether in the Research Report or in any communication, written or oral. The group interview will last between 1 and 1 1/2 hours.

Consent to particpate

I have understand the purpose of this group interview. I am aware that it will be audio taped, with the tape made available only to the Penn State moderator. I agree to participate in the group interview, knowing that I may decline to answer any question and that I may withdraw from the interview at any time.

Name	Date
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APPENDIX D: LETTER FROM THE SECRETARY OF THE PENNSYLVANIA DEPARTMENT OF CORRECTIONS TO THE SUPERINTENDENTS OF THE SCIs, REGARDING THE STUDY

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF CORRECTIONS
P. O. BOX 598
CAMP HILL, PENNSYLVANIA 17001-0598

OFFICE OF THE
SECRETARY OF CORRECTIONS

May 12, 1999

SUBJECT: Penn State Research Study

TO: Superintendents

FROM: Martin F. Horn
Secretary
Pa Department of Corrections

Two Penn State faculty members will contact you shortly to discuss an issue with broad state and national implications. This issue involves the increasing number of inmates who need long-term care. As you are aware, the prison population is aging and, therefore, the need for such assistance is increasing. I encourage your cooperation in this study.

The breadth of this challenge is reflected in The National Institute of Justice award of a research grant to The Pennsylvania State University at Harrisburg to study this very issue. The Pennsylvania Department of Corrections (DOC) provided key cooperation in a preliminary study conducted by the Penn State researchers prior to their gaining NIJ support, and we are quite interested in their current efforts.

The purpose of this study is 1) to identify the various approaches (or models) through which help is provided to inmates who need such assistance in the Pennsylvania State Correctional System and 2) to identify the key issues in developing and implementing those approaches. I particularly note that this is not an evaluation project; this study will not attempt to assess the effectiveness of any approach at any SCI.

The study also will provide much needed information about inmates with special needs to the DOC, Bureau of Health Care Services (BHCS). This is particularly valuable as the Bureau moves forward in providing health care to the prison population as it embraces change.

Professor's Cynthia Massie Mara and Christopher K. McKenna, the principal investigators on this research project, will contact you shortly to discuss how this issue affects your SCI. Attached is the set of questions they will use as a guide in the interview. Your CHCA should review the Interview Guide prior to the interview itself, and if they have questions they may contact the Bureau of Health Care Services, Cathy McVey or Joan Trees (717-731-7031), who in turn will consult with the Penn State principal investigators.

The schedule of activities that directly involve your SCI is as follows:

Task	Date	Activities	SCIs
1.	By mid-to-late May	**On-site** interviews with Superintendent and CHCA	Houtzdale Camp Hill Rockview
2.	Late May	Researchers will adjust the Interviewers' Guide according to what they learn in Task 1	
3.	Late May through mid-June	**Telephone interviews** with Superintendent and CHCA	All SCIs not included in on-site interviews of Task 1
4.	By end of June	Identification of: 1. models for providing assistance to inmates in need of long-term care. And 2. SCIs at which the various models are implemented	
5.	During July	On-site group interviews with corrections staff, care providers and inmates who need assistance with activities of everyday life.	The 6 – 8 SCIs will be identified after completion of Task 4.

Dr. Mara will contact the Superintendents noted in Task 1 for gate clearance for Dr. McKenna and herself. The BHCS will contact the Superintendents that will be identified at a later date in Task 5 for gate clearances for the Penn State research investigators.

While your participation in this effort will be an imposition on your busy schedules, I encourage your cooperation.

Attachment

cc: Deputy Executive Secretary Beard
Deputy Secretary Fulcomer
Deputy Secretary Erhard
Deputy Secretary Shaffer
Deputy Secretary Love
Director McVey
Dr. Fred Maue
Dr. Gary Zajac
Bureau of Health Care Services Staff

APPENDIX E: CONSENT FORMS

Penn State Research Project on Long Term Care in Pennsylvania's SCI's

Inmate Consent to Participate in Group Interview

This form will be distributed and explained, and signature obtained, by the Corrections Health Care Administrator prior to the group interview.

Participation is voluntary.

Research Purpose

General purpose: To describe the approaches or models for providing assistance with activities of daily living in Pennsylvania's SCI's, and to describe the factors that influence these approaches. Specific purpose for the group interviews: To gain information from service providers and recipients in the SCI's in order to describe the approaches.

Description of group interviews of inmates

Inmates will assemble and discuss the issues raised and respond to questions offered by the Penn State group moderator(s). The interviews will be audio recorded as a source of notes for later analysis by the moderator. The tape will be destroyed within six months. Comments will not be attributed to individual group members, whether in the Research Report or in any communication, written or oral. The group interview will last between 1 and 1 ½ hours.

Consent to participate

I have read the purpose of this group interview. I am aware that it will be audio taped, with the tape made available only to the Penn State moderator. I agree to participate in the group interview, knowing that I may decline to answer any question and that I may withdraw from the interview at any time.

_____ _____

Name **Date**

Penn State Research Project on Long Term Care in Pennsylvania's SCIs

Staff Consent to Participate in Group Interview

This form will be distributed and explained, and signatures obtained, before the start of the group interview.

Participation is voluntary.

Project Principals and Group Moderators:

Dr. Cynthia Massie Mara

Dr. Christopher K. McKenna

Penn State Harrisburg
Middletown, PA 17057
717 948 6694

Purpose

General purpose: To describe the approaches or models for providing assistance with activities of daily living in Pennsylvania's SCIs, and to describe the factors that influence these approaches;
Specific purpose for the group interviews: To gain information from service providers and recipients in the SCIs in order to describe the approaches.

Description of group interviews of staff

Staff will assemble and discuss the issues raised and respond to questions offered by the Penn State group moderator(s). The interviews will be audio recorded as a source of notes for later analysis by the moderator. The tape will not be made available to anyone other than the moderator. The tape will be destroyed within six months. Comments will not be attributed to individual group members, whether in the Research Report or in any communication, written or oral. The group interview will last between 1 1/2 and 2 hours.

Consent to participate

I have read the purpose of this group interview. I am aware that it will be audio taped, with the tape made available only to the Penn State moderator. I agree to participate in the group interview, knowing that I may decline to answer any question and that I may withdraw from the interview at any time.

....

Name Date

APPENDIX F: WHEELCHAIR AND WHEELCHAIR PUSHER GUIDELINES

WHEELCHAIR OPERATING GUIDELINES

It is the responsibility of the inmate who has been assigned a wheelchair to ensure the following Guidelines are followed:

- Do not shift your weight or sitting position toward the direction you are reaching as the wheelchair may tip over.
- Do not tilt wheelchair up onto two wheels, (i.e. doing wheelies).
- Never travel from compound to Dining Facility, Visiting, Medical, Laundry, CI Shop, or Commissary without assistance of attendant.
- The wheelchair is equipped with wheel locks, always engage both wheel locks before attempting to transfer in or out of the wheelchair.
- To prevent unusual wear and tear, wheel locks must be completely disengaged while operating wheelchair.
- Wheelchairs should not be utilized for anything other than their intended purpose (i.e., stand for television, step ladder, etc.)
- Wheelchairs should be operated on paved areas only.
- Wheel locks are not brakes. Do not attempt to stop a moving wheelchair with the wheel locks.
- Wheelchair attendants must use two hands while pushing chair.
    - Never stand on back of wheelchair, especially while chair is moving.
    - Always operate wheelchair at a normal walking pace.
- If inmate attendant is not operating the chair safely or properly, the wheelchair user is required to report this to the Unit Management Team and /or the Medical Department.

Any violation of the above guidelines may result in disciplinary action.

f:whelchgl

FROM: _____
Unit Manager's Signature

SUBJECT: INMATE ORIENTATION FOR WHEELCHAIR PUSHERS

_____ _____ _____
NAME (LAST, FIRST) DC # UNIT/CELL

The below listed areas were covered for assignment of the above individual. This orientation is in compliance with Department of Corrections Policy requiring all inmates to receive an orientation prior to employment.

INTRODUCTION

_____ Introduce inmate to staff and other inmates he will be working with.
Explain who directly supervises him while working.
_____ Explain work assignment and the importance of it.
_____ Explain the importance of two way communications (ask questions).

SCHEDULE/PAY

_____ Explain schedule to inmate (reporting time, days off, etc.)
_____ Explain procedures for reporting off work.
_____ Explain starting wage (STEP 1A) and how to advance (attitude towards work assignment, etc.).
_____ Cover pay raises, eligible every 60 days with favorable work report.
Will advance one (1) step at a time to maximum pay of Step 1D
_____ Cover specific reasons for not paying (i.e., sick call, ATA, visit).

WORK ASSIGNMENT/DUTIES

_____ As a wheelchair pusher, you assist the handicapped on all mainline movements(i.e., dining room, visiting , medical, school lines, work lines and commissary).

SAFETY CONCERNS

_____ Do not tilt wheelchair up on two wheels.
_____ You must use two hands while pushing chair.
_____ You must travel at normal walking pace.
_____ Wheelchair must be operated on paved areas only.
_____ Never stand on back of chair, especially while chair is moving.
_____ Any violation of the above guidelines may result in loss of job or disciplinary action.

I have received an orientation by my work supervisor covering all areas checked above.

_____
Inmate's Signature

I conducted an orientation with the above individual covering all checked items.

_____ _____ _____
Staff Signature Title Date

Form will be initiated by Unit Manager whom will copy the inmates assigned and DC-14 file on Unit.

I, _____ have read and understand
Inmate name DOC #

the Wheelchair Operating Guidelines, and accept the responsibilities discussed.

Wheelchair # _____

Serial # _____

_____ _____
Inmate Signature Date

_____ _____
Witness Date

f: whelchgl
dir:k

APPENDIX G: LONG-TERM CARE REFERRAL AND ASSESSMENT FORMS

Attachment I

LONG TERM CARE REFERRALS

(For BHCS Use Only)
DATE:

Received _____

Reviewed _____

Approved _____

Transferred _____

SCI: _____

INMATE NAME: _____

INMATE # _____

ADMITTING DIAGNOSIS: _____

PRESENT LEVEL OF CARE: ☐ Geriatric ☐ Intermediate ☐ Skilled

AGE: _____ CUSTODY LEVEL: _____

CRIME: _____

BEHAVIOR ADJUSTMENT (May use PACT description): _____

_____

_____

_____

PRIMARY MEDICAL REFERRAL: _____

_____

_____

_____

MEDICAL EQUIPMENT: _____

_____

_____

_____

PSYCHIATRIC HISTORY: _____

_____

_____

_____

_____ _____

Nurse Signature Date

Attachment II

ACTIVITIES OF DAILY LIVING ASSESSMENT

Inmate Name	Inmate#	Date

(Upon Completion Forward to the Bureau of Health Care Services)

INSTRUCTIONS: Please place the functioning code which best indicates the inmate's functioning level in the box to the right of each question. If a score of 2 to 4 is recorded for any ADL, in the comment section, please describe how the inmate currently manages these activities.

LEVELS OF ADL FUNCTIONING	CODE
INDEPENDENT - Performs tasks safely without assistance	1
INDEPENDENT WITH ASSISTANCE - Performs tasks with the assistance of devices, requires additional time to perform ADLS and/or only completes tasks with great difficulty	2
LIMITED ASSISTANCE - Performs tasks under limited assistance, supervision, and/or coaxing	3
SIGNIFICANT ASSISTANCE - Performs tasks only with direct assistance. Assistance required to perform more than half of the activity listed	4

DOES THE INMATE:	ASSIGNED CODE
1. Have the ability to bathe without assistance? Comments:	☐
2. Have the ability to dress or undress? Comments:	☐
3. Have the ability to perform daily grooming: Comments:	☐
4. Have the ability to transfer himself/herself in and out of a bed or chair without difficulty? Comments:	☐

BLADDER AND BOWEL MANAGEMENT LEVEL	CODE
INDEPENDENT - No accidents	1
SELF CARE - Self care of devices or ostomy. No accidents	2
LIMITED ASSISTANCE - Performs with some supervision, setup or assistance with equipment. Infrequent accidents.	3
SIGNIFICANT ASSISTANCE -Performs with maximum help and/or daily accidents	4

DOES THE INMATE:	ASSIGNED CODE
1. Have the ability to control bladder function? Comments:	☐
2. Have the ability to control bowel function? Comments:	☐

INMATE NAME:	DC# :	DATE.

Instructions: Please place the functioning code which best indicates the inmate's functioning level in the box to the right of each question. If a score of 2 to 4 is recorded for any question, in the comment section, please describe how the inmate currently manages these activities.

MOBILITY FUNCTIONING LEVELS	CODES
INDEPENDENT - Performs tasks safely without assistance	1
INDEPENDENT WITH ASSISTANCE - Performs tasks with the assistance of devices, requires additional time to perform ADLS and/or only completes tasks with great difficulty	2
LIMITED ASSISTANCE - Performs tasks under limited assistance, supervision, and/or coaxing	3
SIGNIFICANT ASSISTANCE - Performs tasks only with direct assistance. Assistance required to perform more than half of the activity listed	4

DOES THE INMATE:	CODE
1. Walk safely indoors Comments:	☐
If a Code of 2 to 4 is listed, is the impairment described likely to be: A. Temporary_____; B. Long Term_____; C. Permanent_____; D. Unknown_____	
2. Walk safely outdoors Comments:	☐
If a Code of 2 to 4 is listed, is the impairment described likely to be: A. Temporary_____; B. Long Term_____; C. Permanent_____; D. Unknown_____	
3. Climb Stairs Comments:	☐
If a Code of 2 to 4 is listed, is the impairment described likely to be: A. Temporary_____; B. Long Term_____; C. Permanent_____; D. Unknown_____	
4. Require a Wheel Chair Comments:	☐
If a Code of 2 to 4 is listed, is the impairment described likely to be: A. Temporary_____; B. Long Term_____; C. Permanent_____; D. Unknown_____	

ADDITIONAL MOBILITY QUESTIONS	YES	NO
5. Would any medical restrictions change the above ratings? (Attach restrictions)		
6. Is inmate at risk of falling?		
7. Has the inmate fallen recently?		
8. Does the inmate require special housing or housing adaptations?		
Does the inmate require specialized institutional assignment?		
9b. If yes, indicate recommended assignment (e.g. infirmary, special needs unit, general population)		

Nurse Signature _____ Date _____

Attachment III

TRANSFER HEALTH INFORMATION

Sending Facility: _____ Date: _____ Time: _____

Receiving Facility_____ Date of Transfer:_____

Allergies/Drug Sensitivities: _____

Current Acute Health Problems: _____

_____

Chronic Health Problems: _____

_____

Current Medications (Name, Dosage, Frequency, Duration, Route):_____

_____

_____

Other Treatment: _____

Follow-up Care Needed: _____

_____

Other Significant Medical History: _____

_____

Restrictions (Dietary, Housing, Employment): _____

Pending Specialty Referrals (Appointment date if available): _____

hysical Disabilities / Limitations: _____

Assistive Devices / Prosthetics: _____ Eyeglasses: ☐ Yes ☐ No

MENTAL HEALTH HISTORY:

Substance Abuse: ☐ Yes ☐ No Specify:_____

☐ History of Suicide Attempt: Date of last attempt: _____

☐ History of Psychotropic Medication Specify:_____

TB INFORMATION

Date of last PPD_____ Result: ☐ Negative ☐ Positive mm:_____

Date of last chest x-ray_____ Result:_____

☐ History of TB prophylaxis: Medication_____ Start Date_____ Stop Date_____

☐ History of treatment for TB disease: Medication_____

Start Date_____ Stop Date_____

_____

Nurse Signature, Title Date/Time

Transfer Health Information
Commonwealth of Pennsylvania
Department of Corrections
DC-487

Inmate Name:

Inmate Number:

DOB:

Institution:

APPENDIX H: LONG-TERM CARE UNIT POLICIES AND PROCEDURES

Kathy Zwierzyna
Director, Health Care

POLICY STATEMENT
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject: Long Term Care Unit Referral Process		Policy Number: 13.7.2
Date of Issue: September 17, 1997	Authority:	Effective Date: September 17, 1997

I. AUTHORITY:

The Authority of the Commissioner of Corrections to direct the operation of the Department of Corrections is established by Sections 201, 206, 506, and 901-B of the Administrative Code of 1929, Act of April 9, 1929, P.L. 177, No. 175, as amended.

II. PURPOSE:

The purpose of this policy is to establish guidelines and procedures for referral and admission to, and discharge from the Long Term Care Unit at SCI Laurel Highlands.

III. APPLICABILITY:

This policy is applicable to all Department of Corrections' inmates and employees including contracted health care providers.

IV. DEFINITION:

Geriatric Care Health related care and services provided to inmates who require either intermittent care and/or occasional assistance with activities of daily living.

Intermediate Care Health related care and services, other than hospital or skilled nursing care, provided by licensed and qualified personnel to inmates because of a medical or mental health condition.

Long Term Care Admission Committee A committee composed of staff from the long term care facility: including the Deputy for Centralized Services, the Inmate Program Manager, Psychologist, Corrections Health Care Administrator and the Intelligence Captain.

Long Term Care Coordinator The Corrections Health Care Administrator or designee at SCI Laurel Highlands who is responsible for coordinating admissions to and discharges from the Long Term Care Unit.

Long Term Care Unit A unit designed to provide long term medical treatment and nursing care to those inmates who have a medical or mental health condition whereby the inmate is unable to function in general population.

Skilled Care Professionally supervised nursing care and related medical and other health services provided on an inpatient basis in a long term care facility other than a hospital for a period exceeding twenty-four hours.

V. POLICY:

It is the policy of the Department of Corrections to establish a Long Term Care Unit designed to meet the needs of inmates who, because of certain medical or mental health conditions are unable to function in the general population, a special needs unit and/or have exhausted other treatment sources.

VI. PROCEDURE:

A. Admission Criteria

To be eligible for admission to the long term care unit, an inmate must have:

1. A diagnosis of a significant medical or mental health condition or illness which requires active nursing and medical care; or

2. A physical or mental health condition which prevents the inmate from independently caring for the activities of daily living and personal hygiene needs; or

3. A need for geriatric, intermediate, or skilled nursing care.

B. Referral Process

The following process shall be used to refer inmates to the Long Term Care Unit:

1. The Long Term Care Referral Form (Attachment I) and the Activities of Daily Living Assessment Form (Attachment II) must be completed and submitted to the Bureau of Health Care Services, Clinical Coordinator for review.

2. When tenative approval is received the referring institution will forward a transfer petition to the Bureau of Inmate Services.

3. The final approval for admission is made by the Bureau of Health Care Services in consultation with the Bureau of Inmate Services, and the Long Term Care Admission Coordinator.

4. Immediately prior to the inmate's transfer, the sending facility will complete the Transfer Health Information Form (Attachment III) and forward the form to the Long Term Care Coordinator.

C. Discharge

An inmate may be discharged from the Long Term Care Unit when:

1. The Long Term Care Unit Medical Director assesses the inmate and documents that the need for Long Term Care has been resolved; and

2. The inmate demonstrates the ability to manage medical conditions with periodic support by medical staff; and

3. Discharge planning is arranged with the receiving facility.

VII. SUSPENSION DURING EMERGENCY:

In an emergency situation or extended disruption of normal institutional operation, any provision or section of this policy may be suspended by the Commissioner or his/her designee for a specific period of time.

VIII. RIGHTS UNDER THIS POLICY:

This policy does not create rights in any person nor should it be interpreted or applied in such a manner as to abridge the rights of any individual. This policy shall be interpreted to have sufficient flexibility so as to be consistent with law and to permit the accomplishment of the purpose of the policies of the Department of Corrections.

IX. SUPERSEDED POLICY AND CROSS-REFERENCE:

A. Supersedes: 13.7.2 South Mountain Referral and Transfer Process Policy, February 5, 1996.

B. Cross Reference:

1. Administrative Manual: N/A

2. ACA: 3-4292, 3-4343, 3-4344, 3-4348, 3-4357, 3-4360

POLICY STATEMENT
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject:		Policy Number:
Long Term Care Unit Referral		13.7.2
Date of Issue:	**Authority:** Draft Date: 5-17-99 Martin F. Horn	**Effective Date:**

DRAFT

I. AUTHORITY

The Authority of the Secretary of Corrections to direct the operation of the Department of Corrections is established by Sections 201, 206, 506, and 901-B of the Administrative Code of 1929, Act of April 9, 1929, P.L. 177, No. 175, as amended.

II. PURPOSE

The purpose of this policy is to establish guidelines and procedures for referral, admission to, and discharge from the Long Term Care Unit at SCI Laurel Highlands.

III. APPLICABILITY

This policy is applicable to all Department of Corrections inmates and employees including contracted health care providers.

IV. DEFINITIONS

All the definitions for this document are contained in the procedure manual concerning this document.

V. POLICY

It is the policy of the Department of Corrections to establish a Long Term Care Unit designed to meet the needs of inmates who, because of certain medical or mental health conditions, are unable to function in the general population, a special needs unit and/or have exhausted other treatment sources[1].

[1] 2-CO-4E-01, 3-4292, 3-ACRS-4E-01, 3-ACRS-4E-21, 1-ABC-4E-05, and 1-ABC-4E-35.

VI. PROCEDURES

All pertinent procedures and/or terms are contained in the procedure manual for this policy.

VII. SUSPENSION DURING AN EMERGENCY

In an emergency or extended disruption of normal institutional operation, the Secretary, or designee may suspend any provision or section of this policy, for a specific period of time.

VIII. RIGHTS UNDER THIS POLICY

This policy does not create rights in any person nor should it be interpreted or applied in such a manner as to abridge the rights of any individual. This policy should be interpreted to have sufficient flexibility so as to be consistent with law and to permit the accomplishment of the purpose(s) of the policies of the Department of Corrections.

IX. RELEASE OF INFORMATION AND DISSEMINATION OF POLICY

A. Release of Information

1. Policy

This policy document is public information and may be released to members of the general public, staff, legislative, judicial, law enforcement and correctional agencies and/or inmates upon request.

2. Procedure Manual (if applicable)

The procedure manual for this policy is not public information and shall not be released in its entirety or in part, without the prior approval of the Secretary of Corrections or designee. This manual or parts thereof, may be released to any Department of Corrections employee on an as needed basis.

B. Distribution of Policy

1. General Distribution

The Department of Corrections' policy and procedure manuals (when applicable) shall be distributed to the members of the Central Office Executive Staff, all Facility Managers, and Community Corrections Regional Directors on a routine basis. Distribution to other individuals and/or agencies is subject to the approval of the Secretary of Corrections or designee.

2. Distribution to Staff

It is the responsibility of those individuals receiving policies and procedures, as indicated in the "General Distribution" section above, to ensure that each employee

expected or required to perform the necessary procedures/duties is issued a copy of the policy and procedures.

X. SUPERSEDED POLICY AND CROSS REFERENCE

A. Superseded Policies

1. Department Policy

~~a. 13.7.2 South Mountain Referral and Transfer Process Policy issued February 5, 1996, by Secretary Martin F. Horn.~~

a. 13.7.2, Long Term Care Unit Referral Process issued September 17, 1997 by Secretary Martin F. Horn.

2. Facility Policy and Procedures

This document supersedes all facility policy and procedures on this subject.

B. Cross Reference(s)

1. Administrative Manuals:

   a. 13.6.1 Maintenance of Inmate Medical Records Manual

C. ACA Standards

1. Administration of Correctional Agencies: 2-CO-4E-01.
2. Adult Correctional institutions: 3-4292,3-4343, 3-4344, 3-4348, 3-4357, 3-4360, and 3-4361.
3. Adult Community Residential Services: 3-ACRS-4E-21, 3-ACRS-4E-28, and 3-ACRS-4E-29.
4. Adult Correctional Boot Camp Programs: 1-ABC-4E-01, 1-ABC-4E-05, 1-ABC-4E-26, 1-ABC-4E-35, 1-ABC-4E-38, 1-ABC-4E-39, and 1-ABC-4E-54.
5. Correctional Training Academies: None.

PROCEDURES MANUAL
Commonwealth of Pennsylvania • Department of Corrections

Policy Subject:		Policy Number:
Long Term Care Unit Referral		13.7.2
Date of Issue:	**Authority:** Draft Date: 5-25-99 Martin F. Horn	**Effective Date:**

DRAFT

Release of Information:

Policy Document: The Department of Corrections' policy document on this subject is public information and may be released to members of the general public, staff, legislative, judicial, law enforcement and correctional agencies and/or inmates upon request.

Procedure Manual: This Procedure Manual is **not public information** and will not be released in its entirety or in part, without the prior approval of the Secretary of Corrections or designee. This manual or parts thereof, may be released to any Department of Corrections employee on an as needed basis.

Procedure Development: All required procedures will be developed in compliance with the standards set forth in this manual and/or the governing policy. These standards may be exceeded, but in all cases, these standards are the minimum standard that must be achieved. In the event a deviation or variance is required, a written request is to be submitted to the appropriate Regional Deputy Secretary and the Standards and Practices Unit for review and approval prior to implementation. Absent such approval, all procedures set forth in this manual must be met.

Long Term Care Unit Referral Process

DRAFT

Table of Contents.

I. DEFINITIONS

A. BHCS

Bureau of Health Care Services.

B. CHCA

Corrections Health Care Administrator.

C. LONG TERM CARE UNIT

A unit designed to provide long term medical treatment and nursing care to those inmates who have a medical or mental health condition whereby the inmate is unable to function in general population.

E-D. PERSONAL CARE UNIT

A unit designed to provide health related care and services to inmates who require either intermittent care and/or assistance with activities of daily living.

II. PROCEDURES

A. Admission Criteria[1]

To be eligible for admission to the Long Term Care or Personal Care Unit, an inmate must have:

1. A diagnosis of a significant medical or mental health condition or illness which requires significant nursing and medical care; or
2. A physical or mental health condition which prevents the inmate from independently caring for the activities of daily living and personal hygiene needs.

[1] 3-4357, 3-4360, 3-ACRS-4E-8, 3-ACRS-4E-8-1, 1-ABC-4E-21, 1-ABC-4E-38, and 1-ABC-4E-39

B. **Referral Process**

The following process shall be used to refer inmates to the Long Term Care or Personal Care Unit:

1. The **Long Term Care Referral Form, DC-503, (Attachment I)**, and **the Functional Needs Assessment Survey Form, DC-502, (Attachment II)**, must be completed and submitted to the Bureau of Health Care Services (BHCS) Clinical Coordinator and the Corrections Health Care Administrator (CHCA) or designee of the Long Term Care/Personal Care Unit for review[2].

2. When tentative approval is received, the referring facility will forward a permanent transfer petition to the Diagnostic and Classification Coordinator, Bureau of Inmate Services.

3. The final approval for admission is made by the Clinical Coordinator, BHCS, in consultation with the Diagnostic and Classification Coordinator, Bureau of Inmate Services, and the CHCA or designee of the Long Term Care/Personal Care Unit.

4. Immediately prior to the inmate's transfer, the referring facility will complete the **Transfer Health Information Form, DC-487, (Attachment III)**, and forward the form to the CHCA or designee of the Long Term Care/Personal Care Unit[3].

C. **Discharge**

An inmate may be discharged from the Long Term Care or Personal Care Unit when:

1. The Long Term Care/Personal Care Unit Medical Director or designee assesses the inmate and documents[4] that the need for Long Term Care/Personal Care has been resolved;

2. The inmate demonstrates the ability to manage medical conditions with periodic support by medical staff, and

3. Discharge planning is arranged with the receiving facility.

[2] 3-4343, 3-4344, 3-4361, 3-ACRS-4E-28, 3-ACRS-4E-29, 1-ABC-4E-38, and 1-ABC-4E-39
[3] 3-4348, and 1-ABC-4E-54.
[4] 1-ABC-4E-26

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LONG TERM CARE REFERRALS

Admitting Diagnosis: _____

Present Level of Care: ☐ *Long Term Care* ☐ *Personal Care*

Age:_____ Custody Level:_____

Crime:_____

Behavior Adjustment (May use PACT description): _____

_____

_____

_____

(For BHCS Use Only)
DATE:
Received: _____
Reviewed:_____
Approved:_____
Transferred:_____

Primary Medical Referral:_____

_____

_____

_____

Medical Equipment:_____

_____

_____

_____

Psychiatric History:_____

_____

_____

_____

_____ _____
Nurse Signature Date

LONG TERM CARE REFERRAL
Commonwealth of Pennsylvania
Department of Corrections
DC-503

Inmate Name:

Inmate Number:

DOB:

Facility:

DRAFT

FUNCTIONAL NEEDS ASSESSMENT SURVEY

NATURE OF PLACEMENT:					
Temporary:		Permanent:			
Medical History: (Check all that apply)					
Mental Illness:		Nervous System Disorders:		Dementia:	
Medication:					
Current Medications (by general categories, including over the counter):					

NUTRITIONAL ASSESSMENT		
Does the Inmate:	Yes	No
1. Generally have a good appetite?		
2. Usually attend three meals a day?		
3. Appear to have maintained a proper body weight?		
4. Eat food that aids in proper nutrition?		
5. Have a need for special diet plan ordered by the medical department?		
6. Follow the recommended diet plan?		
7. Have the ability to chew properly?		
8. Have the ability to swallow food without difficulty?		
9. Have the ability to eat all food?		
10. Appear to be absent of nutritional problems?		

FUNTIONAL NEEDS ASSESSMENT SURVEY
Commonwealth of Pennsylvania
Department of Corrections
DC-502

Inmate Name:

Inmate Number:

DOB:

Facility:

DRAFT

FUNCTIONAL NEEDS ASSESMENT SURVEY

Functional Assessment		
Assessment Codes: 1=Can do alone 2=Can do with Assistance 3=Unable to do 4=Undetermined		
Function	Code	Comments
1. Bathing or showering		
2. Shampooing		
3. Nail Care		
4. Hair Care		
5. Dressing		
6. Bowel and Bladder		
7. Transferring in and out of bed or chair		
8. Walking		
9. Stairs		
10. Does patient have history of falls?		

Patient Care Requirements			
	Yes	No	Comments
1. Catheter			
2. Colostomy			
3. Oxygen/Respiration Equipment			
4. Walker			
5. Wheelchair			

Signature / Title Date

DRAFT

TRANSFER HEALTH INFORMATION

Receiving Facility: _____ Date of Transfer: _____

	Yes	No	If Yes, Specify
Allergies/Drug Sensitivities			
Chronic/Acute Health Problems			
Current Medications (Name, Dosage, Frequency, Duration, Route)			
Current Treatment Plan			
Follow-up Care Needed			
Significant Medical History			
Restrictions (Dietary, Housing, Employment)			
Pending Specialty Referrals (Appointment Date)			
Physical Disabilities/Limitations			
Eyeglasses			
Dentures			
Assistive Devices/Prosthetic			
Mental Health Problem			
History of Suicide Attempt			Date of last attempt:
History of Psychotropic Medication			
History of Substance Abuse			
Last PPD	Date:		Result: ☐Negative ☐Positive mm:
Last Chest x-ray	Date:		Result:
History of TB prophylaxis	Medication: Start Date:		Stop Date:
History of treatment for TB disease	Medication: Start Date:		Stop Date:

_____

Nurse Signature, Title Date/Time

Transfer Health Information
Commonwealth of Pennsylvania
Department of Corrections
DC-487

Inmate Name:

Inmate Number:

DOB:

Facility:

APPENDIX I: SPECIAL NEEDS UNIT (SNU) POLICIES

COMMONWEALTH OF PENNSYLVANIA
Department of Corrections

December 12, 1994

SUBJECT: SPECIAL NEEDS UNIT POLICY - 7.3.6

TO: All Superintendents/Commander
Bureau Directors

FROM: Laurence J. Reid
Executive Deputy Commissioner

Attached you will find a new policy relative to the operation of Special Needs Units. This policy supersedes and replaces the advisory memorandum of December 16, 1988, entitled Special Needs Units.

This new policy sets forth the procedure under which Special Needs Units (SNU) will operate and require each facility with an SNU to develop a unit operations manual. This manual must be submitted to the appropriate Regional Deputy Commissioner for approval. The procedures also set forth admission and discharge criteria, and a monitoring element which requires monthly reports to the SCAN system.

Please distribute this policy to the appropriate staff locally. Address any questions relative to this policy to the appropriate Regional Deputy Commissioner or your supervisor.

LJR:je
Attachment

cc: Commissioner Lehman
Deputy Clymer
Deputy Fulcomer
Deputy Beard

POLICY STATEMENT

Commonwealth of Pennsylvania • Department of Corrections

Policy Subject:		Policy Number:
SPECIAL NEEDS UNIT POLICY		7.3.6
Date of Issue:	Authority:	Effective Date:
December 12, 1994		Feb. 15, 1995

I. AUTHORITY

The authority of the Commissioner of Corrections to direct the operation of the Department of Corrections is promulgated by Sections 201, 206, 506, and 901-B of the Administrative Code of 1929, Act of April 9, 1929, P.L. 177, No. 175, as amended.

II. PURPOSE

The purpose of this policy is to establish uniform procedures for the handling of inmates who are unable to adjust to the general population of a facility due to a physical, emotional or mental limitation. It is also the purpose of this policy to set forth procedures for the operation of a Special Needs Unit (SNU) and to define who has access to this unit.

III. APPLICABILITY

This policy is applicable to all institutions within the Department of Corrections.

IV. DEFINITIONS

A. DPW Forensic Mental Health Unit

Refers to the forensic mental health units operated by the Office of Mental Health in the Department of Welfare (DPW). The male forensic unit is located at Farview State Hospital, while female DPW forensic units are located at Norristown State Hospital and Mayview State Hospital.

B. General Population Housing Unit

A general population housing unit is a general housing unit within which an inmate may engage in various educational, vocational, and treatment programs.

C. Individual Treatment Plan (ITP)

An Individual Treatment Plan (ITP) is a series of written statements specifying the particular course of treatment and the roles of staff in carrying it out. It is based on an assessment of the inmate's needs, and it includes a statement of short and long-term goals as well as the methods by which these goals will be pursued. When clinically indicated, the treatment plan gives inmates access to the range of supportive and rehabilitative services (such as physical therapy, individual or group counseling, and self-help groups) that the treatment team deems appropriate. To the extent feasible, the inmate shall participate in the development of his/her ITP.

D. In-House Mental Health Unit

Refers to the certified mental health units housed within DOC correctional facilities. These units are operated by vendors under contract to the Department of Corrections. They are licensed and monitored by the Department of Public Welfare (DPW).

E. Mental Health Cases

Inmates who have a mental health stability score of 3 or above, are listed on the institution's Mental Health/Mental Retardation roster, or in the opinion of mental health professionals, may be suffering from a serious mental illness.

F. Mentally Retarded

Refers to individuals whose general intellectual functioning is subaverage and exists concurrently with deficits in adaptive behavior with onset before age 18. Subaverage intelligence is defined as a score on a standard intelligence test of 70 or below.

G. Program Review Committee

A panel of three (3) members consisting of the two (2) Deputy Superintendents, Inmate Program Manager, or Unit Manager. The Superintendent may designate appropriate substitutes. The Program Review Committee conducts Administrative Custody hearings, thirty

(30) day reviews, makes decisions about continued confinement in the RHU/SMU, and hears all appeals of misconducts.

H. Psychiatric Review Team

A team, chaired by the institution's Chief Psychologist or designee, and including the Consultant Psychiatrist, the Unit Manager, and such other staff as may be designated by the institution's Chief Psychologist with input from the Unit Manager or the Inmate Program Manager of the facility. The Psychiatric Review Team reviews the cases of those inmates who experience adjustment or behavioral difficulties related to emotional or mental health problems and who require more in-depth evaluation, and closer monitoring and support. This team may also be referred to as the Multidisciplinary Mental Health Review Team.

I. Serious Mental Illness

A substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or cope with the ordinary demands of life.

J. Special Needs Unit

A housing unit established to provide a safe and secure setting and specialized treatment services for those inmates identified as being unable to function in a general population housing unit. Inmates in this category may include those diagnosed as mentally ill, emotionally unstable, mentally retarded, physically or developmentally challenged. Placement does not require the mental health commitment process.

K. Unit Manager

The individual who is responsible for the supervision of all members of the Unit Management Team and the delivery of security and program services.

L. Unit Management Team

The individuals assigned to operate a housing unit with the responsibilities for security, risk management, and program delivery. The team is composed of, at a minimum, a Unit Manager, Corrections Officers, and a counselor. Other staff may be assigned to the team or provide supportive services to the unit.

V. POLICY

It is the policy of the Department of Corrections to maintain Special Needs Units (SNU) for inmates who are unable to function within the normal prison environment as a result of a physical, emotional or mental limitation. These units provide a controlled environment for their protection and treatment programming aimed at improving their overall level of functioning. Treatment efforts are to focus on reintegration into general population.

VI. PROCEDURES

A. Institution Responsibilities

Security Level 3 and Security Level 4 institutions will operate an SNU in accordance with this policy. Each facility with an SNU is responsible for developing a unit operations manual and local procedures consistent with this policy. The manual and any revisions must be reviewed and approved by the respective Regional Deputy Commissioner. A yearly review of all procedures and post orders governing the SNU operations is to be conducted by unit staff and reviewed by the Superintendent. All revisions, approvals and yearly reviews are to be maintained in the operations manual.

B. Admission Criteria and Process for Transfer

1. The SNU is for inmates with physical, mental, emotional or other limitations which make them unable to adjust in general population. Inmates from all age groups, custody levels (except 5), program codes, and sentence structures are eligible. The following limitations are among those that can be considered:

   a) mental health cases
   b) physical disabilities or illness
   c) severe psychological or personality problems (e.g. overwhelming anxiety, inadequate personality, etc.)
   d) sensory impairment
   e) mental retardation
   f) age
   g) severe emotional or nervous disorders such as Post Traumatic Stress Disorder, Bulimia, or Tourette's Syndrome
   h) Other relevant limitations

2. Referrals from within the facility may be made from unit teams, medical or psychological staff, PRC, PRT or any other staff member who perceives an inmate as having adjustment

difficulties due to a limitation. The referral will be made to the SNU unit management team, who will screen and evaluate the referred inmate. Following the evaluation, the SNU staff will prepare a vote sheet recommending for or against SNU placement. The recommendation will, at a minimum, be forwarded for administrative staff review and action through the Inmate Program Manager and Deputy Superintendents. The Superintendent must review any split votes regarding SNU program admission or rejection.

3. In an emergency situation, the senior official in charge of the facility may authorize immediate admittance into the unit. This decision, however, is subject to review as noted in VI B 2, and will be completed on the next normal working day.

4. Referrals from other institutions where there are no SNU's (such as Security Level 2 facilities) or from Security Level 3 or 4 institutions that have an inmate whose special needs they cannot accommodate or where a separation is required, can be considered. Transfer requests will be via the regular petition process as outlined in the Classification Policy Statement 11.2.1, Chapter V-02. Inmates on the Mental Health Tracking System will require an ITP per Supplement I of 11.2.1.

5. In those cases where an inmate has been approved for SNU placement, and where space within the program does not exist, staff will prioritize placement into the program. The following criteria will be utilized.

   a) ability to function within general population
   b) alternative placements available
   c) length of time inmate is likely to be in program
   d) programming offered in the SNU
   e) objectives of the inmate's individualized treatment plan

   Inmates with greater need, where alternative placement is not suitable or more restrictive than required, who can benefit from the program and who have time to do so shall be given the greater priority.

6. Every attempt should be made to place any inmate needing SNU programming into a suitable unit within 30 days of the initial evaluation. This would include transfer to other institutions of suitable security level where space is available.

7. In those cases where an inmate is seriously disruptive within the unit, the SNU management team will determine the appropriate housing.

C. SNU Usage Monitoring and Inter-Institutional Transfers

1. SNU usage will be reported monthly in the SCAN report. The following information will be included:

   a. Capacity of SNU;
   b. Number in SNU at beginning of month;
   c. Number admitted to SNU during the month;
   d. Number released from SNU during the month and;
   e. Number in SNU at end of month.

2. The Bureau of Inmate Services will maintain waiting lists and will coordinate the transfer of inmates who have been approved for transfer and placement into another facility's SNU.

3. The parent facility which initiated the transfer request to another facility's SNU will make the inmate available for transfer once the transfer petition is approved by Central Office.

4. Facilities with SNU's and who have available beds in the unit(s) will report the available beds to Central Office in the daily bed report.

D. SNU Individual Treatment Plan

Within 14 days of admission to the SNU, the SNU staff will complete an ITP. (See admission form and completion guidelines attached). SNU staff will review the ITP every 120 days and make appropriate revisions.

E. Treatment Programming

1. The SNU will offer at least 35 hours of programming per week for all inmates housed in the SNU. This programming may include two (2) hours each day of unstructured recreational activity. Participation in employment or educational programs is also to be included in the total number of hours.

2. Programming will be assigned to inmates on an individual basis by being incorporated into the SNU ITP.

3. All programming will be designed to stabilize and stimulate special needs inmates with the ultimate goal, where appropriate, of re-integration into a general population housing unit.

4. Appropriate inmates in special needs housing will be encouraged to attend group activities and other programs with

general population inmates.

5. A suggested menu of programming for special needs inmates is as follows:

Group Therapy	Recreation
Anger Management	Aerobics
Self Esteem	Special Exercise Class
* Medication Compliance	Recreational Therapy
Hygiene Group	Art Therapy
Prison Adjustment	Music Therapy
Drug & Alcohol	Specially Designed Tournaments
Sex Offender	Bingo
Support Based Groups	Structured Card Games
Daily Living Skills	Yard-Out Activities
Inter-Personal Relations	Sports Activities
Communication Skills	
Stress Management	
Human Sexuality	

Religion	Education
Religious Studies	ABE
Regular Services	GED
Musical Group or Choir	Life Skills
	Literacy

Employment

Regular Institution Inmate Details
Specially Designed Details for Special Needs Inmates
Block Workers
Janitors

* Required in all units which deal with inmates who have mental health problems.

6. Programming may be designed to be provided in the SNU. Enlistment of a variety of institutional staff or community volunteers is essential in development of appropriate programs.

F. Staffing

Staffing needs for each SNU will vary based on the unit's size, physical structure, type of inmates serviced, etc. Minimum requirements have been established. Other staff should be utilized as time, space, and resources allow. * Note: some institutions may have

specific staffing requirements due to court orders.

1. Minimum Staffing Requirements

- Unit Manager

  The Unit Manager is responsible for supervision of all members of the treatment team as well as the delivery of security and program services for the SNU. The Unit Manager will work in conjunction with other supervisors/department heads in providing staff and services for the unit. The Unit Manager will chair the selection and discharge committee, attend unit meetings, and will visit the unit on a daily basis (M-F), if space does not permit a permanent office on the unit.

- Corrections Officers

  Officers must be selected to work in the SNU by a committee consisting of at least the Unit Manager, Major, Shift Commander, and/or Zone Lieutenant. The committee will select those officers who have demonstrated ongoing interest in and effective management skills with special needs inmates. Officer assignment to the unit should be on a regular basis to foster investment in the program as well as to maintain continuity of care. When possible, regular alternate officers should be selected to replace primary officers during off days, vacation or illness. These alternates can also be used to replace the primary officers when they are rotated or otherwise leave the unit.

- Psychological Staff

  A member of the psychology staff will be responsible for providing ongoing monitoring, individual and group therapy, developing individual treatment programs as well as required assessments and reports. The psychology staff member should visit the unit on a daily basis and attend all unit meetings. The Policy Standards Manual recommends one (1) psychology staff member for each 150 special needs inmates. Staff should be assigned based on unit size. For instance, in a unit with 75 inmates, a psychology staff member would be assigned for 20 hours per week.

- Corrections Counselor

  Counselors will manage the casework duties for all inmates assigned to the unit. They will complete all necessary reports, staffings, assist in the development of individualized treatment

plans, and provide individual and group counseling. Counselors will attend all unit meetings and visit the unit on a daily basis (M-F), if space does not permit a permanent office on the unit. The Policy Standards Manual recommends one (1) counselor for each 75 special needs inmates. Thus, a unit with 25 inmates would have a counselor assigned approximately 13 hours per week.

- Chief Institutional Psychologist and Psychiatrist

  The chief institutional psychologist and psychiatrist will serve as consultants for program development and staff training and will provide services to the unit as needed.

2. Centralized Services Staff

   Staff from other departments may be assigned to the unit to provide specific services. Any assignments should be by the same person to foster investment in the program and maintain continuity of care. When possible, services should be provided on the unit. The following list is not mandatory nor is it all inclusive:

   - Medical Staff

     Nursing staff assigned to the unit should monitor the medical needs of the inmates on the unit, medication compliance, coordinate psychiatric referrals, and provide health and hygiene education.

   - Activities Staff

     Corrections activities staff should provide structured recreational programming, plan and run special events, and coordinate the scheduling of space, supplies, and equipment. Requests for funding for supplies and equipment may be submitted to the Inmate General Welfare Fund through the activities department.

   - Educational Staff

     Special education programs should be developed in accordance with the needs of the inmates being serviced in the unit.

   - Drug and Alcohol Specialists

     Drug and alcohol treatment staff should develop and implement programs for dually diagnosed individuals and others with drug and alcohol problems.

- Contracted Services

  Institutions which have specific services provided by contracted vendors should review their agreements and, in conjunction with the director of the service, provide services for those inmates in need. Services such as art, music, recreational or occupational therapists may be obtained utilizing the Inmate General Welfare Fund as the funding source.

- Volunteer/Student Interns

  When possible and appropriate, community volunteers or groups should be utilized to provide support services. Institutions with student intern programs may assign students from appropriate fields to work in the unit.

3. Staff Training and Development

   All contact staff in the institution will receive basic training in suicide prevention and signs and symptoms of mental illness. SNU staff should receive additional, ongoing training in such areas as behavior modification, conflict intervention, managing the mentally retarded, etc.

G. Discharge and Transfer Procedures

1. Inmates will be considered for discharge by the SNU management team when they no longer need the security, structure or programming provided by the unit. This process is also to be used when alternate housing may be appropriate for seriously disruptive inmates.

2. The recommendation for discharge of the inmate to general population or to other housing will be done via vote sheet by the SNU management team. Included in the body of the vote sheet will be a discharge summary that documents the inmate's progress, reasons for completion, and recommendations for future programming and continuing care. The vote sheet will be sent, at a minimum, through the Inmate Program Service Manager and Deputy Superintendents for final action. The Superintendent must review all split votes.

3. In those cases where the inmate is to be returned to another institution, a transfer petition will be submitted as prescribed in 11.2.1. Inmates on the Mental Health Tracking System must have an Individual Treatment Plan attached to the petition per 11.2.1 Supplement I.

VII. SUSPENSION DURING EMERGENCY

In an emergency situation or extended disruption of normal institution operation, any provision or section of this policy may be suspended by the Commissioner or his/her designee for a specific period of time.

VIII. RIGHTS UNDER THIS POLICY

This policy does not create rights for any person nor should it be interpreted or applied in such a manner as to abridge the rights of any individual. This policy should be interpreted to have sufficient flexibility so as to be consistent with law and permit the accomplishment and purpose of the policies of the Department of Corrections.

IX. SUPERSEDED POLICY AND CROSS REFERENCES

This policy establishes procedures for the operation of SNU's within the Department of Corrections. It supersedes the Advisory memorandum entitled Special Needs Unit of December 16, 1988.

POLICY CROSS REFERENCES

Mental Health Procedures Policy 7.3.1, issued 2/26/93
Classification Policy 11.2.1, issued 9/1/93
Psychiatric Outpatient Clinics, 55 PA Code Chapter 5200
Policy Standards Manual, issued 7/7/93

ACA CROSS REFERENCES

3-4292, 3-4330, 3-4336, 3-4337,
3-4349, 3-4355, 3-4360, 3-4369

SNU INDIVIDUAL TREATMENT PLAN

(1)NAME _____ (2)DC# _____ (3)ASSIGNED PSA _____

(4)CD CODE _____ (5)ASSIGNED PSYCHIATRIST _____

(6)DATE OF LAST TREATMENT PLAN REVIEW _____

(7)PROBLEMS & GOALS MINIMUM OF (2)	(8)TREATMENT OBJECTIVES (OBSERVABLE & MEASURABLE)				(9)OBJECTIVES TARGET DATE
TREATMENT MODALITIES CHECK ALL THAT APPLY	PROJECTED FREQUENCY & DURATION OF TREATMENT				( )ANTICIPATED LENGTH (10) OF TREATMENT
	Once/wk	Twice/wk	Every 2 wks	Once/Mo	Up to 3 Mos. _____ Up to 6 Mos. _____ More than 1 year _____
(11)INDIVIDUAL					
(12)GROUP					
(13)COLLATERALS					
(14)EDUCATION					
(15)OTHER (SPECIFY)					

REVIEW/UPDATES

Review and Update Treatment Plan on a new form as follows:

1. Initial Review (to be completed within 14 days of admission).
2. SNU reviews a minimum of one every 120 days.
3. At the request of Unit Manager.

_____ _____ _____ _____

(16)Client Signature Date (18)Counselor Signature Date

_____ _____ _____ _____

(17)PSA Signature Date (19)Psychiatrist Signature Date (20)Unit Manager Signature Date

SNU ITP GUIDELINES FOR COMPLETION

1, 2, 3 and 5	Require identifying information so that client and staff are aware of assigned responsibilities. Assigned staff may not necessarily be the same staff who develop and sign the SNU ITP below.
#4	ICD code is requested since problems and goals should be developed with the diagnosis in mind.
#6	If initial SNU ITP then it should be noted in the space provided.
#7	Problems and goals should be stated in descriptive terms.
#8	How the frequency/duration of targeted goals will be changed need to be stated in behavioral terms.
#9	The time frame to accomplish this should be a reasonable estimate to affect change.
#10	This is the estimated time frame established until general population placement may be feasible.
#11, 12	Any staff reviewing the SNU ITP will be able to discern the treatment modality and frequency.
13	This category includes inmate relatives, close friends or staff/volunteers from other agencies. Also staff (work supervisor, administrators, C.O.'s) or institutional volunteers who may have an ongoing relationship/rapport with the client and may want to offer encouragement and motivation to the client.
#14	Educational participation may enhance communication skills.
#15	Programs (institutional and/or volunteer) may be attended by SNU residents off site with permission of administrative staff.
#16	If client refuses to sign – refusal to sign procedure should be followed.
#17, 19	PRT members or designee.
#18, 20	SNU Counselor and Unit Manager or designee.

SNU INDIVIDUAL TREATMENT PLAN

AME: ______________________ DC# __________

(1)DATE:	(5)PROGRESS NOTE:
(2)TIME:	
(3)TIME SPENT: (4)DEPT:	(6)COMPLETED BY: DATE:
DATE:	PROGRESS NOTE:
TIME:	
TIME SPENT: DEPT:	COMPLETED BY: DATE:
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TIME:	
TIME SPENT: DEPT:	COMPLETED BY: DATE:

SNU INDIVIDUAL TREATMENT PLAN
PROGRESS NOTES
GUIDELINES FOR COMPLETION

#1 Document date of contact with client.

#2 Document time of contact.

#3 Document duration of time of contact.

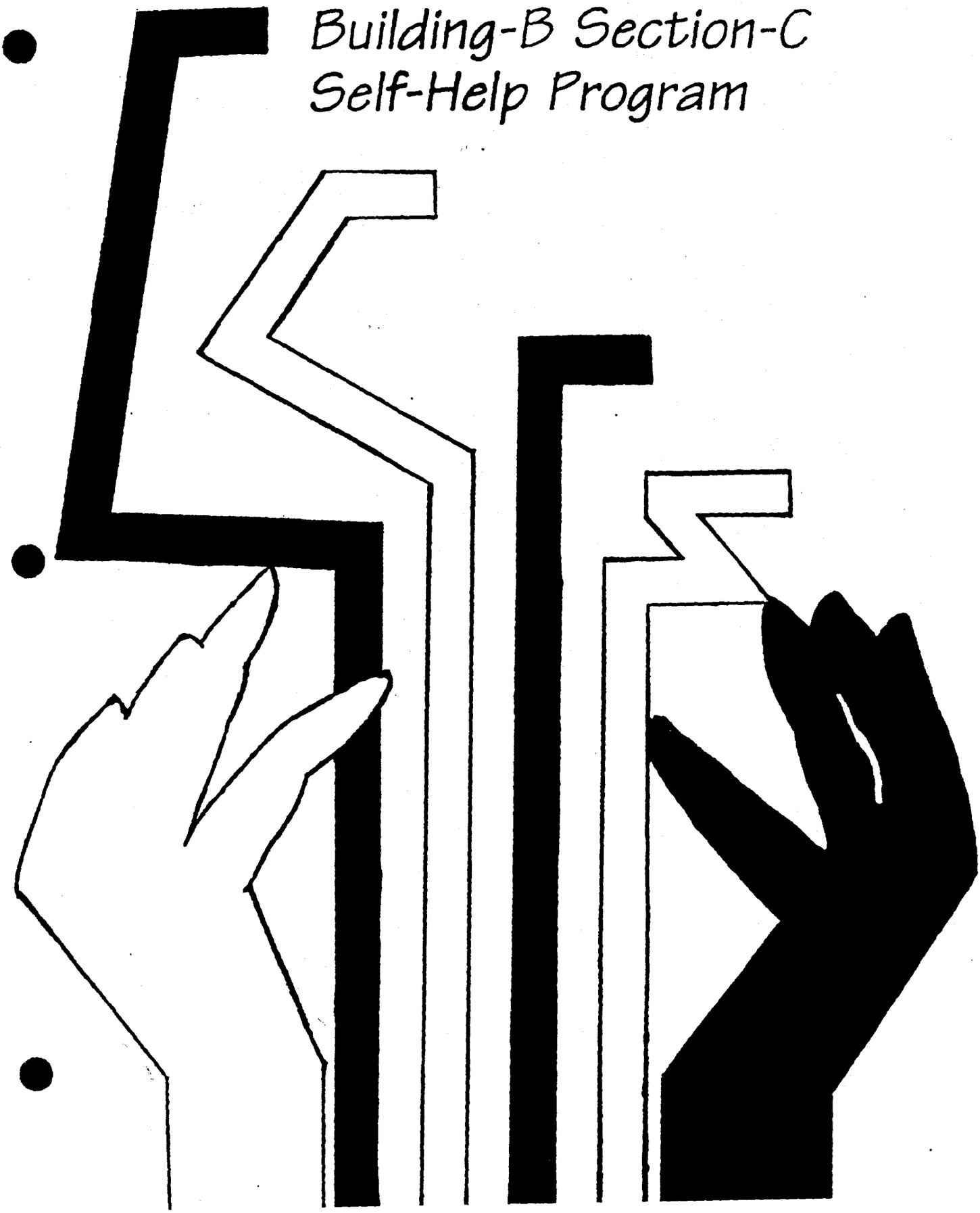
#4 Department should be specified since this may not be apparent by signature of staff only. This will make statistical reporting easier to tally.

#5 Enter brief note on progress.

#6 Staff signature to document content of progress note. Date may differ from date of contact since entry may not be made immediately after contact. With multi-departmental documentation, staff may be making entries out of chronological (date of contact order). Therefore, actual date of entry of progress note would account for out-of-sequence recording.

APPENDIX J: SELF-HELP PROGRAM (EXAMPLE)

Building-B Section-C Self-Help Program



Updated: MAY 1998