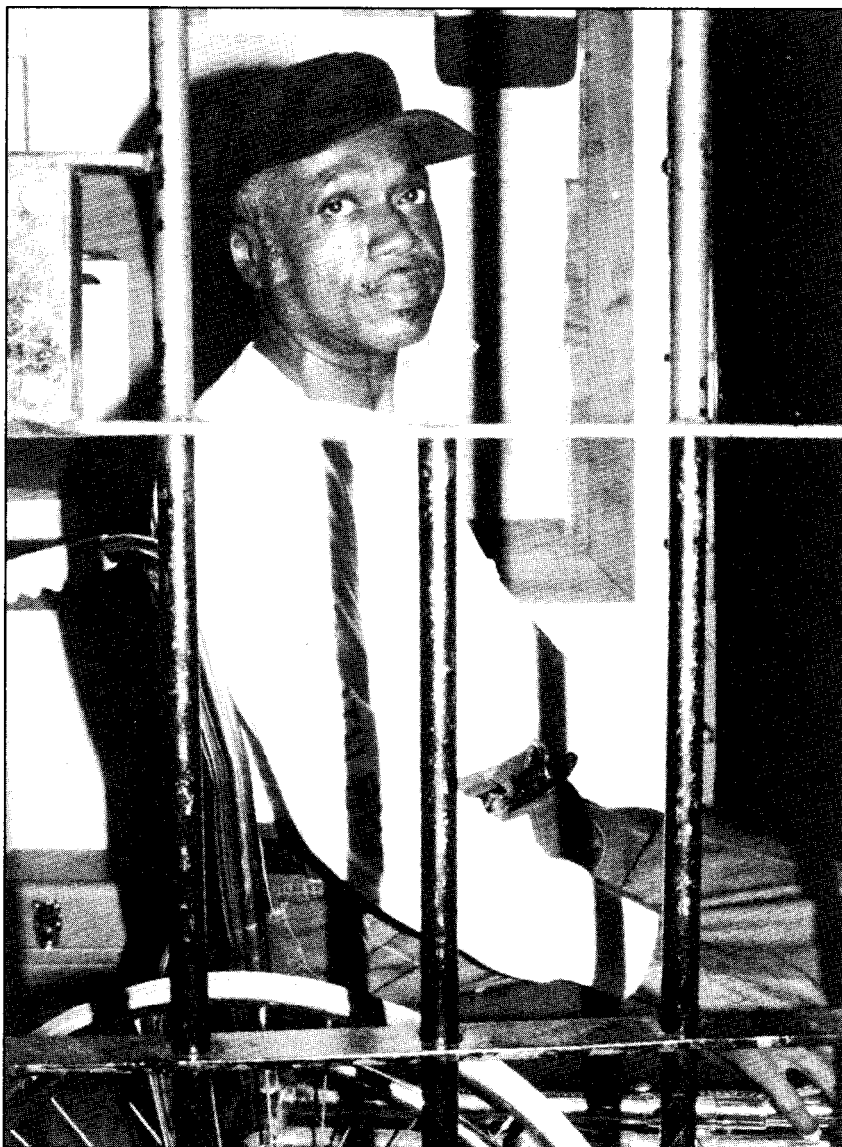




An Administrative Overview of the Older Inmate



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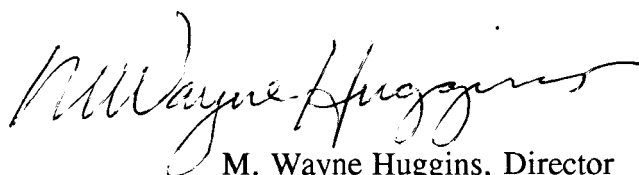
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Foreword

As prison systems throughout the country experience an increasing number of older inmates, correctional administrators need to develop strategies to provide care and custody in a cost-effective, humane manner.

This document examines the problems older offenders pose for correctional policymakers, administrators, and staff, and explores policy and program issues relevant to this population. It provides insight into programs that might prove effective in meeting the challenges older inmates present.

We hope this information will help policymakers and practitioners identify areas of concern that should be addressed as well as guide them in improving the care and custody of older inmates.

A handwritten signature in black ink, reading "M. Wayne Huggins". The signature is written in a cursive style with a large, sweeping initial "M".

M. Wayne Huggins, Director
National Institute of Corrections
August 1992

Chapter One

Introduction



“In general, older people are more heterogeneous than any other age group. This places an additional burden on prison systems because more attention to individualized assessment, programming, planning, and monitoring is required.”

The picture of a frail elderly man seated in a wheelchair peering through steel prison cell bars catches the public's attention. People generally hold the stereotype of prison inmates as physically active, aggressive young men. Prison administrators are finding that the "graying" of America is indeed reflected in the prison population.

Those 65 and older comprise the fastest growing age group in the United States (Feldman, 1989). By the year 2000, 34 million Americans will be over age 65 -- 8 million more than in 1980 (Statistical, 1991). Americans over 50 years of age will comprise 33 percent of the United States population by the year 2010 (Moritsugu, 1990). In 1992, this group comprised only 26 percent of the total U. S. population.

This basic demographic change is reflected in the prison population. Older inmates are increasing both in number and in percentage of the total population in state and federal prison systems. The number of inmates 55 and older more than doubled from 1981 to 1990 (Bureau of Justice Statistics, 1982; ACA, 1991). In 1988, the Federal Bureau of Prisons predicted that by 2005, the number of federal inmates 50 and older would increase from 11.7 percent of the prison population to 16 percent (1989). This means that by the year 2000 the Bureau of Prisons alone will house 17,000 inmates in the age 50 and over category (Moritsugu, 1990).

Studies indicate that most existing prisons are not designed structurally or programmatically for older in-

mates, nor do they meet their needs, Vito & Wilson, 1985, Morton & Anderson, 1982; Newman, Newman & Gewirtz, 1984; Chaiklin & Fultz, 1983; Elderly, 1985; Walsh, 1989; Dugger, 1988; Bernat, 1989). Planning and programming for this age group present many challenges for prison administrators who are hampered, to some extent, by the lack of a common definition of the term "older offender."

Some define "older" chronologically, starting in the age range of 40 to 65. Others do not address the issue of chronological age at all. They say that because of the impact of lifestyle, access to medical care, environmental factors in the aging process, and the background of most inmates, their physiological age may well surpass their chronological age (Moritsugu, 1990). However, because the older inmate is not defined chronologically, there is no uniform point of reference for research, planning, and/or programming efforts.

Correctional administrators need to become more knowledgeable about the issues that must be addressed to meet the needs of the older prison population. Should older inmates be segregated from the general prison population or should they be integrated into the mainstream of prison life? Should both these options be available? What specific gerontological issues should be addressed relative to older inmates?

For example, since aging is the result of a complex interaction of several factors including heredity, socioeconomic status, and lifestyle, older people are more diverse and have

greater individual differences than younger people. Therefore, more individualized programming is needed that reflects the diverse biological, psychological, and social functioning levels of older inmates. These levels of functioning must be taken into account throughout all aspects of institutionalization, from intake assessment to release. Ignoring these differences and other needs of older inmates may result in serious fiscal and legal implications for many prison systems.

Agencies also need to share information about programs that successfully address the special needs of older inmates and to identify resources that might contribute to these efforts. This sharing may include the transfer and adaptation of ideas from disciplines other than corrections.

This document provides a brief overview of existing literature related to older prison inmates, including relevant federal statutes. It recommends a specific definition of "older inmate" and identifies primary policy and programmatic issues and needs that should be considered relative to this population. The document briefly describes existing special unit programs designed or modified for older inmates and lists resources available for those attempting to meet the needs of older inmates.

Chapter Two

Defining the Older Inmate



“It is recommended that correctional agencies nationwide adopt age 50 as the chronological starting point to define older offenders. This is based on a number of factors including socioeconomic status, access to medical care, and lifestyle of most offenders.”

What is “Old”?

It is recommended that, in order to have a uniform reference point, correctional agencies nationwide adopt age 50 as the chronological starting point to define “older offenders.” This is based on a number of factors including socioeconomic status, access to medical care, and lifestyle of most offenders.

Growing older, or aging, has been defined as the “sum total changes occurring in an individual from the time of birth throughout the course of a life time” (Mummah & Smith, 1981, p.21). To define the age at which individuals become “old,” either in the community or in prison, is a complex task.

In general, there is no specific chronological age at which people are considered to be “old.” The Social Security Act places retirement at age 65 but provides the option to draw reduced benefits at age 62. Other federal programs have varying definitions of “old.” Subsidized public housing is available to those 60 and older, while eligibility for nutrition and other community programs begins at an age range of 50 to 55. The Federal Age Discrimination in Employment Act covers workers 40 years and older, and the Job Training Partnership Act (JTPA) designates those 55 and over as “older workers.”

Even gerontologists do not agree on a specific chronological starting point for the study of aging. Instead, they often group people into categories. Some categorize “older population” as 55 and older, “elderly” as 65

and older, and “aged” as 85 and older (Holtzman, et al., 1987). Other gerontologists refer to the “young-old” as 60 to 74, the “middle-old” as 75 to 84, and the “old-old” as 85 and over (Yurick, et al., 1984).

The consensus among experts is that chronological age is only one factor used in the definition of aging. Aging is also defined in terms of physical, emotional, social, and economic changes. Further complicating the issue of aging is the fact that individuals do not grow old at the same rate or in the same manner. People age as a result of the interaction of a number of factors including heredity, lifestyle, socioeconomic conditions, and access to medical services (Yurick, et al., 1984; Feldman, 1989).

The complexity of the relationship among the various inherited and environmental factors results in wide variations among individuals relative to aging. Some individuals might be physically or mentally “old” at 50, while others might be active and “young” at 70. Whether or not people are considered “old” increasingly depends on their individual physical, emotional, social, and economic level of functioning (Yurick, et al., 1984).

In general, older people are more heterogeneous than any other age group (Foner, 1986; Feldman, 1989). This fact places an additional burden on prison systems because more attention to individualized assessment, programming, planning, and monitoring is required to meet the needs of this diversified, growing group.

Despite the difficulties of determining a common chronological starting point for the definition of the “older” inmate, it is necessary to establish one so that comprehensive planning, programming, evaluation, and research within and among prison systems can be accomplished. It is important that this chronological starting point be at a young enough age to allow for early health care, intervention, and preventative programs to minimize some of the long-term medical costs and other problems associated with older offenders.

The Aging Process

It is critical that correctional administrators and others avoid stereotyping older offenders. Gross generalizations can negatively affect planning, programming, and strategies for working with this group (Evans, 1990). Stereotypical thinking about health care needs, emotional and mental health status, levels of learning, compliance, and flexibility of older persons often overlooks the fact that the vast majority of older Americans function adequately and independently in the community (Mummah & Smith, 1981; Butler 1985, Feldman, 1989).

Understanding the normal aging process is essential to planning and programming efforts directed toward older inmates. Designing new or adapting existing policies and practices that encourage healthy lifestyles and optimal functioning of older inmates will save financial and human resources in the long run. For example, preventative approaches to health care may not eliminate expensive medical costs

but may curb their rate of growth. Physical and mental health changes involved in the aging process and other factors that have implications for today's prison systems are now discussed.

Physical Health

As people age, certain physiological changes take place. While these changes may vary from individual to individual, they generally affect body tissue, sensory perceptions, circulation, and other physical and mental functions. Tissue changes include the decline of lean body and bone mass and the increase of fat mass (Masoro, 1987). Bones become brittle due to decreased mineral content (Zoller, 1987) and joints lose elasticity. Muscle strength weakens and susceptibility to debilitating injury from falls increases (AMA, 1990). Skin becomes dry and wrinkles appear. Decreased functioning of sweat glands and other changes leave the body less able to regulate temperature, causing older people to be more susceptible to heat and cold (Mummah & Smith, 1981). The water content in the body decreases, creating a requirement to ingest more fluids (Zoller, 1987).

The senses of smell, taste, touch, sight, and hearing become dulled. Usually these changes occur gradually and may not be noticeable to either older individuals or those around them. By age 70, about two-thirds of the body's taste buds are dead (Mummah & Smith, 1981). The skin loses flexibility, which interferes with the person's ability to distinguish by the sense of touch (Zoller, 1987). With age, muscles

in the eye become inflexible; the lens thickens; the pupil opening narrows; and the ability to see, distinguish colors, perceive changes in depth, and respond to light diminishes (Mummah & Smith, 1981). Certain eye problems such as cataracts, glaucoma, and retinal disorders are common among the elderly (Aging, 1986). Nerve endings in the ear gradually die, leading to loss of perception of high tones and the ability to hear (Mummah & Smith, 1981). The sum total of these losses is less intake of sensory information and less ability to respond quickly or appropriately to stimuli (Mummah & Smith, 1981).

With aging, the respiratory system changes dramatically. The lung capacity of a 70-year-old is half that of a 20-year-old (Zoller, 1987). This means the lungs need more energy to breathe and there is a loss of oxygen for all bodily functions, including digestion. After 50 years of age, the renal system in the kidneys begins to lose mass (Zoller, 1987). This, combined with loss of muscle flexibility, often causes frequent urination or incontinence among the elderly (AMA, 1990).

In 1992, the U.S. Public Health Service issued new guidelines, which stated that 80 percent of those with incontinence or bladder conditions (three-quarters of whom are older women) could be cured or greatly helped with proper treatment.

Hormonal changes experienced in the aging process reduce fertility. Sex drive also declines but usually remains throughout very old age (Mummah & Smith, 1981).

Changes that affect the immune system make older people more susceptible to illness and require them to be immunized or re-immunized against certain illnesses (Benkert, 1989). This means older inmates are quite vulnerable to tuberculosis and other contagious diseases and may need additional immunization.

The nutritional needs of older people are altered, and changes in the gastrointestinal system make a high-fiber diet necessary. Among other things, it is recommended that all elderly persons ingest 800 milligrams of calcium daily since this nutrient is usually deficient (Freedman & Ahronheim, 1985).

Because of physical changes among the elderly, prison systems need to survey facilities and see that precautions are taken to minimize the potential for falls. Contrasting colors between stair steps and risers can improve visibility and accommodate the needs of this population. Additionally, something as simple as ensuring the availability of eye examinations and securing properly fitting glasses can also prevent a costly fall.

The need for frequent urination may require modifications in transportation schedules of older inmates. Other modifications such as unimpeded access to toilet facilities may also be needed. The problem of incontinence should be addressed by medical staff. Modifying standardized diets and implementing preventative health programs will also help ensure that older inmates function more effectively and have decreased health care costs.

Mental Health

In the area of mental health, a study by the American Psychiatric Association found that 15 to 25 percent of the elderly suffer from mental illness (Let's Talk, 1988). Depression was the most common mental disorder reported. Second was dementia, a mental condition characterized by confusion, memory loss, and disorientation. The most serious form of dementia, Alzheimer's Disease, is of grave concern because of its debilitating nature. Symptoms resembling dementia are often caused by overmedication, poor diet, or other mental problems. Substance abuse ranked third among mental disorders, with alcohol abuse often beginning in early life but progressing in severity as individuals age (Green, 1990). Since many inmates have a history of substance abuse, prison systems need to be particularly vigilant of mental health problems in this area.

Medical Care

Individuals over 50 use more prescription drugs than younger people (Williams & Rush, 1986). Most elderly persons have 10 to 20 bottles of medication that they take frequently (AMA, 1990). Also, more than any other age group, older people are more likely to have adverse reactions to medications (Williams & Rush, 1986).

People 65 and older are likely to spend twice as much time in medical facilities and have three times the health care costs as younger adults (Holtzman, et al., 1987). Health care professionals and others

often lack sensitivity to medical and mental health problems of older individuals, which can exacerbate the problems (Epstein, 1977). Lavizzo-Mourey (1988) identified six skills essential for medical personnel, particularly physicians, to develop:

- respect where the patient is coming from,
- understand the aging process,
- understand the level of functioning of the older person,
- recognize the impact that reduced levels of functioning can have on the individual,
- recognize the problems medication can cause,
- recognize and assess what resources are available to treat or improve the problem.

These skills are necessary to compensate for unreported symptoms and to be able to distinguish normal aging from the disease process.

Despite the rather grim overview of the mental and physical aging process presented, most Americans over the age of 65 consider themselves to be in good health (Feldman, 1989). Only 5 percent of the population is housed in health care facilities (Mummah & Smith, 1981).

Some gerontologists assert that individual lifestyle and health-related behavior are the most important generic determinants of health status in the United States (Everly, Sherman, & Smith, 1989).

Prison personnel, particularly medical staff, must be aware of the relationship between health and aging. Over or under medicating can have devastating effects on older inmates. Procedures for sick call and dispensing medications may need modification.

Due to the importance of lifestyle in the aging process, it is particularly critical that correctional systems address diet, exercise, and smoking with preventative programs in the ongoing operation of facilities. While aging cannot be eliminated, some of the debilitating consequences can be minimized or delayed, resulting in considerable savings to the correctional system. One heart bypass operation necessitated by poor diet, limited exercise, and smoking can cost in excess of \$150,000.

Other Factors

In addition to physical and emotional changes, aging brings other challenges. Some of these are summarized by Pelham (1985), Foner (1986), and Salmon (1986):

- Retirement, with accompanying reduction in interaction with others and feelings of self-worth that come with gainful employment.
- Increased fear of dying or, more specifically, concern about pain, helplessness, and being kept alive by machines.
- Death of relatives, peers, friends, and pets.
- Reduced physical strength and endurance.

- Reduced income and increased expenses, including those for medical care.
- Major life changes such as loss of independence through inability to drive an automobile or moving to a relative's home or nursing home.

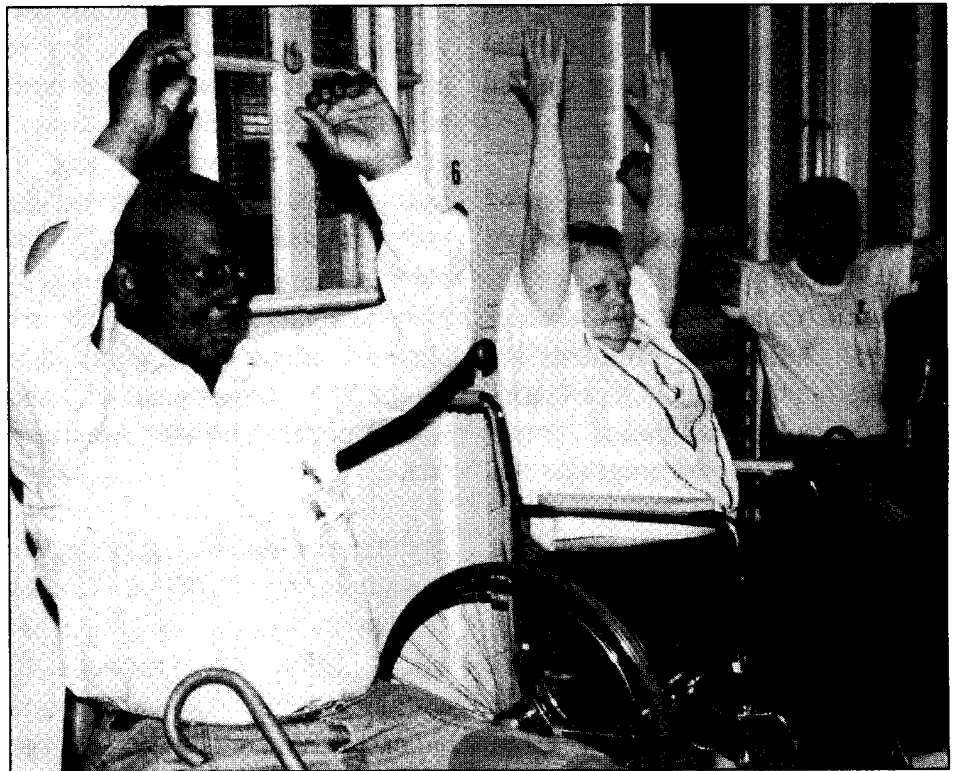
Health and social services staff and others interacting with older people need training to become more sensitive to these changes and the high levels of stress they create among the elderly.

Generally, older people have needs similar to other people including the need for independence; friends; pets or special possessions; a safe, pleasant living environment; food and other necessities; access to stimulating activities; and the expectation to be treated with dignity. Needs for privacy and for physical and emotional intimacy remain very strong in most older people (Foner, 1986). Finally, most older people have an emotional need and overriding desire to remain in control of their own lives.

Usually, people age in much the same way they lived (Kart, Metress, & Metress, 1988). Their characteristics and personality do not change dramatically. If they were impatient with their families at 20 years of age, they will probably have little tolerance for them at age 65. People who were happy and had a positive "can do" attitude at 30 will probably hold the same attitude at 70 (Kart, Metress, & Metress, 1988).

Chapter Three

Research Findings on Older Inmates



“New approaches or modifications to existing policies and procedures that encourage older inmates to improve their lifestyle and maximize their level of functioning will pay dividends in terms of both manpower and the financial drain this group can have on the prison system.”

It is advantageous for correctional administrators and prison staff to recognize the impact of aging on inmates and analyze the effects the general institutional environment will have on them. New approaches or modifications to existing policies and procedures that encourage older inmates to improve their lifestyle and maximize their level of functioning will pay dividends in terms of both manpower and the financial drain this group can have on the prison system.

The majority of studies reviewed reveal that most prisons are designed for younger, physically active inmates and are not adapted for older inmates. Issues and problems are identified in the areas of legislation, classification and assignment, physical plant, specialized programs and services, staff selection and training, and older women offenders. Each of these areas is discussed.

Legislation Related to the Elderly

Several pieces of federal legislation relate to older people and service providers and must be considered in the development and implementation of correctional programs. Some laws require equal treatment of older people. Other acts provide program funding and services that correctional agencies can use to ensure that the special needs of this group are met.

One major piece of legislation related to services for the elderly is the Older Americans Act of 1965 as amended. This Act, administered by the U.S. Department of Health

and Human Services, mandates that each state establish an agency to coordinate services for older people at the state level. Each state is then divided into areas, each of which has an agency on aging. The area agencies work with local service providers to direct program activities for older people. Federal funds, channeled through the state agency, provide partial or total funding for a variety of programs including senior centers, counseling and nutritional services, home and congregate meals, in-home services for frail elderly, elder abuse prevention, and older worker (age 55 and older) community service employment programs. Also, some employment programs are administered by the U.S. Department of Labor (DOL) under the Older Americans Act.

Another example of federal legislation administered by DOL is the Job Training Partnership Act, which provides employment programs for workers 55 and older. Provisions under this Act include assessment and training for older workers, job counseling, and placement services. Jobs for this group can be full- or part-time, with an emphasis on the former.

Another important piece of legislation is the Social Security Act, which, in addition to administering retirement benefits, provides block grant funding to the states for a variety of social services programs including meals, transportation, adult day care, and other activities for those who meet income guidelines regardless of age. Supplemental Social Security health care benefits including

Medicare and Medicaid are other important components of Social Security programs. Correctional agencies need to work closely with the Social Security Administration to ensure that older inmates are certified, or recertified, as eligible to draw benefits in a timely manner upon release. Agencies need to negotiate pre-release agreements with local Social Security offices.

Correctional administrators should be aware of certain federal acts that address the civil rights of older people. For example, the Federal Age Discrimination Employment Act of 1967 makes it unlawful to discriminate in any area of employment on the basis of age, starting at 40 years of age and continuing to age 70. The Equal Employment Opportunity Commission administers this Act, which can impact work release programs and other activities related to the employment of older offenders.

Federal legislation that deals with individuals with disabilities also applies to older people if they meet certain criteria. In both the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, those with disabilities are defined as people with a physical or mental condition that substantially impairs one or more life activities. These activities include such things as caring for one's self, completing basic manual tasks, seeing, hearing, walking, breathing, or working. Both Acts prohibit discrimination against individuals with disabilities and specify equal access to programs, services, and other activities. Mainstreaming -- maintenance of those

with disabilities in the general community -- is encouraged under both pieces of legislation.

The primary emphasis of the Rehabilitation Act of 1973 is on government programs that receive federal funding. The Americans with Disabilities Act (ADA), however, broadens coverage to all government programs, services, and activities regardless of whether they receive federal funding. Equal opportunity for employment and access to buildings and transportation are among the requirements emphasized in the ADA legislation. The vigor with which this latest attempt to provide equal opportunity for those with disabilities, including older people, is implemented will determine its impact on corrections.

Despite the claim that ADA is not civil rights legislation, ultimate responsibility for ensuring compliance with the Act rests on the Civil Rights Division of the U.S. Department of Justice. At the very least, correctional agencies will have to conduct self-assessments and other reporting activities as specified in the legislation. Failure to comply could prove very costly to correctional agencies both in legal expenditures and staff resources. As with other matters involving inmate litigation, making a good faith effort to address the problems and needs of the older inmate on the front end will prove beneficial in the long run.

Classification and Assignment

Studies indicate that older offenders could be categorized into at least three groups based on their criminal

history (Lipman, Lowery & Sussman, 1985). Each group makes unique adjustments in the institution and has varied prognoses upon release. These differences impact security, programming, and supervision (Vega & Silverman, 1988).

The first group consists of those who committed their crime after age 50 and are sentenced to prison for the first time. Their crimes are often serious, they are the most likely to have adjustment problems, and they have the highest potential to be victimized by other inmates. They are also more likely to have community ties and be easier to place upon release than the other two groups of older inmates.

The second group of older inmates includes the career or habitual criminals who are in and out of prison serving a few years at a time throughout their lives. On the surface they appear to make a positive adjustment in the institution, but lack skills necessary to cope in the community. They often have substance abuse problems -- usually alcohol addiction -- which grow more serious as they age. They may also have other chronic problems that make coping with life difficult on the outside. Their community ties are somewhat limited, depending on the tolerance of family and friends, and their employment history is sporadic, making them difficult to place in a meaningful job.

The third older inmate group is comprised of those who receive long sentences at an early age and have long histories in the system. Their crimes are often heinous, so they

spend long periods of time in secure confinement. Many in this group appear to make a good institutional adjustment, but are very difficult to place upon release due to few community ties and limited work history. It has been suggested that career employment ladders be developed for this group in prison industries and other institutional job assignments to help them cope with a lifetime in institutions (Flanagan, 1990).

A primary problem with such diverse groups is to determine whether older inmates should be placed in the general population or if they should be segregated into special housing units designed or modified to meet their needs. On one hand, mainstreaming, or placing older inmates in regular programs, ensures that they are not denied equal access to ongoing programs and services available to younger inmates. Mainstreaming also enables inmates to maintain community ties and receive visits from family and friends, many of whom might be elderly themselves and have problems traveling to a distant, but more centralized location (Morton & Anderson, 1982).

Many view the mainstreaming of older inmates throughout the prison population as beneficial to correctional institutions because the older inmates are perceived to have a calming, settling effect on younger inmates (Kratcoski & Babb, 1990). Also, while many older inmates are convicted of violent crimes (Dugger, 1988; Fry, 1987), the majority are not considered security risks for a variety of reasons including medi-

cal conditions. Mainstreaming would help ensure that older inmates are placed in minimum-security custody when appropriate, based on an assessment of the individual's functioning and risk. Under such a system, expensive, maximum-security bed space could be used more effectively .

On the other hand, there are strong arguments to establish special units designed or modified to house older inmates who are unable to function in the general population. Older inmates fear less for their safety in special units (Moore, 1989). Special units enable the development of programs and services specifically designed for older inmates and provide a concentration of specialized staff and resources for the group (Morton & Anderson, 1982).

In 1985, the National Institute of Corrections found that 11 agencies had special units for older inmates and that assignment to these units was usually based on health status rather than age. A 1990 study of 19 state systems and the federal system found that 6 percent of inmates 50 and older were housed in special units, with 1.2 percent of that group located in an infirmary setting (Hall, 1990).

In a 1991 study involving 40 agencies, 13 states and the Federal Bureau of Prisons reported having some type of special unit or housing for older inmates and using a variety of assignment criteria, including health, program, and security needs as well as the geographic location of the inmate's family. No agency reported using chronological age as

the sole criterion for assignment. This study also found that most systems with special units lacked minimum-security options for placement of the older inmates who were in these special units (Morton, 1991).

Agencies with substantial numbers of older inmates appear to have a need for both options. First, it is important to provide for the mainstreaming of the majority of older inmates. Second, it is important to place a small number of older inmates who need a "protected" environment in special units. Providing both options offers the maximum degree of flexibility in classification and assignment of older inmates.

Physical Plant

As noted earlier, the physical plants of most correctional facilities are designed for young, physically active inmates and are not geared to the needs of older inmates. Prisons designed in the 1980s frequently feature campus-style housing with living units and support services buildings scattered over wide areas. This often requires inmates to walk long distances to obtain meals, medical services, and other essentials. Steps, crowding, limited climate control, and architectural barriers to those with physical disabilities are additional problems older inmates encounter in prison (Newman, et al., 1984).

Moore (1989) found that, when physical plants are designed or modified to meet the needs of elderly offenders, the inmates' overall levels of well-being and satisfaction improve. The changes that have

positive effects include confining them in smaller, less crowded facilities that offer more privacy and providing control over their environment, including regulation of temperature and lighting.

Of particular concern in the physical plant provisions is the lack of complete accessibility for those using wheelchairs and the uniform availability of other accommodations that would enable all older inmates to function to the maximum degree possible (Morton, 1991). For example, lack of accessibility to industry areas precludes inmates with serious physical disabilities from work unless programs are brought to them. Bathrooms inaccessible to wheelchairs limit good hygiene and make older inmates dependent on assistance from others to carry out the routine activities of daily living. In fact, the lack of accessibility might place such facilities in non-compliance with federal law, such as the Americans with Disabilities Act. Legislation mandates that these inmates receive the same or comparable services as other inmates.

Programs and Services

Provision of medical care designed to meet the needs of older inmates, including special diets for proper nutrition, is stressed by many studies. Health education and preventative care are necessary to overcome the effects of debilitating lifestyles many older inmates had prior to their imprisonment. The monitoring and treatment of geriatric health problems is an ongoing need (Lipson, 1990). Since medical conditions of older inmates can rapidly

deteriorate and may be overlooked by staff, regular examinations of visual, auditory, and other modalities of functioning are encouraged (Morton & Anderson, 1982). Wellness activities that keep inmates healthy and improve their lifestyles are strongly recommended (Lipson, 1990).

In addition to adequacy and availability, the cost of health care for older inmates is a significant factor in correctional agency budgets. The Federal Bureau of Prisons found that older inmates have higher incidences of chronic illnesses, including cardiac and hypertensive disorders, than younger inmates. By the year 2005, the inflation-adjusted cost to the Bureau of Prisons for the care of these two illnesses alone is projected to exceed \$93 million per year (Looking Ahead, 1989).

Almost every study of older inmates stresses the need for more programs and services designed for or adapted to meet the needs of older inmates. Recommendations range from specialized addictions treatment that deals with older offenders' high incidence of alcoholism and/or substance abuse (Jennison, 1986; Kratcoski & Pownall, 1989) to counseling about loss, including death and dying.

Of particular concern is the need for individualized pre-release programs and services to aid older inmates' transition back into the community. Chaiklin and Fultz (1983) found a variety of problems among inmates with no family to care for them or place to go upon release, as well as among inmates who need nursing

home placement. Some older inmates simply refuse to leave prison.

Coordinated staff efforts are necessary to resolve release problems, and individualized planning is required due to the complexity of the issues. Strong liaisons with community agencies and organizations are needed to ensure continuity of care and services during incarceration and after release.

Morton's 1991 study of 40 agencies found a serious lack of specialized pre-release programs for older inmates and limited use of outside resources to meet the needs of this group. Only 11 agencies reported having specialized pre-release programs, and only 13 used one or more outside resources to help work with this group. However, this study found that over half of the reporting agencies intended to develop new or expanded programs for older inmates.

Staff Selection and Training

Another area of concern related to older inmates and the correctional system is staff selection and training. Agencies generally select staff whose credentials and expectations relate to working with younger, often aggressive inmates, and staff training programs are designed accordingly. However, those working with older inmates need training specifically designed to deal with the unique emotional and social needs of this age group. There is the need for staff to explore their own feelings about aging and to learn how to treat older inmates with dignity (Morton & Anderson, 1982).

Morton (1991) found that of the 39 states and the Federal Bureau of Prisons surveyed, none reported to have specific guidelines for the selection of staff who work with the elderly. Only six agencies -- Idaho, New Jersey, Ohio, Pennsylvania, South Carolina, and the Federal Bureau of Prisons -- reported having specialized training for staff who work with older inmates. This lack of training is viewed as a critical oversight, which may result in negative legal and programmatic effects on prison systems.

Incarcerated Women

Historically, women offenders have been virtually ignored by policymakers and researchers. Nowhere is this oversight more evident than in the paucity of studies and information concerning older women offenders. As of 1990, women aged 50 and older comprised about 4 percent of women incarcerated in state prisons and the Federal Bureau of Prisons (ACA, 1991). Just as the number of incarcerated women in general is growing due to changes in the criminal justice system such as mandatory sentencing, the war on drugs and substance abuse, and longer sentencing, so is the number of older women in prison increasing.

Morton's 1991 survey found that only 3 of the 39 state prison systems and the Federal Bureau of Prisons responding reported having special units for older women inmates, while 14 agencies reported special units for older men. However, when asked if specialized programs were available to both older male and female inmates, 22 states and the Federal

Bureau of Prisons responded “yes” and 11 states responded “no.” The remaining 7 states did not respond to this question.

One of the few reported programs focusing on the older woman offender was the American Association of Retired Persons Women’s Initiative Project at the Washington Corrections Center for Women in Purdy, Washington. This program addressed the needs of older women inmates transitioning into the community. Project staff cited the need for support groups among older

women and separate activities geared toward their interests, as well as dietary and medical services that may improve their overall health status. The project administrator pointed out that many of the older women had “deeply ingrained passivity” and needed help to become more assertive and take greater control of their lives (Fighting for Rights, 1991, p. 1).

Studies indicate numerous differences between older women and older men. These differences include greater longevity, greater

poverty, a greater chance of living alone, and a greater likelihood of outliving support systems. Of particular concern to prison personnel are the physiological and societal differences that require staff to be gender sensitive in the development and implementation of health and other programs for older women. Even though older women offenders may be considered less threatening, the pervasive economic plight of many, lack of community resources, and negative stereotyping compound the problems they encounter when re-entering the community.

Policy and Programmatic Issues



“*Assessment of older inmates at intake and during their stay in the correctional facility is an important factor for meeting the needs of both the individual and systems planning. . . . Since conditions and status can change so rapidly with older inmates, it is recommended that levels of functioning be assessed on an ongoing basis.”

A review of information concerning the aging process and literature about older inmates suggests that certain administrative issues should be addressed by correctional administrators, program providers, and policymakers outside the field who make administrative, legislative, and judicial decisions regarding corrections. Both agency and institutional decisionmakers should be cognizant of programs that can be implemented for older inmates as well as policies, practices, and strategies that can be applied in the prison setting. The recommendations made here consider both the practical realities of institutional operation and the need to maximize existing but scarce resources.

Older inmates comprise only one segment of a much broader special needs offender group. Increasingly, correctional systems are faced with inmates who have supervision or programmatic needs over and above those of the general population. Inmates may arrive with these needs or develop them while incarcerated. In many cases, older inmates and other special needs offenders possess multiple problems that must be addressed.

The needs of older inmates should be assessed from a systemwide perspective by a multidisciplinary group of individuals from different fields and functional areas within the system. Such a group can review existing and projected populations as well as develop plans and oversee implementation of agency strategies to most effectively and efficiently handle older inmates and other special needs groups. It is often useful

to involve outside specialists in vocational rehabilitation, gerontology, and other areas in this planning, programming, and evaluation process.

Periodic reviews of both system and institutional policies, procedures, and practices should be conducted to ensure that plans are implemented and any problems are resolved. Again, these reviews should be multidisciplinary in nature since the issues and problems of older inmates tend to cross programmatic and functional lines.

As correctional administrators and policymakers begin to address the needs of older inmates, a number of issues must be considered. Six of the most critical ones are reviewed below. They include: 1) assessment, 2) accessibility and adaptation, 3) special units, 4) medical, 5) staff training, and 6) community involvement .

Assessment

Assessment of older inmates at intake and during their stay in the correctional facility is an important factor for meeting the needs of both the individual and system planning. The initial assessment should include evaluation of the inmate's physical and mental health, and level of functioning in other areas such as lifestyle, work, family, community relationships, and criminal history. From this initial program and custody needs assessment, a plan can be developed to provide the security supervision needed and the programmatic emphasis, including work, needed to help ensure that an opti-

mal level of functioning is maintained.

Since conditions and status can change so rapidly with older inmates, it is recommended that levels of functioning be assessed on an ongoing basis. This ongoing assessment can be accomplished through a relatively simple list of questions modified from geriatric assessment questionnaires and administered by a caseworker or classification specialist as a part of the classification review process. If problems are identified, the caseworker can then refer the older inmate to other staff as appropriate. Early detection and treatment are critical to help minimize costs and other problems.

It is important that correctional administrators incorporate aggregate data about older inmates into overall system planning. The issues related to older offenders are too complex for one facility to cope with on its own. Of particular concern is the long-term care of inmates who need intermediate and/or skilled nursing care. It is recommended that administrators see that these individuals receive care in community facilities wherever possible. This may include such strategies as compassionate release or contracting for bed space from other public or private agencies that provide such services.

Agencies may find it necessary to establish multidisciplinary, and perhaps multi-agency, teams to screen, assess options, coordinate placement, and monitor older inmates who are no longer a threat to themselves or others but who need levels of care not available in prison. Given the

demographics of the population and the propensity of society to turn to corrections to find solutions for problem people, the provision of in-house nursing home care above that of "boarding home level" has the potential to create another new population for which corrections will be responsible.

Accessibility and Adaptation

Legal and economic considerations, as well as good correctional practice, dictate that the majority of older inmates be mainstreamed in the general population throughout a correctional system. To ensure that older inmates are able to function in the general institutional environment, systems must provide full accessibility to all programs and services. It is also necessary to adapt institutional policies, practices, and programs to accommodate the normal aging process and enable older inmates to develop or maintain the maximum levels of functioning and a positive quality of life. To do otherwise will almost certainly increase medical and other costs associated with older inmates and could result in lengthy and expensive lawsuits.

One of the first areas that should be addressed relative to accessibility is the physical plant. Agencies should plan all future housing and modify existing facilities to meet universal access standards. All areas of the facility should be accessible to mobility-impaired individuals, including those who use wheelchairs. If there are long distances between needed programs, more time and schedule flexibility may need to be

granted for older inmates. In some circumstances, programs and services may need to be brought to them.

The second area to be considered concerning accessibility and adaptability is the living area. Older inmates may be clustered for security and supervision. They should have single, lower bunks to prevent falls and may need hospital mattresses, extra bedding, or other adaptations. Older inmates may require more heat in winter and air conditioning in summer, depending upon the climate and their medical conditions.

Programs and services are the third area to be considered and probably require the most effort to develop or adapt. Individual programming is often necessary due to the heterogeneous nature of the older population. Practices should foster independence in order to maximize the inmate's ability to remain in the mainstream population. Preventative and health maintenance activities such as wellness education concerning lifestyle, diet, and exercise can help reduce medical and other expenses.

Counseling, leisure time, education, and other programs must be adapted for older people. Strategies that motivate or punish a 20-year-old inmate may not be effective with a 60-year-old. An institution-wide, multidisciplinary effort is necessary since every function from scheduling activities to transportation will be affected. Also, legal services to include provisions for living wills as well as answers to other legal problems experienced by elderly people should be provided.

Inmate work programs must also be assessed. Most older inmates want to be productive and busy, but modifications of full- or part-time work assignments may be necessary to enable them to participate. Administrators must be particularly alert to work or other programs that allow inmates to earn time off sentences, money, and/or other benefits. Where work or program participation earns credit for early release, older inmates may spend more time in prison than their younger counterparts if they are denied access. If older inmates are not provided the opportunity to participate, the system may be vulnerable to charges of age discrimination and other legal challenges.

Release and transition services are critical for older inmates. Existing programs require adaptation to ensure housing, continuity of medical care, and other matters related to older individuals who may not be able to live independently are addressed.

Special units

Placement in a special unit designed for or adapted to meet needs of older inmates may be necessary, especially for those who are frail or have severe medical problems that render them unable to function in the normal institutional environment. Agency policy should clearly define the goals and objectives of special units and specific criteria for admission.

The characteristics, needs, and supervision requirements of the various groups to be located together

should also be carefully analyzed. Combining similar populations, such as older inmates and those with serious physical disabilities, is feasible. Housing frail elderly people with aggressive, younger inmates will not provide the protected environment older inmates may need.

Specific planning and programming should be developed for older inmates in special units. For example, planning for 24-hour medical support that enables emergencies to be handled effectively can relieve the anxiety of staff and older inmates and, in the long term, can reduce the number of emergency calls. Sheltered workshops and modified prison industry programs should be developed to enable older inmates to maintain their maximum levels of productivity and self-worth.

Medical

The cost of medical care for older inmates continues to escalate, just as it does in the community. Prison administrators cannot legally, or ethically, avoid all of these related costs. However, administrators can implement prevention programs to help contain costs and minimize financial problems.

Prevention programs, including education, diet, and exercise, that gradually change the behavior and attitude of inmates toward health maintenance should be implemented. Also, screening high-risk inmates for disease and beginning early treatment can prevent catastrophic illnesses. For example, early treatment of elevated blood pressure is far more efficient than maintaining the vic-

tim of a massive stroke. Early detection and treatment of pre-cancerous or cancerous conditions will be far less costly than massive efforts undertaken when cancer has progressed to critical levels. Regular monitoring of inmates by medical staff can identify gradual changes in individuals and ensure to the degree possible that medical problems are addressed before they become catastrophic and require expensive hospitalization. Good communication among medical and other staff regarding medication and treatment of older inmates is also important.

Public and private medical systems throughout the country are experimenting with a variety of cost-containment measures such as requiring second opinions before certain kinds of surgery. Bulk purchasing, using generic drugs, and, when appropriate, contracting certain procedures to outside service providers rather than developing expensive and sometimes difficult to maintain in-house services are other strategies that can reduce medical care costs.

Other health matters such as the treatment of chronically and/or terminally ill older inmates must also be addressed. Correctional agencies should explore all possible options to avoid providing in-house intermediate or long-term nursing home care for older inmates. As noted earlier, if this problem is not addressed by policymakers in and outside of corrections, prisons may be required to house older people society no longer wants to deal with in the community at large. Deinstitutionalization movements in mental health and other areas, as well as

a general over-reliance on institutionalization for those who offend society norms, have already impacted correctional facilities.

In 1990, 22 states surveyed reported having some type of compassionate release program in place (Hall, 1990). However, no evaluation of these programs' effectiveness has been conducted. All states and the federal government should have in place a viable release program for those whose condition renders them a limited threat to society. These programs should also include systematic reviews of older inmates and the development of community nursing home placements for those who have no other place to go. Voluntary programs, such as the Project for Older Prisoners (POPs) begun in Louisiana, reduce prison costs and are very useful but are limited in the number of inmates they can serve (Turley, 1990). Careful planning and the development of close working relationships with community service providers will help maximize the use of limited prison space and resources. Prison systems must also address the provision of in-house infirmary or hospital beds for inmates who cannot be placed in the community because of security risks.

Finally, systems need to develop in-house hospice programs for those who will die in prison. Care must be taken to prevent misuse of these placements. Specialized counseling for terminally ill inmates, as well as provisions for visitation by family, friends, or volunteers can help older inmates die with dignity. Funerals or memorial services for those without families can help ease the sense

of loss for both staff and inmates who have worked with the deceased person.

Staff Training

All staff, including medical personnel, who come into contact with older inmates -- either in the general population or in special units -- should have training that will enable them to function more effectively with this group. The training should first address the staff's own feelings and concerns about growing older and/or coping with aging parents or relatives. Some staff will have had very positive experiences with older people, while others will have had negative ones. Staff may also experience frustration about the lack of community programs and services available for their own family members or friends. They may need help dealing with their perception that older people in prison may receive better care than those in the community at large.

Training should also present information about the normal aging process. An empathic training model can be used to help staff identify with and better understand disabling conditions such as hearing, visual, and mobility impairments. In this training, participants use glasses, bandages, wheelchairs, and other equipment that simulates the physical disabilities encountered by older inmates. Trainees thus become more sensitized to conditions that challenge the daily living experience.

Interpersonal communications training specifically geared toward working with older people is useful since

aging can impact both speed and clarity of speech and thought processes. A variety of factors such as voice pitch, speech rate, and body position must be considered when working with older inmates. Failure to train in these areas not only prevents staff from performing effectively, but also has serious legal implications.

While prohibited in some states, if inmates are used to assist older inmates, they too must be provided with ongoing training. Careful screening and monitoring of inmate workers is required. Just as staff can experience job "burnout" from the constant pressure of working with older inmates, so too can inmate workers suffer frustration and fatigue. Rotation, time off, and other strategies to alleviate this pressure and burden will pay dividends in the long run for both staff and inmate workers.

Community Involvement

Correctional agencies will need to use available community resources to provide adequate programs and services for older inmates. No single agency or segment of government can provide all the services needed by this complex client group. Community involvement becomes even more critical as inmates prepare for release. Community organizations can be helpful in providing both pre-release programming and follow-up services after release.

Assistance to staff in program planning, service delivery, and training is available from both the private and public sectors. Such assistance

can be provided by paid consultants or volunteers and can range from vocational rehabilitation specialists developing a system-wide approach for training older inmates to a nutritionist developing a special diet for an individual inmate.

Some agencies have found it useful to designate an advocate at the central office level who helps forge community linkages and information sharing. However, the primary focus of day-to-day relationships with community resources lies at the facility level. As with all relationships, community involvement in programs for older inmates will take time and talent to develop. Correctional personnel must be open and understand that community people need information and education about corrections just as correctional staff need to broaden their understanding of the mission and goals of the community organizations with which they work. People outside the prison system will often question correctional personnel and challenge the need for certain practices. This should be expected, and even encouraged, because new and modified approaches will be needed for older inmates.

A commitment from top administrators for joint relationships among correctional agencies and other groups is useful. But these relationships often develop only after concerned staff at lower levels establish mutual respect and understanding of the capabilities of each agency and organization involved.

Most public and private community groups that work with the elderly

have more clients than they can handle. Often correctional facility staff can work with community providers to identify areas where the institution can provide a service in return for technical assistance, training, or other needs. For example, older inmates at Hocking Correctional Institution in Ohio fold news-

letters as a public service for the area agency on aging. Its staff, in turn, works with the institution to develop new programs.

Correctional personnel often find it frustrating to make arrangements for older inmates who are re-entering the community, particularly if

the inmate has no community ties or family. Correctional personnel will find themselves in a position of advocating for older offenders within both corrections and the community. Acknowledgement and encouragement of this approach should be provided by correctional administrators.

Chapter Five

Existing Special Units



“A 1991 survey of state prison systems and the Federal Bureau of Prisons gathered responses from 40 agencies. Eighteen agencies indicated they had some type of special unit or cluster housing arrangements for older inmates. A follow-up survey six months later found 14 special units still in operation. ”

A 1991 survey of prison systems gathered responses from 40 agencies. Eighteen agencies indicated they had some type of special unit or cluster housing arrangements for older inmates. A follow-up survey six months later found two states had abolished special programming for elderly offenders, and two others did not have the type of special programming for older inmates that was requested. The remaining 13 states and the Federal Bureau of Prisons provided descriptions of their programs, including information about physical plant structure; health, food, recreation, work, and other services; pre-release programs; and hospice services as appropriate.

The states responding were Florida, Georgia, Illinois, Indiana, Kentucky, Minnesota, North Carolina, Ohio, South Carolina, Virginia, West Virginia, Wisconsin, and Wyoming. Brief descriptions of the programs follow. Contact persons and their phone numbers are provided for those seeking additional information.

FLORIDA

The Florida Department of Corrections provides special services for older male inmates at Lawtey Correctional Institution and at Hillsborough Correctional Institution as well as a special unit for older female inmates at Florida Correctional Institution. Younger inmates are also housed at these units to provide the necessary work force. Health and food services, including special diets, are designed for the older population. The department receives cooperative assistance from the Florida Department of Elder Affairs.

Contact person:

Alan R. Tudor
Florida Department of Corrections
2601 Blair Stone Road
Tallahassee, FL 32399-2500
904-488-6903

GEORGIA

The medium security Men's Correctional Institution in Hardwick houses aged, sick, infirmed, and physically handicapped male inmates as well as 93 close security inmates. The facility has 24-hour medical care and 60 hospital beds. Programs such as the talking-book service, Sit and Be Fit exercise, and gardening are available for older inmates. Access is provided to the local Social Security Administration, Department of Veteran Affairs, and Vocational Rehabilitation.

Contact person:

Bonnie Riner, Deputy Warden/Care and Treatment
Men's Correctional Institution
P.O. Box 396
Hardwick, GA 31034
912-453-4702

ILLINOIS

Located at the Dixon Correctional Center, the Health Care Unit houses inmates aged 55 and older with one or more chronic illnesses and other special needs inmates. Inmates in this living unit receive a 7-day medication packet delivered by medical staff. Meals and items from the commissary are also delivered for those inmates not capable of walking to the area. Barber shop, legal, library, and chaplaincy services are available on a scheduled basis. The Leisure Time Services Department

offers a variety of activities for the unit including dominoes, chess, pool leagues, and art classes. The Department also prints a monthly newsletter for the unit announcing the various activities.

Contact person:

Terre Marshall
Illinois Dept. of Corrections
100 West Randolph Street
Chicago, IL 60601
312-814-3017

INDIANA

Indiana has two facilities designated for the placement of special needs and older male offenders. Efforts have been made to educate the staff to the special needs of this group. The Department of Corrections developed a strategic plan for health care, which recommends the development of a hospice program, recreation and vocational programs, and accessibility to a gerontologist.

Contact person:

Dean Neitzke
Health Care Services
Indiana Government Center South
302 West Washington St, Rm E329
Indianapolis, IN 43204
317-232-1590

KENTUCKY

The Kentucky State Reformatory Convalescent Care Unit is a 50-bed, medium custody male unit that houses inmates with limited mobility, advanced age, and medical conditions. Inmates are recommended for placement by the Medical Department. A nurse is available during daytime hours, a recreation leader and class-

ification and treatment officer are assigned to the area, and inmate aides are used. The unit is handicapped-accessible and medical services are located on the same floor. A nursing home placement program was recently started. Outside resources used for training purposes include the University of Louisville and the Christian Church Campus of Louisville.

Contact person:

Al C. Parke, Warden
Kentucky State Reformatory
LaGrange, KY 40032
502-222-9441

MINNESOTA

The Minnesota Correctional Facility-STW Senior Dormitory is designed to accommodate 23 self-sufficient men aged 50 and older. If monitoring is required for health reasons, older offenders are assigned to a lo-bed unit in a separate health service area. Inmates in the Senior Dormitory go to meals before the general population to avoid the rush in the cafeteria. They are allowed to work, participate in educational programming, and attend recreational activities. A senior social group meets every other week.

Contact person:

Jeanne Schumacher
MCF-Stillwater Health Unit, PO 55
Stillwater, MN 55082
612-779-5714

NORTH CAROLINA

McCain Correctional Hospital is a minimum custody male facility that

serves inmates with special health care needs, including older offenders. It offers various health services including inpatient care, skilled nursing, laboratory, X-ray, and pharmacy facilities. Hortithery is taught by community college instructors, and ceramics, handicrafts, exercise, and horseshoes are also available. Reminiscent therapy, release planning, and nursing home placement are also offered.

Contact person:

Herbert A. Rosefield, Supt.
McCain Correctional Hospital
P.O. Box 5118
McCain, NC 28361-5118
919-944-2351

OHIO

The Hocking Correctional Facility is designated for 400 older male medium/minimum security offenders. Staff members attend a special course dealing with loss, which is also offered to the inmates. The Ohio Department of Aging with the Correctional Training Academy also offers staff training. A two part pre-release program specific to the older inmate's needs is Presented: 1) for inmates returning to the workforce, and 2) for those who will retire upon release. Work programs include the Blue Bird Project (making bird houses), folding the quarterly newsletter for the Area Agency on Aging, and cutting squares of cloth to be used by community senior citizens who sew quilts for nursing home patients. The Athens County Retired Senior Volunteer Program brings a group of community senior citizens into the facility on a monthly basis.

Contact person:

Carole J. Shiplevy, Warden
Hocking Correctional Facility
16759 Snake Hollow Road
Nelsonville, OH 45764
614-753-1917

SOUTH CAROLINA

In South Carolina the maximum security area for older male inmates is located at the Broad River Correctional Institution, and older women in this custody level are housed at the Women's Correctional Center. Minimum security men and women are housed in a co-correctional setting at State Park Correctional Center, which offers a Work Activities Center, a sheltered workshop where offenders earn wages. State Park also operates a pilot Modified Work Release Program for older offenders, which is funded by the Job Training Partnership Act and offers training, employment, and other opportunities similar to those afforded younger work release participants. Specialized counseling, recreation, horticulture, crafts, education, literacy programs, individual release planning, and other services are provided. Numerous outside agencies are used.

Contact person:

Judy C. Anderson, Warden
State Park Correctional Center
P.O. Box 98
State Park, SC 29147
803-935-6612

VIRGINIA

The Geriatric Program (Psychotherapeutic Support) operates within the

Staunton Correctional Center. It includes specialized exercise groups and a discussion group that addresses many issues relevant to older inmates (e.g., Social Security benefits, aspects of aging, budgeting on a fixed income, and death and dying). Participants in the program must be 55 or older and classified as an "A" or "B" custody inmate.

Contact person:

Brenda C. Rector
Rehabilitation Counselor
Staunton Correctional Center
P.O. Box 3500
Staunton, VA 24401
703-332-7605

WEST VIRGINIA

The West Virginia Department of Corrections has a 45-bed unit for older (60+ years) and medically infirm inmates. Programs and services provided include a full-time counselor, medical care, exercise, gardening, life skills, HOPE (pre-release orientation to work and community), education, and religious services. Outside resources used include Alcoholics Anonymous, Human Services, Social Security, and Vocational Rehabilitation.

Contact person:

William C. Duncil, Warden
Huttonsville Correctional Center
P.O. Box 1
Huttonsville, WV 26273
304-335-2291

WISCONSIN

At the maximum security Waupun Correctional Institution, two special units for male inmates with medical problems are available. The Infirmary Unit is for offenders who need 24-hour a day medical attention. The Self-Care Unit is for those with medical problems who, for the most part, can take care of themselves.

Contact person:

Barbara Drown, Research Analyst
Wisconsin Dept. of Corrections
Bureau of Budget Development
and Facility Management
P.O. Box 7925
Madison, WI 53707-7925
608-267-0932

WYOMING

The Wyoming State Penitentiary has two special units within the Medium Security Unit for male inmates 40 years and older who meet certain screening criteria. Each unit is located between the outside and inner yard fences of the facility, which allows access to programming provided for younger offenders.

Contact person:

Jack J. Sexton, Associate Warden
Wyoming State Penitentiary
P.O. Box 400
Rawlins, WY 82301
307-328-1441

**FEDERAL BUREAU
OF PRISONS**

While the Federal Bureau of Prisons mainstreams the elderly population to meet inmates' security, program, medical, and other special management needs and to give access to family when possible, facilities in Fort Worth, Texas, Carville, Louisiana, and Lexington, Kentucky, house inmates with chronic, long-

term medical needs. The Bureau provides heart-healthy meals and nutrition education, promotes smoke-free housing, and offers inmates educational materials and counseling on healthy lifestyle management. The health services program provides devices and aids necessary to enable inmates with special needs to participate in programs. Hospice programs at the medical referral centers are staffed by community hospice leaders, chaplaincy personnel, and staff psychologists. Educational, recreational, and work programs designed for older inmates are offered.

Contact person:

Kenneth P. Moritsugu, M.D.
Assistant Surgeon General,
Medical Director
Federal Bureau of Prisons
320 First Street, N.W.
Washington, DC 20534
202-307-3226

Recommended Resources and Sources of Information



“The network of service providers and consumer groups that helps meet the needs of the aging is growing larger as recognition of those needs expands and as the older population increases.”

It is critical that correctional administrators reach outside their agencies for help with internal as well as transitional and community programming for older inmates. This chapter provides a list of governmental units and organizations that have all or some of their activities geared toward identifying and meeting needs of elderly citizens. The network of service providers and consumer group that helps meet the needs of the aging is growing larger as recognition of those needs expands and as the older population increases.

In this chapter, federal agencies and national organizations' headquarters are listed with addresses and phone numbers. Local affiliate names may vary but can often be identified through a local phone book or by contacting the national organization. Each of the agencies and organizations has a particular interest or specialty, and the personnel in most will not have experience with either the prison environment or offenders. Most are overloaded with an expanding client group from the community. They may respond positively to arrangements with correctional agencies that can be mutually beneficial to both organizations.

The best starting point for information on the very complex network may be the state or local agency on aging. Under the Older Americans Act, each state is mandated to have an agency to coordinate services for the aging. Administrators should also explore the possibility of negotiating pre-release agreements with local Social Security offices to ensure offenders receive benefits to which they are entitled upon release.

This list was compiled with assistance from the work group members, the South Carolina Commission on Aging, and various sources, including The Caregivers Guide: Helping Elderly Relatives Cope with Health and Safety Problems by Caroline Rob, R.N. (1991). That document also provides an excellent overview of practical information on working with the elderly.

The resource information presented is organized into three major areas:

- 1) criminal justice organizations with information and/or assistance,
- 2) other organizations with concern for older people,
- 3) organizations with specific interests

CRIMINAL JUSTICE RESOURCES

American Correctional Association
8025 Laurel Lakes Court
Laurel, MD 20707
800-ACA-JOIN

ACA has books and training material on older offenders, including a Special Needs Offenders Correspondence Course for correctional officers and a training module, Working with the Older Offender, which includes a documentary videotape.

**National Institute of Corrections
Prisons Division**
320 First Street, NW
Washington, DC 20534
202-307-1300

NIC provides training, technical assistance, and information on older inmates through the various divisions of the agency.

**National Criminal Justice
Reference Service (NCJRS)**
BOX 6000
Rockville, MD 20850
800-85 1-3420

Information about older offenders including bibliographic references, statistical and other data from the NCJRS reference system is offered.

OTHER ORGANIZATIONS FOR OLDER PEOPLE

ACTION

1100 Vermont Avenue, NW
Washington, DC 20525
202-634-9108

A federal agency, also known as the Federal Domestic Volunteer Agency, which coordinates all federally sponsored volunteer programs including Foster Grandparents, Retired Senior Volunteer, and Senior Companion Programs for older citizens. Call or write for free publications.

Administration on Aging (AOA)
330 Independence Avenue, SW
Washington, DC 20201
202-619-0724

AOA is an advocate for the elderly and is the principal agency implementing programs of the Older Americans Act.

**American Association of Homes for
the Aging**
1129 20th St., NW, Suite 400
Washington, DC 20036
202-296-5960

An association of nonprofit agencies that provides housing, skilled nursing, and related services for elderly. It holds an annual conference, provides educational seminars, and has state associations as well as a journal and newsletter.

American Association of Retired Persons (AARP)
1909 K Street, NW
Washington, DC 20049
202-872-4700

This membership organization's purpose is to enhance the quality of life for persons aged 50 and older. Local chapters provide a variety of community services, and the national organization provides a wide range of free pamphlets on aging, health, exercise, etc., as well as a bimonthly magazine and monthly newspaper. Annual dues in 1992 were \$5.

American Society on Aging
833 Market Street, Suite 512
San Francisco, CA 94103
415-543-2617

A large, nonprofit membership organization for professionals, practitioners, researchers, and advocates in the field of aging dedicated to improving the lives of older persons. The Society has an annual conference, quarterly journal, and bi-monthly newsletter.

Association National Pro Personas Mayores
2727 West 6th Street, Suite 270
Los Angeles, CA 90057
213-487-1922

Provides advocacy for the needs of Hispanic elderly through direct services, research, and information dissemination.

Association for Gerontology in Higher Education
600 Maryland Avenue, SW
west wing 204
Washington, DC 20024
202-484-7505

Membership organization of over 200 colleges and universities to fos-

ter increased commitment of institutions of higher education to the field of aging through education, research, and public service. It holds an annual conference and publishes a national directory of educational programs in gerontology and other publications.

Gerontological Society of America
1275 K Street, NW, Suite 350
Washington, DC 20005-4006
202-842-1275

A multidisciplinary membership organization devoted to improving the condition of older people through research and education. It has an annual meeting, local chapters, and publications including the Journal of Gerontology, the Gerontologists, and a newsletter.

Gray Panthers
1424 16th Street, NW, Suite 602
Washington, DC 20036
202-387-3111

This is an activist group that targets laws and attitudes that discriminate against people based on their age. Many locally based chapters offer a variety of opportunities for older individuals, including public education seminars.

National Association of Area Agencies on Aging (NAAAA)
1112 16th Street, NW, Suite 100
Washington, DC 20036
202-296-8130

This is an umbrella organization that represents the area agencies on aging mandated by Congress to help older people. It serves as a communication link between them and other national organizations. Names of local agencies vary from state to state, and this association can pro-

vide the names and phone numbers of area agencies across the country.

National Caucus and Center on Black Aged, Inc.
1424 K Street, NW, Suite 500
Washington, DC 20005
202-637-8400

This organization was formed to make policymakers and the general public aware of the needs and status of older Black Americans.

National Council on the Aging, Inc.
409 Third Street, SW
Washington, DC 20024
202-479-1200

A membership, nonprofit organization of professionals and volunteers in aging and related fields that provides information and training and supports research. It publishes a variety of publications, including Abstracts in Social Gerontology, and conducts an annual conference.

National Indian Council on Aging
6400 Uptown Boulevard NE
Suite 510 West
Albuquerque, NM 87110
505-888-3302

The Council offers various services to elderly American Indians and Alaskan Natives. A quarterly newsletter is available. Membership fees to the Council are \$10.

National Institute on Aging (NIA)
9000 Rockville Pike
Bethesda, MD 20892
301-496-1752

NIA is a part of the National Institutes of Health and is the principal federal agency for conducting and supporting research related to aging. It offers a variety of free publications for older people, including

Age Pages, which are fact sheets on a wide range of topics related to aging and health promotion. Information is available on request.

**National Interfaith Coalition
of Aging (NICA) c/o NCA**

**409 Third Street, SW
Washington, DC 20002
202-479-6689**

NICA is a division of the National Council on the Aging and includes representatives of Catholic, Jewish, and Protestant religious bodies as well as all other faiths. It supports research and plans assistance to religious groups that serve older adults.

**National Pacific/Asian Resource
Center on Aging**

**2033 6th Avenue, Suite 410
United Airlines Building
Seattle, WA 98121
206-448-0313**

This organization promotes the needs of older Pacific/Asian persons and works to improve the delivery of services to them.

**Older Women's League (OWL)
730 11th Street, NW, Suite 300
Washington, DC 20001
202-783-6686**

OWL seeks to educate the public about the problems of middle-aged and older women and to change policy to improve their status. Local OWL chapters offer mutual aid and supportive services, particularly to women who are alone.

**United Way of America
701 North Fairfax Street
Alexandria, VA 22314-2045
703-836-7100**

This is the national association for local United Way agencies. Local

agencies fund a variety of programs that can aid older people in the community. If the local agency can not be identified in the phone book, the national office can provide information across the country.

**Department of Veterans Affairs (VA)
810 Vermont Avenue, NW
Washington, DC 20420
202-389-3781**

The Department of Veterans Affairs (VA) offers benefits for former members of the Armed Forces and their dependents. Some benefits include compensation for disabilities or death related to military service, pensions based on financial need for totally disabled veterans or certain survivors, burial, and medical services including hospitals and clinics. For more information contact the local VA office.

**ORGANIZATIONS WITH
SPECIFIC INTERESTS**

Alcoholism

**Alcoholics Anonymous (AA)
P.O. Box 459
Grand Central Station
New York, NY 10163
212-870-3400**

AA is a peer support organization for recovering alcoholics and offers daily meetings. Chapters are listed in local phone books.

**National Clearinghouse for
Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20852
800-729-6686**

The clearinghouse offers information on substance abuse prevention. A free catalog is available.

**Women for Sobriety
P.O. Box 618
Quaker-town, PA 18951-0618
800-333-1606**

This organization addresses special needs of women alcoholics.

Arthritis

**Arthritis Foundation
P.O. Box 1900
Atlanta, GA 30326
800-283-7800**

A voluntary organization that supports research to find a cure for arthritis and provides services to improve the quality of life of individuals suffering from the disease. Call for free brochures and locations of chapters that provide physician referrals, exercise programs, support groups, and courses in arthritis management.

**National Arthritis and Musculo-
skeletal and Skin Disease
Information Clearinghouse**

**Box AMS
Bethesda, MD 20892
301-495-4484**

Contact the clearinghouse for information about federal programs related to rheumatic and musculoskeletal diseases and skin diseases. Free publications are available upon request.

Bones and Feet

**American Academy of Orthopaedic Surgeons
P.O. Box 618
Park Ridge, IL 60068
708-832-7186**

The Academy is an organization of doctors who specialize in treating disease and injuries of the muscu-

loskeletal system. Free brochures are available upon request.

American Podiatric Medical Association (APMA)
312 Old Georgetown Road
Bethesda, MD 20814
301-571-9200

The APMA is a professional organization of doctors of podiatric medicine, who specialize in the diagnosis and treatment of foot injuries. Free brochures are available.

Cancer

American Cancer Society (ACS)
1599 Clifton Road, NE
Atlanta, GA 30329
404-320-3333 or 800-ACS-2345

A voluntary organization that funds cancer research and offers programs to educate the public and health care professionals about prevention, detection, and treatment.

National Cancer Institute (NCI)
Cancer Information Service
Building 31, Room IOA24
Bethesda, MD 20892
800-4-CANCER

NCI, a section of the National Institutes of Health, is the government's principal agency for funding cancer research and distributing information about cancer to health care professionals and the public. Free publications are available.

Caregiving Support -- Information

Brookdale Center on Aging
425 East 25th Street
New York, NY 10010
212-481-4426

This academic gerontology center offers professional training and

advice to those who provide social services to older people. Information about respite services and legal services is available.

Diabetes

National Diabetes Information Clearinghouse
9000 Rockville Pike, Box NDIC
Bethesda, MD 20892
301-468-2162

Sponsored by the National Institutes of Health, the clearinghouse is a resource and local referral service for those who have diabetes, their caregivers, and medical professionals. A list of free publications is available upon request.

Digestion

National Digestive Diseases Information Clearinghouse
Box NDDIC
Bethesda, MD 20892
301-468-6344

Sponsored by the National Institutes of Health, NDDIC is an information and local referral service for those who have disorders of the digestive tract, including constipation, hemorrhoids, ulcers, diverticulosis, dry mouth, and swallowing difficulties. A list of publications is available upon request.

Employment and Training

JTPA Program Employment and Training Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20213
202-523-6050

The JTPA Program provides funding in all 50 states for programs for

older workers and contains a set-aside for corrections clients. Since the structure of the program varies from state to state, contact the local private industry council listed in your local phone book or your state governor's office for the agency responsible for the program.

Hearing

National Institute on Deafness and Other Communication Disorders Clearinghouse Information Office
9000 Rockville Pike
Bethesda, MD 20892
301-496-7243

This clearinghouse is a division of the National Institutes of Health. Call for free written information.

Heart Disease and Stroke

American Heart Association
7320 Greenville Avenue
Dallas, TX 75231
214-373-6300

The nation's largest voluntary health organization, it funds research and sponsors public education programs about the prevention and treatment of heart disease and stroke. Numerous local chapters offer stroke clubs and exercise, diet and smoking cessation programs, and pamphlets.

National Heart, Lung, and Blood Institute Information Center
4733 Bethesda Avenue, Suite 530
Bethesda, MD 20814
301-951-3260

This is the government's principal agency for research on diseases of the heart, blood, and lungs and distributes information to health care professionals and the general public. A list of materials is available.

**National Institute of Neurological
Disorders and Stroke**

Office of Scientific and Health

**Reports
Building 31, Room 8A06
9000 Rockville Pike
Bethesda, MD 20892
301-496-5751**

This is the government's principal agency for research and dissemination of up-to-date information about neurological diseases, including stroke, Parkinson's disease, multiple sclerosis, epilepsy, and Alzheimer's disease. Brochures, fact sheets, and current reports are available upon request.

**National Rehabilitation Information
Center**

**8455 Colesville Road, Suite 935
Silver Spring, MD 20910-3319
800-3462742**

This organization was established by the U.S. Department of Education to provide information about disabilities and rehabilitation, conduct research, and provide referral service. Information is available upon request.

Home Care

**Foundation for Hospice and Home
Care**

**519 C street, NH
Washington, DC 20002
202-547-7424**

Dedicated to helping people set up quality home care, the Foundation has certification programs and workshops for home health aides and publishes educational materials. Free pamphlets (All About Home Care and Consumer's Guide for Hospice Care are available along with referrals to home health care agencies.

Hospice

**National Hospice Organization
(NHO)**

**1901 N. Moore Street, Ste. 901
Arlington, VA 22209
703-243-5900 or 800-658-8898**

The NHO promotes quality care for terminally ill patients and provides information about hospice and local hospice services. A list of publications is available.

Housing and Nursing Homes

**National Citizens Coalition for
Nursing Home Reform**

**1224 M Street, NW, Suite 301
Washington, DC 20005
202-393-2018**

The Coalition initiates and monitors nursing home reform laws and regulations. A free consumer packet is available.

**Nursing Home Information Service
National Council of Senior Citizens**

**1331 F Street, NW
Washington, DC 20004
202-347-8800**

This organization provides information about all aspects of long-term care. Written materials are available upon request.

Legal Services

**Concern for Dying -- Society for the
Right to Die**

**250 West 57th Street
New York, NY 10107
212-246-6962**

This organization provides information about issues of terminal care and the rights of patients to control treatment decisions. It also provides living wills for all of the states.

**National Academy of Elder Law
Attorneys**

**655 N. Alvernon Way
Alvernon Place, Suite 108
Tucson, AZ 85711
602-881-4005**

Members of the Academy are attorneys who specialize in the legal needs of older people. A free booklet, Questions and Answers When Looking for an Elder Law Attorney, is available to those sending a self-addressed envelope.

Lung Diseases

American Lung Association

**1740 Broadway
New York, NY 10019
212-3 15-8700**

A voluntary organization that funds research and conducts educational programs on lung disease. Local chapters offer a variety of educational programming. Free publications are available upon request.

Mental Health

**National Institute of Mental Health
(NIMH)**

**Public Inquiries Office
600 Fishers Lane, Room 15C-05
Rockville, MD 20857
301-443-4513**

The NIMH conducts and supports research on the causes, prevention, and treatment of mental illness. Free publications are available.

Neurological Diseases

Alzheimer's Association

**919 N. Michigan Ave., Suite 1000
Chicago, IL 60611-1676
800-272-3900**

A voluntary organization that funds

research on the prevention, cause, and treatment of Alzheimer's disease. Information, referrals to local chapters, and written information available upon request.

Osteoporosis

National Osteoporosis Foundation
2100 M Street, NW, Suite 602
Washington, DC 20037
202-223-2226

A voluntary health agency dedicated to reducing the widespread prevalence of osteoporosis. A list of free publications is available upon request. An NOF membership includes the quarterly newsletter.

Parkinson's Disease

American Parkinson's Disease Association
60 Bay Street, Suite 401
Staten Island, NY 10301
800-223-2732

The Association is a nonprofit organization that promotes research and care for those who have Parkinson's disease and their families. It also provides referrals to medical specialists, local chapters, and support groups along with up-to-date information. Free publications, such as The Parkinson's Disease Handbook and Be Active, are available upon request.

Urinary Tract and Incontinence Problems

Help for Incontinent People (HIP)
P.O. Box 544
Union, SC 29379
803-579-7900 or 800-BLADDER
HIP is a nonprofit advocacy organization with a mission to educate the

public and health care professionals about causes, diagnosis, treatment, and management of urinary incontinence. Call for information, referral services, and a publications list.

Vision

American Council of the Blind
1155 15th Street, NW, Suite 720
Washington, DC 20005
800-424-8666

The Council seeks to improve the lifestyles of those who are blind or visually impaired. It offers referral services and provides information on low-vision devices, treatment and services. Free educational materials are available in large print or audio-cassette.

American Foundation for the Blind
15 West 16th Street
New York, NY 100011
212-620-2000
800-232-5463

A nonprofit foundation that offers services to blind and visually impaired individuals and their families. It also offers educational and training programs to educators, health care workers, and other professionals and volunteers who work with blind and visually impaired people. A catalog of free publications and products is available upon request.

National Association for Visually Handicapped (NAVH)
22 west 21st street
New York, NY 10010
212-889-3141

NAVH is the only nonprofit organization devoted to individuals who are not totally blind but do not have adequate vision. It distributes large-print books and newspapers and pro-

vides counseling in the use of low-vision aids. Information, publication catalogs, and listings of low-vision clinics and services for each state are provided.

National Eye Institute (NEI)
Information Building 31, Room 6A32
Bethesda, MD 20892
301-496-5248

A section of the NIH, NEI is the government's principal agency for funding research and distributing information to health care professionals and the general public about the prevention, detection, treatment, and rehabilitation of eye disorders. A list of brochures is available upon request.

National Society to Prevent Blindness
500 East Remington Road
Schaumburg, IL 60173
800-221-3004

With a mission of educating the public about preserving sight and preventing blindness, the Society offers information through the toll free number and free publications.

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