An Examination of Elder Inmates Services
An Aging Crisis

Florida House of Representatives
Criminal Justice & Corrections Council
Committee on Corrections
Representative Allen Trovillion, Chair

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Honorable Ray Sansom, Chair

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The project contemplated an unprecedented level of cooperation and interagency information sharing amount the Florida House of Representatives Criminal Justice and Corrections Council and the Florida Corrections Commission. The Project was unique in that two different reports -- one from the House Committee on Corrections and one from the Florida Corrections Commission -- were produced. The final text of the documents, as well as the Findings and Recommendations of the two reports, differs somewhat as a result of the different direction and perspective given to each group.

The considerable contribution of the Florida Corrections Commission staff includes substantially all of the research on existing literature, as well as a first draft of the materials which form Parts III, IV, V and VI of this report. The Committee has independently assessed the research as well as the preliminary draft language furnished by the Corrections Commission, and committee staff has created this final product. Additional assistance was provided by the Correctional Medical Authority and the House Committee on Crime and Punishment. The Committee staff would also like to acknowledge the contributions made by the many employees of the Department of Corrections who participated in the information surveys, as well as various researchers who provided insight into the realities of working with this inmate population.

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I. INTRODUCTION

Individuals age 65 and older comprise the fastest growing age group in the United States. Correctional systems throughout the country are also seeing a growth in the number and proportion of elderly inmates. The number of inmates 55 and older more than doubled from 1981 to 1990 in our nation. Sixteen southern states studied in 1997 reported that inmates over the age of 50 increased by 480 percent between 1985-1997, while the total inmate population rose only 147 percent. By the year 2000, an estimated 125,000 inmates in this country will be 50 or older, with 35,000 individuals in United States prisons over the age of 65.

Florida, with its large elderly population, will experience the impact of the problems that may result from this burgeoning elderly prison population. Florida has the third largest number of prisoners over age 50 in the nation.

The aging of prison populations reflects the aging of our population in general. People are staying healthy longer, living longer, and are capable of committing crimes longer, sometimes for the first time in their lives. Another reason for the increase in the number of elderly prisoners is the recent enactment of laws that require mandatory minimum and longer sentences.

Researchers disagree about whether an increase in the rate of crime committed by elderly offenders has actually occurred. While the proportion of crimes committed by older persons remains quite low, the real number of crimes committed is growing. There is also disagreement concerning whether the factors predicting illegal behavior are the same at all ages. Generally, the factor most predictive of violent behavior is past offenses. But many older first time offenders have no past record of violent behavior; so past offenses is not a good indicator. Yet for persons over age 65, aggravated assault is the violent offense most often committed, followed by murder.

Prisons currently work under the assumption that incoming prisoners will be young and will still be young when released. This assumption underestimates the medical needs of elderly prisoners, which increases the burden on already strained prison health resources. Programs geared to the young will frequently be ineffective or unrealistic for those over 50, and some of these programmatic funds may be more efficiently spent on programs meeting the needs of elderly prisoners. Similarly, the physical limitations of some of the elderly population should present opportunities for security savings if systematically addressed.

It is generally reported that the cost of incarcerating a geriatric prisoner is three times that of maintaining a regular prisoner. A California study found that the cost of younger inmates was about $21,000 annually; for those inmates over the age of 60, the cost rose to $60,000. Another study projects that 30 percent of the inmate population aged 50 and older will have some form of cardiac and hypertensive disorder requiring substantial medical attention.

This report will assess long-term, older offender needs in Florida's prison system. The need for specialized attention for the elderly inmates in prisons will be illustrated. Opportunities for alternative uses of program and security dollars to help off-set these expenses will be explored to realistically assist in controlling the costs of aging inmates, who represent the fastest growing segment in our nation's prison population.

Findings submitted by Committee Staff

Finding 1 Florida has the third largest number of prisoners over age 50 in the nation. The number of inmates in Florida prisons over the age of 50 has increased 377 percent since 1982. Inmates over 60 have increased 348 percent in the same time period.

Finding 2 The number of elderly inmates in corrections facilities around the country is increasing, primarily due to changes in criminal behavior, law enforcement practices, tougher sentencing laws, and policies affecting the criminal justice system.

Finding 3 There is a lack of a common definition of the term “older inmate.” (Most researchers recommend that correctional agencies adopt age 50 as the chronological starting point for defining older inmates).

Finding 4 Because of the lifestyles of many individuals before incarceration, and the lack of medical care associated with that lifestyle, the physiological age of an inmate may well surpass chronological age. In general, inmates of a certain age can be expected to have more health problems than the general population of the same chronological age.

Finding 5 Studies indicate that the current cost of housing, programming, and providing medical care to older offenders is three times that of younger offenders.

Finding 6 Costs associated with incarceration of elder offenders will continue to rise as a result of the unprecedented growth of "life sentences" and the number of elderly individuals in prisons.

Finding 7 State or federal correctional agency inmate assignment is seldom based exclusively on the chronological age of its inmates. Instead criteria such as health and physical condition, security requirements, inmate program needs, and geographic proximity of the affected inmate’s family are used.

Finding 8 Older offenders have greater social, psychological, and physical health needs than the general incarcerated population. They tend to have many chronic health problems requiring specialized, continuous health care, including special nutrition and diets, pharmacy services, physical therapy, skilled nursing care, and other supportive services.

Finding 9 A substantial number of elderly inmates are first time offenders, sent to prison at age 60 or older. Many elderly first offenders commit a violent crime against a family member.

Finding 10 The rate of recidivism is known to decrease with age.

Finding 11 Older inmates tend to function better in prison environments that have age-segregated housing units and smaller inmate populations.

Finding 12 Corrections officials often lack professionally trained prison staff to handle elderly inmate's special needs.

Finding 13 Because the older inmate is not defined chronologically, there is no uniform point of reference for research, planning, or programming.

Recommendations submitted by Committee Staff

Recommendation 1

The Department of Corrections should collect data on the existing costs for the medical treatment of elderly inmates. Analysis of the specific medical problems and the number of elder inmates affected with each problem, as well as the diagnostic, medical, and pharmaceutical cost of treatment to the individuals should be conducted.

Recommendation 2

The department should assess and identify simple and inexpensive preventative health measures which will improve or maintain the existing physical and mental health of elderly inmates. For example, the opportunity for daily walking in age appropriate conditions to maintain general health, circulatory fitness, muscle and bone mass should be considered. The department should implement and evaluate pilot programs for the identified measures.

Recommendation 3

The department should develop modifications to existing policies and procedures to permit staff to regularly assess the level of elder inmate functioning in order to avoid more costly treatments. Simple safe alternatives to accommodate various kinds of reduced functioning should be identified and implemented. An example might be to identify certain elderly inmates who may need to be placed in lower bunks to reduce the danger of broken bones.

Recommendation 4

The department should evaluate existing programs and activities directed at the general inmate population for usefulness, appropriateness, or effectiveness with elderly inmates. Modifications to existing programs should be considered. Alternative programs, which encourage older inmates to maximize their levels of functioning, should be developed and implemented to lessen the financial impact of elderly inmates on the Corrections system.

Recommendation 5

The department should identify the facilities which house elderly inmates and assess them for structures or conditions which are dangerous to both elderly and impaired inmates. Simple and inexpensive measures, such as painting concrete curb edges a bright color, should be implemented. Other conditions requiring more substantial modifications should be identified and then prioritized.

Recommendation 6 The department should develop specialized training for corrections officers working with elderly inmates. This training should help staff to better understand: (a) the aging process and its associated high levels of stress in an institutional environment; (b) the existence and impact of reduced levels of functioning in elder inmates; and (c) problems and side effects associated with medications frequently taken by elderly persons.

Recommendation 7 The department should conduct an assessment of the security risks posed by the general elderly inmate population. A savings in security costs may be realized as a result of segregation from other inmates. If a savings is found, a redirection of the funds to other needed services for elderly inmates should result.

Recommendation 8 The department should develop a pilot program which segregates minimum security elderly inmates.

Recommendation 9 The Federal Violent Offender Incarceration and Truth-In-Sentencing Incentive Grants Program, 42 USC § 13701 et seq, provides exceptions to offenders serving 85 percent of their sentence as a precondition to states receiving building grants including Section 13704(c) which permits earlier release of geriatric inmates. The Legislature should expand statutory authority for alternatives to expensive incarceration for elderly offenders who no longer pose a danger to society in general, as a result of a specific medical condition or a general decline in physical functioning. Consideration should be given to amendments to Chapter 940 on executive branch clemency, changes to Section 947.149, which concerns conditional medical release, and creation of a new section specifically concerning geriatric inmates.

Recommendation 10 The Department of Elder Affairs, in conjunction with the Department of Corrections, should study existing elderly first time offenders to develop community based programs which would intervene before elders commit violent crimes against family. Such a program could keep these generally law abiding individuals in the community, thereby reducing both the number of elderly inmates and the high costs associated with them.

Recommendation 11 Correctional agencies and facilities in Florida should adopt the age of 50 as the chronological age at which to initially define elderly inmates

II. METHODOLOGY

The findings and recommendations in this report are based on the following research methodology:

- A literature review on relevant topics conducted primarily by the Florida Corrections Commission.
- A survey questionnaire administered to ten corrections departments with the highest inmate populations over the age of 50;
- Data collected through site visits to specified institutions in the State of Florida;
- Relevant information collected from the Florida Department of Corrections and other corrections departments; and,

III. THE EFFECTS OF AGING - THE AGING PROCESS

A. 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, respiration, and other physical and mental functions. Tissue changes include the decline of lean body and bone mass and the increase of fat mass. Muscle strength weakens and susceptibility to debilitating injury from falls increases. 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. The water content in the body decreases, creating a requirement to ingest more fluids. After age 50, the renal system begins to lose mass. This, combined with loss of muscle flexibility, causes problems with incontinence or frequent urination.[1] Bones become brittle due to decreased mineral content and joints lose elasticity.

The aging process varies from person to person.

The senses of smell, taste, touch, sight, and hearing become dulled. Muscles in the eye become inflexible; certain eye problems such as cataracts, glaucoma, and retinal disorders are common among the elderly. Nerve endings in the ear eventually die, leading to the loss of hearing and perception of tones. The sum total of these losses is less intake of sensory information and less ability to respond quickly or appropriately to stimuli.[2]

With aging, the respiratory system changes dramatically. The lung capacity of a 70-year old is half that of a 20 year old. The older lungs need more energy to breathe and there is a loss of oxygen for all bodily functions, including digestion.[3]

Changes in the gastrointestinal system require a high-fiber diet, and the nutritional needs of older people are also altered. Because the elderly are more sedentary and their bodies contain less muscle tissue, they need less protein and require fewer calories. Vitamins and minerals must be monitored

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[1] *An Administrative Overview of the Older Inmate*. Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 2; *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments.(1998) p. 5; "Addressing the Needs of Elderly Offenders: Medical Care, Physical Environment Are of Special Concern." Connie L. Neely, Laura Addison, Delores Craig-Moreland. Corrections Today. Vol. 59 # 5 August 1997. p. 5.

[2] *An Administrative Overview of the Older Inmate*. Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 5.

[3] *An Administrative Overview of the Older Inmate*. Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 5.

closely, especially since many medications decrease vitamin and mineral absorption.[4] Many of the elderly need special diets to help avoid illnesses that prove to be more detrimental and costly in the long run. Older people often require longer time for eating.[5]

The elderly are more susceptible to illness because of changes that affect the immune system, and this requires them to be immunized or re-immunized. Suppressed immune systems leave older individuals quite vulnerable to tuberculosis and other contagious diseases. People 65 and older spend twice as much time in medical facilities when compared to those under 65.[6]

B. Mental Health

Aging brings changes in addition to the physical challenges. These include:

- reduction in interaction with others and feelings of self-worth that come with gainful employment;
- increased fear of dying, concern about pain, helplessness, and being kept alive by machine;
- death of relatives, peers, friends, and pets;
- reduced physical strength and endurance; and
- major life changes such as loss of independence.[7]

These changes create high levels of stress among the elderly. The sources of this stress are unlikely to be observed by casual on lookers. Needs for privacy and for physical and emotional intimacy

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[4] Persons over 50 use more prescription drugs and are more likely to have adverse reactions to medications.

[5] *An Administrative Overview of the Older Inmate*. Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 5-6; *Aging Inmate Population*. Todd Edwards, Southern Legislative Council of The Council of State Governments (1998) p. 11.

[6] *An Administrative Overview of the Older Inmate*. Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 5-6.

[7] *An Administrative Overview of the Older Inmate*. Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 6-7.

remain very strong in this population. Most have an emotional need and overriding desire to remain in control of their own lives.[8]

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[8] *An Administrative Overview of the Older Inmate*. Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 7.

IV. THE ELDER INMATE

A. Characteristics

The number of inmates older than 50 is rapidly growing and is creating extensive problems for the corrections system.

Older inmates have a higher proportion of mental problems than younger prisoners: 15 to 25 percent of the elderly offenders have some form of mental illness. Depression is the most common mental illness found in the elderly, followed by senile dementia, including Alzheimer's disease. Substance abuse is the third. Alcohol abuse beginning early in life but progressing in severity with age is fourth. Older inmates are also known to suffer from organic brain disease, personality disorder, functional psychosis, and paranoid schizophrenia. [9]

Kidney failure, advanced heart disease, lung cancer from increased smoking, other cancers, as well as complicated diseases are more prevalent among the elderly than the younger inmates.

1. Classification

While there are some general characteristics, an "average older inmate" cannot be identified. These inmates are diverse; elder inmates have greater individual differences than younger people. This diversity in the elderly population must be recognized and incorporated into rehabilitative programs. A range of behaviors and physical abilities will be found among elderly inmates, and sub-classifying types of elderly prisoners based on such factors as disciplinary conduct or adjustment would assist in the development and implementation of programs and strategies.[10]

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[9] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 6; "Releasing the Elderly Inmate: A Solution to Prison Overcrowding." Jason S. Ornduff. The Elder Law Journal. (September 1996) p. 181-182; "Incarceration of Older Criminals: Balancing Safety, Cost, and Humanitarian Concerns." William E. Adams, Jr. Nova Law Review. Vol. 19. (1995) p. 472.

[10] "Addressing the Needs of Elderly Offenders: Medical Care, Physical Environment Are of Special Concern." Corrections Today. (August 1997) p. 120; *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 2; "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 53; "Old and Ornery: The Disciplinary Experiences of Elderly Prisoners." Marilyn D. McShane and Frank P. Williams III. International Journal of Offender Therapy and Comparative Criminology. 34(3), (December, 1990) p. 198.

There are three basic groups of older inmates which researchers have identified: first offenders; career or habitual offenders; and aging offenders.[11] Each group is unique in its adjustments to institutional living. Differences between the groups impact the security, programming and overall supervision at the prison. Moreover, not all elderly prisoners adjust well or conform their behavior to institutional expectations. Current management approaches are based on the stereotypical well-behaved senior and there are few strategies that exist for handling the difficult geriatric inmate.[12]

a. First Offenders

It has been estimated that approximately 50 percent of elderly inmates are first offenders, sent to prison when they were 60 or older. Among this group of elderly offenders, crimes of passion are frequently the cause for incarceration. As the range of social interaction between individuals diminishes with advancing age, primary relationships become more intense, and there are more opportunities for conflict. These older first offenders committed their offense in a spontaneous fashion; they do not consider themselves to be criminals. Offenses committed later in life can also be precipitated by biological changes due to aging. Chronic brain syndrome may be associated with loss of inhibitions, which results in illegal sexual behavior. It may also result in rigidity, suspiciousness, and quarrelsomeness, with consequent aggressiveness.[13]

Older first offenders are more likely to be sentenced for violent offenses against a person, usually involving a family member, or for sexual offenses committed during a middle age crisis or later.

Sexual offenses involving child victims are common among the elderly. Nearly one third of older inmates in Tennessee were committed for sex crimes. Other offenses include white-collar property crimes, sale of drugs, and vehicular manslaughter while under the influence of alcohol.[14]

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[11] "Addressing the Needs of Elderly Offenders: Medical Care, Physical Environment Are of Special Concern." Connie L. Neely, Laura Addison, Delores Craig-Moreland. Corrections Today. Vol. 59 # 5 August 1997. p. 121; "Aging In Prison: A Case Study Of New Elderly Offenders." Ronald H. Aday. International Journal of Offender Therapy and Comparative Criminology. 38(1): p. 79; "The Graying of America's Prison Population." Edith E. Flynn. The Prison Journal. Vol. 72, Nos. 1 & 2. (1992) p. 85; *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 11.

[12] "Old and Ornery: The Disciplinary Experiences of Elderly Prisoners." Marilyn D. McShane and Frank P. Williams III. International Journal of Offender Therapy and Comparative Criminology. 34(3), (December, 1990) p. 199.

[13] "Aging In Prison: A Case Study Of New Elderly Offenders." Ronald H. Aday. International Journal of Offender Therapy and Comparative Criminology. 38(1): (1994) p. 80-83.

[14] "Aging In Prison: A Case Study Of New Elderly Offenders." Ronald H. Aday. International Journal of Offender Therapy and Comparative Criminology. 38(1): (1994) p. 80; p. 83.

These new elderly inmates typically are maladjusted in society and poor at adapting to change. Other characteristics could include: a volatile personality; being at risk for suicide and violence against other inmates; having poor mental health including general withdrawal from society; and having the highest potential for victimization by other inmates. New offenders are more likely to maintain some community ties and would be easier to place upon release.[15]

b. Career or Habitual Offender - Prison Recidivists

These inmates have long histories of crime and a sequential career of institutional commitments. They usually adjust well upon re-entry because they know the prison routine. They can help the first time offenders adjust.[16]

The career criminals often have substance abuse problems and other chronic problems that make coping with life outside an institution difficult. Some of these offenders may not represent a serious threat of physical harm to others; they generally serve numerous short sentences of imprisonment for lesser crimes. This group of offenders will most likely become geriatric inmates.[17]

c. The Aging Offender

This inmate has a long-term history in the system and is the least volatile. Aged long-term offenders are very difficult to place after incarceration because they have few ties and limited work history in the community. Additionally, inmates imprisoned for long periods may be fearful of leaving institutional life.[18]

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[15] "Addressing the Needs of Elderly Offenders: Medical Care, Physical Environment Are of Special Concern." Connie L. Needy, Laura Addison, Deplores Craig-Moreland. Corrections Today. Vol. 59 # 5 (August 1997) p. 121; *An Administrative Overview of the Older Inmate.* JoAnn B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 11.

[16] "Aging In Prison: A Case Study Of New Elderly Offenders." Ronald H. Aday. International Journal of Offender Therapy and Comparative Criminology. 38(1): (1994) p. 79; "Addressing the Needs of Elderly Offenders: Medical Care, Physical Environment Are of Special Concern." Connie L. Neely, Laura Addison, Delores Craig-Moreland. Corrections Today. Vol. 59 # 5 (August 1997) p. 121.

[17] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 11.; "Three Strikes: Can We Return to Rationality?" (partial article) Michael Vitiello. The Journal of Criminal Law 7 Criminology. Vol. 87, No. 2. (1997) p. 440.

[18] "Addressing the Needs of Elderly Offenders: Medical Care, Physical Environment Are of Special Concern." Connie L. Neely, Laura Addison, Delores Craig-Moreland. Corrections Today. Vol. 59 # 5 (August 1997) p. 121; "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 53.

2. General Observations

In all three groups, the aging prisoner often represents a special population in terms of criminal patterns, health care needs, problems of individual adjustment to institutional life, and problems with family relationships. They pose special difficulties to the prison system regarding custody, rehabilitation, and parole.[19]

Elderly offenders who have committed crimes in their later years have a hard time adjusting to incarcerated life.

On the average, older inmates have low IQ's and a high divorce rate. The older criminal has a history of part-time or unemployment and an unstable family life due to alcohol abuse. The combination of joblessness, lack of family ties, and alcohol abuse increases the likelihood of criminal behavior in the elder offender. Older offenders who commit violent crimes are likely to be unmarried males, nonwhite, with lower incomes and fewer dependents. One major difference between elderly prisoners and the general inmate population is medical history.[20]

Some older inmates report prison life to be a positive experience for them. They are not exposed to heavy labor or heavy drinking; they eat well, rest often, and have easy access to medical care.

Conditions and status can change rapidly with older inmates.

But many older inmates experience negative aspects of incarceration. Many withdraw into themselves because of the lack of privacy in most prisons. Aging prisoners can feel frightened, ridiculed, and anxious. They become more dependent upon, and cooperative with, the prison staff for protection; they can no longer compete physically with younger inmates. One study found that older prisoners in Florida experienced more interpersonal problems with other inmates than staff. While most older inmates eventually adapt to prison life, they also demonstrate high levels of stress and

Assessment of older inmates at intake and during their stay in prison is an important factor for meeting the needs of the offender and system planning.

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[19] "Aging In Prison: A Case Study Of New Elderly Offenders." Ronald H. Aday. International Journal of Offender Therapy and Comparative Criminology. 38(1): (1994) p. 79-80.

[20] "Releasing the Elderly Inmate: A Solution to Prison Overcrowding." Jason S. Ornduff. The Elder Law Journal. (September, 1996) p. 181-182; "Incarceration of Older Criminals: Balancing Safety, Cost, and Humanitarian Concerns." William E. Adams, Jr. Nova Law Review. Vol. 19. (1995) p. 472; "Old and Ornery: The Disciplinary Experiences of Elderly Prisoners." Marilyn D. McShane and Frank P. Williams III. International Journal of Offender Therapy and Comparative Criminology. 34(3), (December, 1990) p. 209.

hopelessness about the future. Death and loss must be dealt with often. An elder inmate's loss of freedom presents a special challenge in confronting the probability of dying while incarcerated.[21]

Older inmates often outlive relatives and friends or commit crimes against family members that cause estrangement. As the length of imprisonment increases, contacts with family and outside friends diminish, and the inmate becomes more dependent on the institution (institutionalization). Factors such as health, education, crime history, and geographical location can effect the maintenance of outside connections.[22]

Both types of inmates -- those who feel the negative effects of incarceration and those who find it to be a positive experience -- favor older inmates being grouped together for safety and support.[23]

B. Gender Differences

As the number of incarcerated women increases, the number of older women in prison is also increasing. This is due to changes in the criminal justice system such as mandatory sentencing, longer sentencing and problems with substance abuse.

In 1990, women age 50 and older comprised approximately 4 percent of the total number of women incarcerated in both state and federal prisons. Studies indicate numerous differences between older women and older men. The differences for the women include greater longevity, greater poverty, greater chance of living alone, and a greater likelihood of outliving their support systems. Older women offenders are historically perceived as less threatening upon release. But the lack of community resources, negative stereotyping and lack of vocational and educational training results in great economic hardship for the women after release from incarceration.[24]

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[21] "Old and Ornery: The Disciplinary Experiences of Elderly Prisoners." Marilyn D. McShane and Frank P. Williams III. International Journal of Offender Therapy and Comparative Criminology. 34(3), (December, 1990) p. 198; "Incarceration of Older Criminals: Balancing Safety, Cost, and Humanitarian Concerns." William E. Adams, Jr. Nova Law Review. Vol. 19. (1995) p. 475; "South Carolina Strives to Treat Elderly and Disabled Offenders." Judy C. Anderson and R. Daniel McGehee. Corrections Today. (August 1991) p. 127.

[22] "Aging In Prison: A Case Study Of New Elderly Offenders." Ronald H. Aday. International Journal of Offender Therapy and Comparative Criminology. 38(1): (1994) p. 85.

[23] "Aging In Prison: A Case Study Of New Elderly Offenders." Ronald H. Aday. International Journal of Offender Therapy and Comparative Criminology. 38(1): (1994) p. 81-82; p. 89.

[24] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 14.

C. Medical Care

Medical and other associated costs for the elderly are on the average of three times greater than that required for the care of more youthful offenders. For example, individuals over 50 use more prescription drugs than younger people. Often elderly persons have between 10 to 20 different medications prescribed. There is also an increased need of the elderly for dental care and special foods.

V. SPECIAL NEEDS OF THE ELDERLY INMATE

A. Health Care

On average, each inmate over age 55 suffers from three chronic health problems, including hypertension, diabetes, alcoholism, cancer, emphysema, and stroke. They have a higher incidence of disease and significant functional disabilities. These conditions frequently require highly specialized and expensive medical procedures. Although the government may have had to help pay for this treatment in general society through such programs as Medicare and Medicaid, when these individuals are incarcerated, government has the additional economic burden for transporting the inmate from the prison to the hospital accompanied by guards. Additionally, a lack of previous dental care now requires government to provide dental prosthesis and long-term dental care.[25]

There is a problem adequately defining an "elderly inmate."

Because their medical and social histories include high risk sexual and health behaviors, high incidences of tobacco use and drug and alcohol use/abuse, "an inmate's appraised age averaged 11.5 years more than their chronological age." The majority of this group reported their health was poor when compared to the general population of their age and that their condition had worsened in the past two years.[26]

Due to the importance of selecting healthy lifestyles in ameliorating the aging process, it is critical that correctional systems address diet, exercise, smoking cessation, preventive health programs, and health education. The cost of one heart bypass operation caused by the effects of unhealthy behaviors can exceed $150,000. Many of the chronic diseases common to older offenders require long-term care. Regular examinations of visual, auditory, and other functions, in addition to wellness activities, are very beneficial to this population and may assist in controlling medical costs.[27]

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[25] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 8; *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 13; "Releasing the Elderly Inmate: A Solution to Prison Overcrowding." Jason S. Ornduff. The Elder Law Journal. (September 1996) p. 186; "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 49.

[26] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 8; "Aging in Prison: A Case Study of New Elderly Offenders." Ronald H. Aday. International Journal of Offender Therapy and Comparative Criminology. 38(1): (1994) p. 86.

[27] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 6; p. 13.

The inmates' medical health problems are compounded by excessive worry, feelings of disgrace, improper diet, a stressful environment, and a lack of stimulating work. The physical, intellectual, and emotional deterioration brought on by long confinement can cause the elderly inmate to become pessimistic about their future status. The high incidence of depression found in the elderly, along with the death of friends and family, and the medical difficulties that accompany aging, effect their emotional well-being, and frequently have an impact on their physical health as well. Many fear dying in prison. Behavior therapy and cognitive therapy for these inmates can help not only their mental health, but their physical health as well.[28]

Elderly inmates are especially prone to feelings of depression.

1. Appropriate Training of Medical Staff

A lack of training in the medical and mental health problems of the elderly by correctional medical staff can exacerbate costs and problems. The National Institute of Corrections lists six skills essential for medical personnel to develop in working with the elderly:

- appreciation of the patient's perspective;
- understanding of the aging process;
- understanding of the level of functioning of older persons;
- recognition of the impact that reduced levels of functioning can have on an individual;
- recognition of the problems medications can cause; and
- recognition and assessment of the resources available to treat or improve the problem.[29]

Prison personnel must be educated concerning the relationship between health and aging. They must be trained to recognize unreported symptoms, and to distinguish normal aging from the disease process. The improper administration of medication can have devastating effects on older inmates. Procedures for sick call and dispensing medications may need to modified to better accommodate

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[28] "Aging in Prison: A Case Study of New Elderly Offenders." Ronald H. Aday. International Journal of Offender Therapy and Comparative Criminology. 38(1). (1994) p. 81; *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 9.

[29] "*An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 6.

older inmates and their reduced mobility. According to one correctional professional, "correctional health care is going to move toward a geriatric specialization."[30]

2. Telemedicine

Many prisons are located in remote areas which make it difficult to maintain the necessary medical and mental health personnel. Telemedicine is increasingly used for prison health needs in response to the problem of remoteness. Telemedicine involves the use of diagnostic testing and procedures at the remote facility and the exchange of medical information from the remote site to a more comprehensive facility via electronic communications. Telemedicine can be used for health education for the patient or health care provider; most importantly it is used for the purpose of improving patient care.

Telemedicine opportunities include informal case consultations or case discussions, pathology reviews, real-time or recorded observations of cardiograms, vascular ultrasound exams or endoscopic procedures, reviews of x-rays, and the participation of specialized medical professionals in trauma and emergency care cases at remote facilities via telecommunications. Telemedicine can also support medical personnel recruiting efforts in remote locations. Consolidation of health services can also been used to address the cost of health care to elderly inmates.[31]

3. Co-payments

Co-payments for health care are being assessed in many correctional systems. In many cases, fees are waived for indigent and geriatric inmates due to their physical inability to work and their need for more frequent, and costly, medical services. Since 1983, Social Security benefits have been suspended to convicted felons while they are incarcerated.[32]

B. Housing

The issues concerning the care of elder inmates are similar to those for the physically disabled, those who have HIV-AIDS or other terminal illnesses, or those with debilitating mental impairments. These populations have many special needs in common. Most states take the length of sentence and

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[30] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice (August 1992) p. 6; *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 8.

[31] "Elder Care: Louisiana Initiates Program to Meet Needs of Aging Inmate Population." Jean Wall. Corrections Today. (April 1998) pp. 137-138; *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 10.

[32] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 10.

physical condition of the individual, rather than age, into consideration when inmates are classified, custody graded, and given work, program, or housing assignments.[33]

A key question for prison administrators concerning elderly inmates is whether this population should be mainstreamed or segregated. There are strong arguments for both sides. Agencies with substantial numbers of older inmates appear to have a need for both options: segregation and mainstreaming. However, one study pointed to a scarcity of minimum-security options for older offenders in corrections systems providing special housing units for this population.[34]

There are some arguments against segregation of elderly inmates.

Mainstreaming ensures equal access to existing programs, including visiting privileges. It makes federal requirements for mainstreaming the elderly and disabled easier to meet. Housing the elderly with the other inmates has historically had a stabilizing effect on the general population, although in this instance, officials are usually referring to inmates between the ages of 35-50.[35] The majority of older inmates are not generally considered security risks because of their medical condition, and minimum custody can be used when appropriate. Not all inmates identify with their age group, so mainstreaming may be appropriate for these individuals. When age groups are separated by housing units, the disciplinary philosophies and opportunities for interaction with staff may vary significantly and affect disciplinary infraction rates.[36]

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[33] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 4-5; "The Graying of America's Prison Population." Edith E. Flynn. The Prison Journal. Vol. 72, Nos. 1 & 2. (1992) p. 81.

[34] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 12; "The Graying of America's Prison Population." Edith E. Flynn. The Prison Journal. Vol. 72, Nos. 1 & 2. (1992) p. 82.

[35] "The Graying of America's Prison Population." Edith E. Flynn. The Prison Journal. Vol. 72, Nos. 1 & 2. (1992) p. 86; *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 11-12; "Releasing the Elderly Inmate: A Solution to Prison Overcrowding." Jason S. Ornduff. The Elder Law Journal. (September 1996) p. 184.

[36] "Releasing the Elderly Inmate: A Solution to Prison Overcrowding." Jason S. Ornduff. The Elder Law Journal. (September 1996) "Old and Ornery: The Disciplinary Experiences of Elderly Prisoners." Marilyn D. McShane and Frank P. Williams III. International Journal of Offender Therapy and Comparative Criminology. 34(3). (December, 1990); "Aging in Prison: A Case Study of New Elderly Offenders." Ronald H. Aday. International Journal of Offender Therapy and Comparative Criminology. 38(1). (1994) p. 199.

Steps, crowding, limited climate control, regulation of light, and architectural barriers to those with physical disabilities are additional problems older inmates encounter in prison.

The arguments for establishing special units are also compelling. Special units provide a concentration of specialized staff and resources needed by the group. They are able to identify, monitor, and treat geriatric health problems as they develop.[37] These units save money by providing care which prevents high-cost illnesses and by reducing the need for guards, which account for about 50 percent of prison expenditures. A large percentage of elderly inmates do not pose a high security risk to management and could qualify for less than high-security housing. Providing separate, low-custody facilities for older inmates can free up close custody beds for younger, more violent inmates.[38]

When physical plants are designed or modified to meet the needs of elderly offenders, the inmates' overall levels of well-being and satisfaction improved. Some inmates' medical conditions require a form of protective housing, but this is not necessarily round-the-clock nursing care.[39]

Younger inmates may prey upon elderly inmates.

Older inmates are more concerned about their safety, too. Prison officials need to segregate vulnerable inmates from potential aggressors. The more vulnerable the potential victim, the greater the duty on prison officials to segregate likely aggressors.[40]

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[37] "Senior Scoundrels: Another Look." Karen Fisher. State Legislatures. (March 1992) p. 11; "The Graying of America's Prison Population." Edith E. Flynn. The Prison Journal. Vol. 72, Nos. 1 & 2. (1992) p. 87.

[38] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 13.

[39] "Addressing the Needs of Elderly Offenders: Medical Care, Physical Environment Are of Special Concern." Connie L. Neely, Laura Addison, Delores Craig-Moreland. Corrections Today. Vol. 59 # 5 (August 1997) p. 123.

[40] "The Graying of America's Prison Population." Edith E. Flynn. The Prison Journal. Vol. 72, Nos. 1 & 2. (1992) p. 87; "Civil Liability Against Prison Officials for Inmate-on-Inmate Assault: Where Are We and Where Have We Been?" Michael S. Vaughn and Rolando V. Del Carmen. The Prison Journal. Vol. 75, No. 1. (March 1995) p. 80.

Older inmates have a greater need for privacy, safety, structure, and emotional feedback than younger inmates.

There are several other reasons to segregate older inmates. Existing programmatic activities such as currently conducted physical recreation are largely unsuited for this sub-population. General education, vocational training, and work programs have little meaning for an offender population which is unlikely to return to work. Stimulation of social interaction among fellow elderly inmates can help them to avoid feelings of loneliness and enhance their self-respect, and assist with their general health. Additionally, these things help decrease the negative effects of institutionalization upon the elderly.[41]

Ironically, the creation of a specialized elderly facility can become a "self-fulfilling prophecy" and be quickly filled with prisoners who might otherwise have not been sentenced to prison had such a facility not been available. The National Institute on Corrections describes the building of elderly care prisons as a "Catch-22." Because there becomes a responsible way of dealing with elderly inmates in ways that meet their needs, their numbers will likely increase.[42]

Separate facilities cannot be justified in systems where there are few elderly inmates. This is true particularly for aging female inmates, as they typically make up a very small portion of the total female population.[43]

Wherever they are housed, special considerations should be given to safe accommodation of the handicapped and less physically able, including the elderly.

In facilities designed to accommodate the elderly, stairs should be minimal and distances from various facilities within the institution reduced. Precautions should be taken to minimize falls. Something as simple as assuring the availability of eye examinations and securing properly fitting glasses can prevent a costly fall. Older inmates should be assigned the lower bunk. The need for frequent urination may require modifications in transportation schedules of older inmates who may also benefit from unimpeded access to toilet facilities. One correctional system is considering introducing a new line of prison uniforms with Velcro closures. Standard diets can be modified to meet the high-fiber, low-calorie

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[41] "The Graying of America's Prison Population." Edith E. Flynn. The Prison Journal. Vol. 72, Nos. 1 & 2. (1992) p. 86-87; *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 12; p. 6; "Releasing the Elderly Inmate: A Solution to Prison Overcrowding." Jason S. Ornduff. The Elder Law Journal (September 1996) p. 184.

[42] "Old Folks in Prison." Bruce Baird. http://www.slweekly.com/news/story/story_961226_1.html. (March 11, 1999) Salt Lake City Weekly. 1996

[43] "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 53.

needs of the elderly inmate. Some facilities employ psychologists and counselors with professional training in geriatrics.[44]

C. Programming

Prison staffs may discourage elderly inmates from participating in programs because they view such programs as designed for younger inmates.

While the numbers of elderly inmates continues to rise, programming for elderly inmates has not kept pace. Few older inmates participate in programs and activities offered by the institution which involve interaction with other prisoners, including social and recreational activities, and or formal programs such as counseling, education, and vocational training. As a result, the elderly tend to become idle. As one expert noted, "the present modality of 'warehousing' these inmates with minimal programming or activities intensifies day-to-day management concerns" and significantly contributes to the general decline in the individual which escalates daily cost of institutional and health care.[45]

Older inmates who have some sense of control over their daily lives adjust better.

Administrators need to recognize the impact of aging on inmates. New approaches to existing policies and procedures which encourage older inmates to improve their lifestyle and maximize their level of functioning will reduce institutional management concerns and the cost of care. Keeping older inmates active is important. They should be offered activities that are practical for their ages and physical conditions, and should be allowed to keep reasonable assignments in the institutional work force as a way of maintaining dignity and positive self-image. Daily maintenance and attention are the best options in the long run.[46]

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[44] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 5; p. 12; "Insiders: Stealing Time." Karen Bowers. Denver westword.com. http://www.westword.com/1996/080196/feature12.html. (November 17, 1998); "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 49.

[45] "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 53; "Releasing the Elderly Inmate: A Solution to Prison Overcrowding." Jason S. Ornduff. The Elder Law Journal. (September 1996) p. 184; *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 12.

[46] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 10; "Addressing the Needs of Elderly Offenders: Medical Care, Physical Environment Are of Special Concern." Connie L. Neely, Laura Addison, Delores Craig-Moreland. Corrections Today. Vol. 59 # 5 (August 1997) p. 123; "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 45.

Often earned work credits may be available to only those who work jobs. The question for the system then becomes what to do with the elderly inmate that becomes too infirm to perform existing work assignments. While they are still able, suitable assignment of jobs or tasks should be given to older inmates.[47] Consideration should be given to creating new tasks the elderly could perform.

The elderly inmate population has diverse interests and abilities. Therefore, more individualized programming which reflects the variety of their biological, psychological, and social levels of functioning should be considered. Instead of traditional inmate vocational activities, the emphasis should be upon leisure activities that can later be translated into a cottage industry; part-time work or volunteer activities within the institution; or a recreational outlet, such as gardening, woodworking, basketry and other crafts.[48]

Instead of current programs which prepare the inmate for re-entry as a productive member of society, wellness programs which aim to keep the individual alert and active are recommended for elderly individuals. Services should be adapted to meet the needs of older inmates, such as addictions treatment that deals with older offenders' high incidence of alcoholism and/or substance abuse. Counseling concerning loss is also recommend.[49]

In most prisons, counseling is geared to rehabilitating younger inmates rather than coping with issues such as chronic illness or death.

Agencies also need to share information about programs that successfully address the special needs of older inmates and adapt ideas from disciplines other than corrections. Strong liaisons with community agencies and organizations are useful to ensure continuity of care and services during incarceration and after release. Pre-release programs and services are vital to the elderly inmate.[50]

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[47] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 10; p. 13.

[48] "South Carolina Strives to Treat Elderly and Disabled Offenders." Judy C. Anderson and R. Daniel McGehee. Corrections Today. (August 1991) p. 127; *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 2.

[49] "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 53; *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p.13.

[50] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 2; p. 13.

1. Early Release

A new option for dealing with elderly inmates consists of early release programs that specifically target elderly prisoners who no longer pose a threat to society. Some geriatric prisoners could qualify for unconditional release, and low risk prisoners may be suitable for special parole. Inmates having a mid-level of risk might be released but required to wear an electronic monitoring device. What is important is not the specific option, but the fact that such dispositions be pursued with planning and deliberation.[51]

Many inmates have outlived or alienated their families, or they are too sick or frail to work.

Releasing older prisoners may impact other existing situations. If significant numbers of elders are paroled, some officials think parole or community corrections agencies would find it difficult to deal with an influx of new releases. "The probation and parole people who supervise inmates who are released are not enthusiastic about developing a plan for offenders who have been locked up for 20 or 30 years and who are going to need a lot of attention." Others say the myriad of programs already in the community for the elderly -- many funded with federal and private money -- are better equipped to meet the needs of older prisoners.[52] For these individuals, outright release may provide a better option.

Some researchers believe there is a net savings in releasing elderly inmates. The prisoners will receive better, more efficient care. Prison cells may not have to be built.

Because older inmates are less likely to commit more crimes, the recidivism rate will decline.

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. Referrals to long-term care and assisted-living facilities and eligibility counseling for Medicaid should be made. Helping elderly inmates find jobs upon release can be very difficult.[53]

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[51] "Releasing the Elderly Inmate: A Solution to Prison Overcrowding." Jason S. Ornduff. The Elder Law Journal. (September 1996) p. 194; "Senior Scoundrels: Another Look." Karen Fisher. State Legislatures (March 1992) p. 11; "The Graying of America's Prison Population." Edith E. Flynn. The Prison Journal. Vol. 72, Nos. 1 & 2. (1992) p. 88.

[52] "Senior Scoundrels: Another Look." Karen Fisher. State Legislatures. (March 1992) p. 11.

[53] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 10; *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments. (1998) p. 10.

2. Project for Older Prisoners (POPS)

One program dedicated to the release of elderly inmates is Project for Older Prisoners (POPS) which was founded in 1989 by Professor Jonathan Turley while on the staff of the Tulane Law School. It began as a public advocacy group whose primary goal was to reduce and relieve overcrowding by identifying low-risk, high-cost offenders for early release. POPS uses volunteer law students to study cases of older inmates and determine whether they are safe to release. The program does not handle sex offenders or first-degree murderers.[54]

POPS is discriminating in the cases it will accept, and it only assists ten percent of prisoners interviewed for consideration in the program. Candidates must be at least 55, have already served the average time for their offense, and have been evaluated as unlikely to commit further crimes in the future. Another unique requirement is that the victim, or the victim's family, must agree to early release. As a result of these rigid standards, no prisoner released by POPS has ever returned to prison for committing another crime. The program also helps its clients receive Social Security payments or find a job.[55]

3. Hospice

In general, the cost of hospice care is less than that of traditional treatment.

Providing appropriate care for dying offenders is a growing problem for the nation's correctional institutions. More inmates are dying in prison due to AIDS and the imposition of longer prison sentences. Not all elderly or terminally ill inmates are suitable for release. In response to these conditions, some correctional systems have adopted a formal hospice program. By focusing on managing pain rather than curing illness, hospice programs emphasize humane care designed to provide the best quality of life for the terminally ill.

The Louisiana State Penitentiary at Angola, the largest prison in the United States, is located north of Baton Rouge on 18,000 acres of farmland along the Mississippi River. Due to the state of Louisiana's tough sentencing laws and numerous life sentences, one of Angola's five compounds was established as a hospice for the elderly population. The compound is referred to as the "Geriatric Camp."[56]

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[54] "Prisons Grapple with Upcoming Surge of Elderly Inmates." Associated Press. (August 17, 1997). Http://www.naplesnews.com/today/florida/ad06060.htm. (November 17, 1998).

[55] "Releasing the Elderly Inmate: A Solution to Prison Overcrowding." Jason S. Ornduff. The Elder Law Journal. (September 1996) p. 195.

[56] "Dying in Prison." *PDIA Newsletter,* (September, 1998) No. 3.
Note: Two of the programs, California and Colorado, were licensed by other state agencies; others had applied for licensure.

In 1998, the National Institute on Corrections conducted a survey on formal hospice programs. According to the study, all twelve programs were governed by specific policies concerning:

Eleven states and the federal prison system have these programs.

- Admission procedures;
- Special privileges for terminally ill inmates - relaxed visitation, who is considered "family," special diets;
- Housing options; and
- "Do not resuscitate" orders.

In addition, there were operational issues including:

- The use of inmate volunteers;
- The appropriateness of an interdisciplinary approach which would allow team members to include administrative or security staff, chaplains, mental health staff, medical personnel, social workers, dietitians, recreation staff, pharmacists, and volunteers;
- The evaluation of the impact of links with outside hospice programs;
- The provision of hospice services to the families of the inmates; and
- Training; and
- Case closure[57]

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[57] *Hospice and Palliative Care in Prisons*. National Institute of Corrections. U.S. Department of Justice. (September 1998) p. 5-6.

According to a study by the National Institute of Corrections, surveyed institutions cited the following advantages and disadvantages of their hospice programs:

Advantages	***Disadvantages***
• Compassionate program in a difficult setting • Death with dignity • Improved continuity of care • Inmate volunteers say this is an enriching experience • Improved inmate morale concerning health care • Improved relationships with family members for both staff and offenders • Cuts down on trips to outside hospital • The program has been cost effective because it has been implemented without increase in staff or funding • Decreased custodial problems • Good public relations • Team management concept has improved overall cooperation and communication	• Inmates not wanting to accept terminal diagnosis, distrustful of staff • Staffing requirements and expensive FTEs • Need better links to community hospice program • Misperceptions by security staff of the mission and value of hospice in a prison setting • Staff turnover • Security issues sometimes override hospice management issues

Source: National Institute of Corrections. U.S. Department of Justice [58]

D. Recidivism

Elderly inmates have the lowest recidivism rates. One study reported that 45 percent of offenders age 18-29 commit a new crime after release from prison while only 3.2 percent of those over 55

[58] *Hospice and Palliative Care in Prisons*. National Institute of Corrections. U.S. Department of Justice. (September 1998) p. 7-8.

recommit. The New York State Department of Correctional Services has maintained statistics correlating age and recidivism and reported the following rates for the various age groups: [59]

Age	Percentage
16-18	> 70%
18-44	N/A
45-49	26.6%
50-64	22.1%
over 65	7.4%

Source: New York State Department of Corrections

[59] Criminal Justice Myths of the Month: September-Once a Criminal, Always a Criminal. http://www.nciant.org/ncia/myth96.html. (November 17, 1998); "Three Strikes: Can We Return to Rationality?" (partial article) Michael Vitiello. The Journal of Criminal Law 7 Criminology. Vol. 87, No. 2. (1997) p. 437.

VI. PLANNING

The elderly inmate population is not, at present, tracked and monitored separately by the majority of corrections systems, which could cause difficulties in future planning. Researchers strongly recommend that state systems that currently do not track this population begin the necessary planning to meet the needs of this growing population and to protect the health and safety of a particularly susceptible group. Some officials believe that in the future, "every state is going to have to end up with one or two facilities that are essentially nursing homes."[60]

A. Federal Mandates Related to the Elderly

There are several federal laws that govern the treatment of the elderly, regardless of location or status. The Older Americans Act of 1965 mandates that each state establish an agency to coordinate services for older people at the state level with the U.S. Department of Health. The Federal Age Discrimination Employment Act of 1967 makes it unlawful to discriminate in any area of employment on the basis of age for individuals between the ages of 40 to 70. The Job Training Partnership Act of 1986 provides employment programs for workers 55 and older.[61]

In both the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, those with disabilities are defined as people with physical or mental conditions that substantially impair one or more life activities. The Rehabilitation Act of 1973 barred discrimination on the basis of disability against inmates in federal prison. In 1998, the U.S. Supreme Court ruled in *Pennsylvania* v. *Yeskey*, 524 U.S. 206 (1998), that the ADA extended this non-discrimination to state prisons.[62]

The ADA affects how correctional facilities deliver their programs and services to inmates with disabilities.

The act requires prison facilities to evaluate each program, service, and activity in such a way that, when viewed in its entirety, the program, service

[60] "The Graying of America's Prison Population." Edith E. Flynn. The Prison Journal. Vol. 72, Nos. 1 & 2. (1992) p. 80-81; p. 89; "Releasing the Elderly Inmate: A Solution to Prison Overcrowding." Jason S. Ornduff. The Elder Law Journal. (September 1996) p. 187.

[61] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 10.

[62] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p.10; *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 12.

or activity is readily accessible to and usable by *eligible* inmates with disabilities.[63]

A "qualified individual with a disability" means an individual with a disability who, with or without reasonable modifications, meets the essential eligibility requirements for the receipt of services or the participation in programs provided by the public entity.[64] An inmate whose participation in a particular activity poses a "direct threat" to the health or safety of others will not be "qualified," but that determination must be based on an individual assessment. Determination of who is "qualified" requires analysis of the particular activity to identify the "essential eligibility requirements" and analysis of the particular inmate.[65]

To ensure compliance with ADA mandates, corrections administrators should look at three distinct areas when evaluating the accessibility of their facility's programs, services, and activities: (1) policies and procedures, (2) architectural barriers, and (3) communications.[66]

Pursuant to the ADA inmates, visitors, staff, and volunteers with disabilities are entitled to physical access to the facility and an effective means of communicating. These requirements can be accomplished without construction and they may be achieved by relocating services and activities.[67] Auxiliary aids may be required to meet these conditions. Architectural barriers may not be as significant an issue for mentally disabled inmates, but the barriers effect inmates with other disabilities.

Because of the prevalence of mental disabilities among inmates, especially among the elderly, significant ADA issues arise. An estimated 6.4 percent of prisoners in the United States have a severe mental disability. The percentage of female inmates with a mental disability may be as high as 13 percent. The ADA distinguishes between mental illness and developmental disability (retardation).[68]

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[63] *Americans With Disabilities Act and Criminal Justice: Mental Disabilities and Corrections.* Paula N. Rubin and Susan W. McCampbell. National Institute of Justice. U.S. Department of Justice. (July 1995) p. 1-2.

[64] *Americans With Disabilities Act and Criminal Justice: Mental Disabilities and Corrections.* Paula N. Rubin and Susan W. McCampbell. National Institute of Justice. U.S. Department of Justice. (July 1995) p. 1-5.

[65] *Americans With Disabilities Act and Criminal Justice: Mental Disabilities and Corrections.* Paula N. Rubin and Susan W. McCampbell. National Institute of Justice. U.S. Department of Justice. (July 1995) p. 2-3.

[66] *Americans With Disabilities Act and Criminal Justice: Mental Disabilities and Corrections.* Paula N. Rubin and Susan W. McCampbell. National Institute of Justice. U.S. Department of Justice. (July 1995) p. 4.

[67] *Americans With Disabilities Act and Criminal Justice: Mental Disabilities and Corrections.* Paula N. Rubin and Susan W. McCampbell. National Institute of Justice. U.S. Department of Justice. (July 1995) p. 4-5.

[68] *Americans With Disabilities Act and Criminal Justice: Mental Disabilities and Corrections.* Paula N. Rubin and Susan W. McCampbell. National Institute of Justice. U.S. Department of Justice. (July 1995) p. 1. Please see Appendix for definition of these two conditions.

Moreover, it is not sufficient to provide separate services to those with mental disabilities; mainstreaming of the disabled population is a hallmark of the ADA. An inmate whose disability requires maintenance on psychotropic medications, but who is stable enough for general population settings, may be eligible to participate in the facility's regular programs.[69]

B. National Institute of Corrections Recommendations

The recommendations summarized below were made by the National Institute of Corrections in 1992, and they consider both the practical realities of institutional operation and the need to maximize scarce existing resources. Older inmates comprise only one segment of a much broader special needs offender group sought to be accommodated. In many cases, older inmates and other special needs offenders pose multiple problems. The needs of older inmates should be assessed from a system-wide perspective by a multi-disciplinary group of individuals from different fields and functional areas within the system. Periodic reviews of both system and institutional policies, procedures, and practices should be conducted.

1. 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. Levels of functioning should be assessed on an ongoing basis. Early detection and treatment of disease and illness are critical to help minimize costs and other problems. It is important that correctional administrators incorporate aggregate data on older inmates into overall system planning.

2. Accessibility and Adaptation

The majority of older inmates should be mainstreamed in the general population throughout a correctional system. All programs and services should be fully accessible.

The first area that should be addressed is the physical plant. All future housing and modification of existing facilities should be planned to meet universal access standards. More time and schedule flexibility may need to be granted to older inmates in recognition of the distances between various facilities. Programs and services may have to be brought to these inmates.

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[69] *Americans With Disabilities Act and Criminal Justice: Mental Disabilities and Corrections.* Paula N. Rubin and Susan W. McCampbell. National Institute of Justice. U.S. Department of Justice. (July 1995) p. 3-4.

The second area to be addressed is the living area. Single, lower bunks should be provided to the elderly to prevent falls, and hospital mattresses may be needed. Elderly inmates require more heat in the winter and air conditioning in the summer.

Practices for older inmates should foster independence and preventative and health maintenance activities, such as diet and exercise.

The third area to be addressed for accessibility and adaptation is that of programs and services area. Most older inmates want to be productive and busy. Current inmate work programs must be assessed. Strategies that motivate a 20-year old should not realistically be expected to motivate a 60-year old. Counseling, education, and leisure time activities should be provided. Administrators must be alert to work or other programs that allow elderly inmates to earn time off sentences, money, and other benefits. Release transition services are critical for older inmates.[70]

3. Special Units

Placement in special units 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. Department policy should clearly define the goals and objectives of special units and specific admission criteria. Combining similar populations is feasible. Some states are developing "nursing home-like settings" within the prison environment.[71]

4. Medical

As noted earlier, administrators can implement prevention programs to help contain costs and minimize financial expenditures. Screening high-risk inmates for disease and beginning early treatment can prevent catastrophic illnesses. Good communication among medical and other staff regarding medication and treatment of older inmates is important. Correctional agencies should explore all possible options to avoid providing in-house intermediate or long-term nursing home care for older inmates. In-house hospice programs need to be developed. Privatization to reduce health care costs is also an option, although a system may wish to experiment on a regional basis first.[72]

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[70] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 16-17.

[71] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 17-18; "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 49.

[72] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 18; *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 8.

5. Staff Training

Staff often lack sensitivity to medical and mental health problems of the elderly which can exacerbate the problems.[73] Those working with older inmates need training specifically designed to recognize the unique emotional and social needs of this age group. Special training could also include: the dynamics of death and dying; procedures for identifying depression; and referral to experts in the community.[74]

A lack of adequately trained prison staff is a barrier in responding fully to the special needs of the aging inmate.

A few facilities now employ psychologists and counselors with professional training in geriatrics. For example, administrators are working with the Department of Gerontology of Northeast Louisiana University to better prepare themselves to understand and serve the special needs of an aging prison population.[75]

Special training for staff should first address the staff's own feelings and concerns about growing older and coping with aging parents. Information about the normal aging process and interpersonal communications training geared toward working with older people should be provided. An empathetic training model can be useful to help staff understand hearing, visual, and mobility impairments. If inmates are used to assist older inmates, they too must be provided with ongoing training and rotation to avoid burnout.[76]

6. Community Involvement

No single agency can provide all the services needed by this complex group of clients. Community organizations can be helpful in providing both pre-release programming and follow-up services after release. Some agencies have found it useful to designate an advocate for the elderly at the central

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[73] "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 53; *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 6.

[74] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 13; *Aging Inmate Population.* Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 11.

[75] "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 49; "Elder Care: Louisiana Initiates Program to Meet Needs of Aging Inmate Population." Jean Wall. Corrections Today. (April 1998) p. 137.

[76] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 19.

office level who helps forge community linkages and information sharing. A commitment from top administration for joint relationships among agencies is necessary.[77]

Recommendations from other researchers include the systemic development and maintenance of baseline data on the elderly offender. This will facilitate needs assessment, legal compliance, and the planning and modification of existing classification systems to mainstream the elderly, if consistent with their physical and mental health needs, as well as with institutional and inmate safety. Special efforts should be made to assign older inmates to the least-restrictive security housing consistent with risk and program safety.

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[77] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 19.

VII. ELDERLY INMATE SERVICES

A. Florida

Florida, with its large elderly population, can be expected to experience the difficulties resulting from a burgeoning elderly prison population. Florida has the third largest number of prisoners over age 50 in the nation. The chart below lists the corrections systems with the largest inmate populations over the age of 55 in September, 1998.

Ten Highest Inmate Populations Over Age 55

State / Agency	*Total Number Over Age 55*
Federal Bureau of Prisons	7,244
California	4,385
Florida	2,396
Texas	2,380
New York	2,380
Ohio	1,963
Pennsylvania	1,871
Georgia	1,298
Arizona	1,015
Virginia	910

Source: American Correctional Association (1999)

A recent review conducted by the Department of Corrections revealed that since 1982, the number of inmates in Florida prisons who are at least 50 years old has increased 377 percent. Inmates age 60 and older have increased 348 percent in this same 17 year time frame. In contrast, the overall prison population increased only 157 percent, which is less than half as much as the increase in the population of those 50 years and over.

There has been a marked increase in the percentage of inmates age 50 and older in the last four years. The increase was 5.4 percent in 1995 and 7.4 percent for the first half of 1999. The following chart reflects the percentage change in the number of elderly inmates between the specified years.

Growth of Elder (50+ Years) Inmate Population 1995-1999, as of June 30										
	1995		1996		1997		1998		1999	
Category	**Total**	**% of Total**	**Total**	**% of Total**	**Total**	**% of Total**	**Total**	**% of Total**	**Total**	**% of Total**
50 to 54	1,585	2.6	1,756	2.6	2,065	3.2	2,276	3.4	2,589	3.8
55 to 59	851	1.4	990	1.5	1,054	1.6	1,134	1.7	1,235	1.8
60 to 64	438	0.7	505	o.8	551	0.9	626	0.9	670	1.0
65 to 69	221	0.4	258	0.4	286	0.4	314	0.5	337	0.1
70 +	186	0.3	206	0.3	220	0.3	238	0.4	251	0.0
TOTAL	3,281	5.4	3,715	5.7	4,176	6.4	4,588	6.9	5,082	7.4
										54.9%

Source: Florida Department of Corrections

1. Department of Elderly Affairs

Through an interagency agreement, the Department of Elderly Affairs (DOEA) provides the Department of Corrections (DC) with brochures and a monthly newsletter that lists local contacts for senior citizens in their local community. These materials are provided to the institutions' resource officers to be distributed to elder inmates prior to release. In 1996, a steering committee composed of DOEA and DC employees met to discuss a comprehensive plan for elderly offenders. Several meetings were held, but the steering committee never released a formal plan.[78]

During the 1998 Legislative Session, HB 3423 was introduced. It would have required certified officers to receive training in recognizing elder abuse, as well as awareness of and the differentiation between illnesses and diseases common to elderly people. The bill was withdrawn with an assurance from the Florida Department of Law Enforcement that an elective training course in this area would be developed for corrections officers. The curriculum includes sensitivity training regarding the concerns of the elderly, and participation in the training can be used to secure continuing education credits. (The Criminal Justice Standards and Training Commission, which administers the certification of law enforcement, correctional, and correctional probation officers, is located in FDLE.) Under a federal Byrnes Grant through the Department of Community Affairs the curriculum was developed by the Department of Elders Affairs, and it is awaiting approval from the Criminal Justice Standards and Training Commission. [79]

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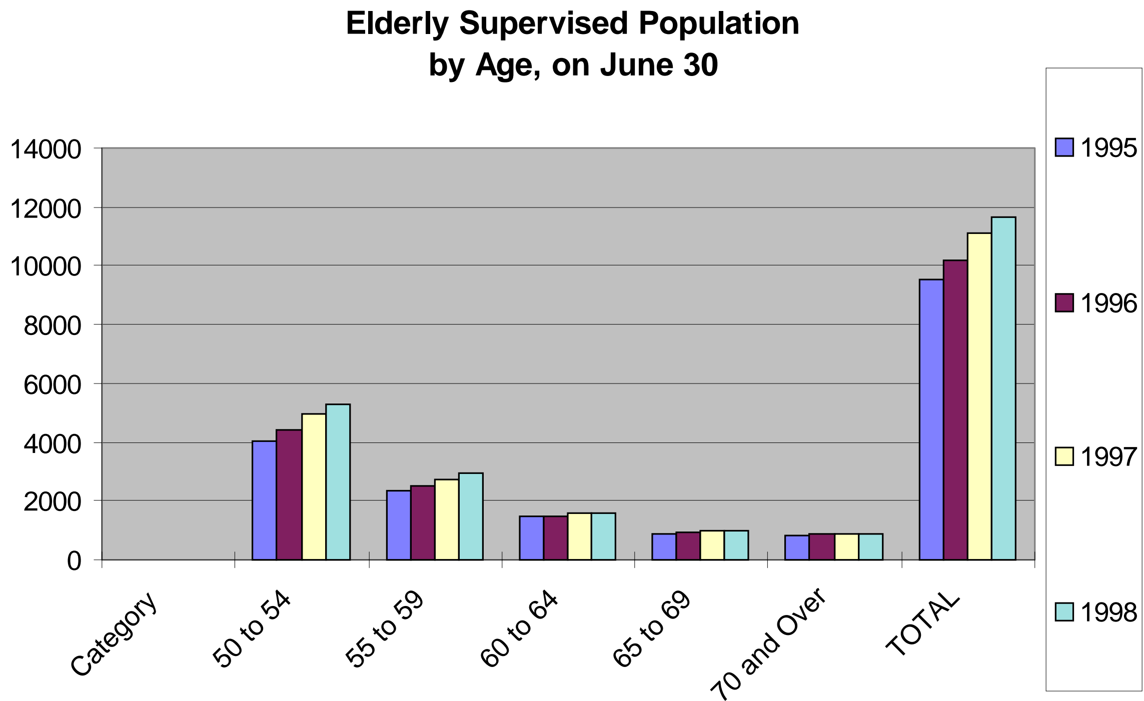
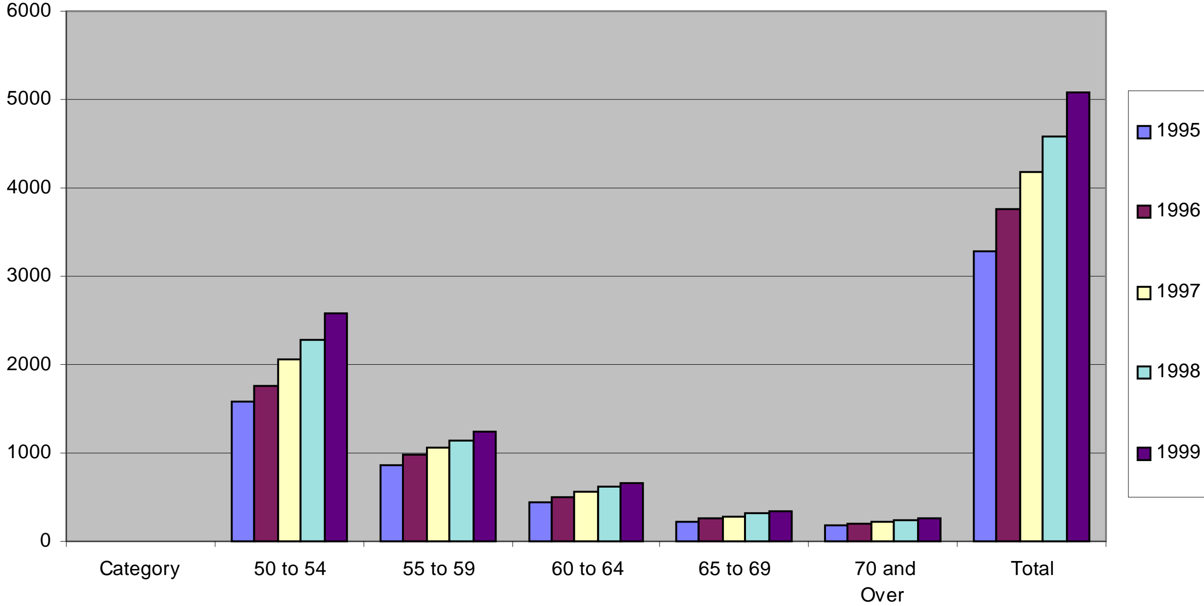
[78] Interview by Florida Corrections Commission staff with Lou Comer, DOEA, (July 14, 1999).

[79] Interview by Florida Corrections Commission staff with Michael Murphy, DOEA, (July 14, 1999).

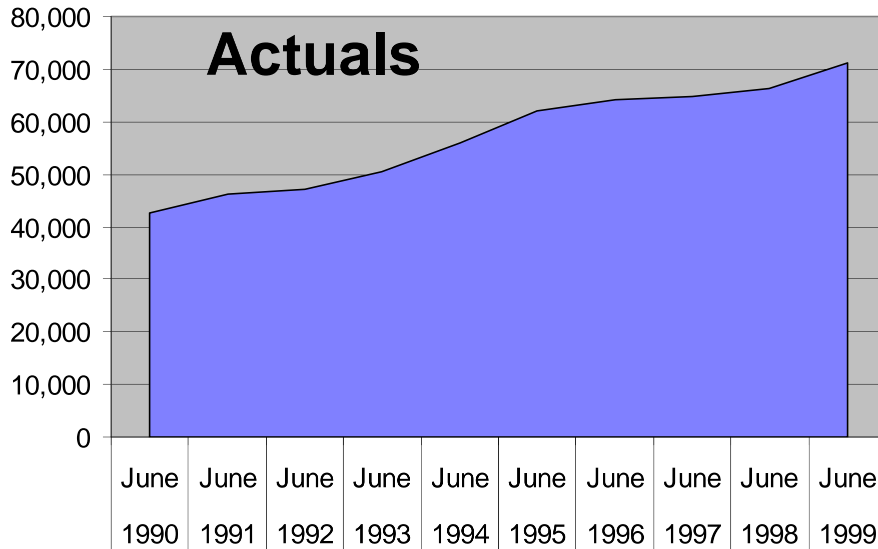
2. Department of Corrections

The first two charts depict the data for the past five years on the number of elderly inmates incarcerated and supervised in the community, respectively. The third and fourth charts reflect the actual and projected populations of Florida's inmates.

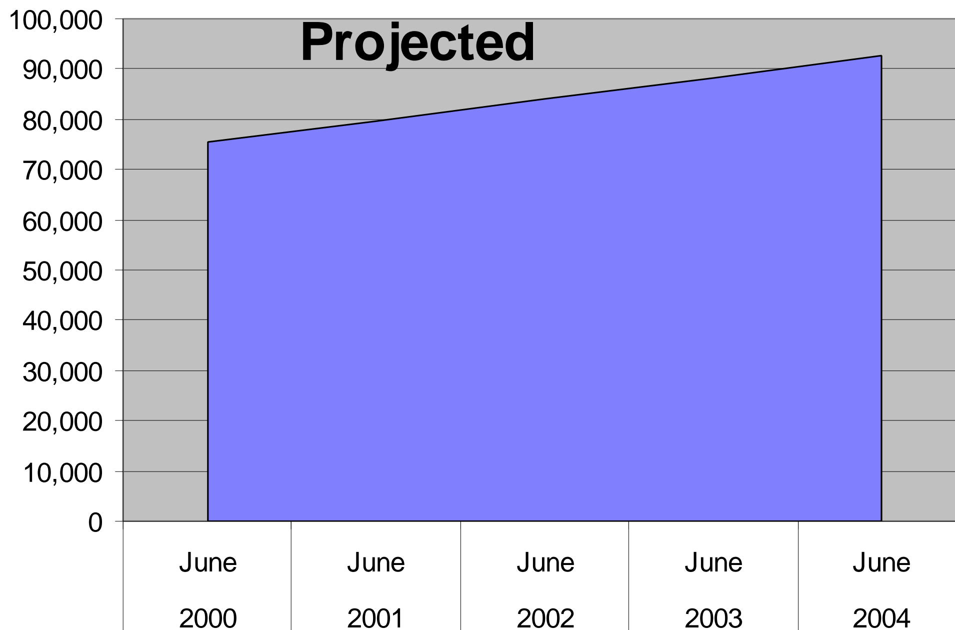



Elderly Inmate Population by Age, on June 30
6000
5000
4000
3000
2000
1000
0
Category
50 to 54
55 to 59
60 to 64
65 to 69
70 and Over
Total
1995
1996
1997
1998
1999

Florida Department of Corrections Inmate Population from June 1999 to June 2004



Florida Department of Corrections Projection of Inmate Population from June 2000 to June 2004



a. Criminal History of Florida's Elder Inmates

The following table illustrates the primary offense of elderly inmates in Florida. A large majority (74.4 percent) are incarcerated for violent offenses; 12.4 percent for burglary or property offenses; 12.8 percent for drugs; and 4.4 percent for all other offenses.

Primary Offense of Florida's Elder (50+ Years) Inmates as of December 31, 1998												
	Age In Years											
	50-54		55-59		60-64		65-70		>70			
Offense	No.	%	No.	%	No.	%	No.	%	No.	%	Total	Percent
Murder	581	24.4	320	27.1	220	34.7	113	31.3	85	42.3	1,319	27.7
Sexual/ Lewd	531	22.3	315	26.7	200	31.5	1339	38.5	85	42.3	1,270	26.7
Robbery	215	9.0	101	8.6	29	4.6	20	5.5	6	3.0	371	7.8
Violent, Other	216	9.1	100	8.5	51	8.0	20	3.0	4	2.0	391	8.2
Burglary	214	9.0	82	6.9	25	3.9	11	3.6	3	1.5	335	7.0
Property Theft	155	6.5	66	5.6	20	3.2	13	7.8	2	1.0	256	5.4
Drugs	374	15.7	144	12.2	55	8.7	28	1.1	9	4.5	610	12.8
Weapons	40	1.7	23	1.9	12	1.9	4	3.6	3	1.5	82	1.7
Other	59	2.5	30	2.5	22	3.5	13	100.0	4	2.0	128	2.7
Total	2,385	100.0	1,181	100.0	634	100.0	361		201	100.0	4,762	1.0
Percent	50.1		24.8		13.3		7.6%		4.2%		100.0	

Source: Bureau of Research and Data Analysis, Department of Corrections

The following table shows the total number of elderly offenders and the number of them serving terms of natural life (life without the possibility of parole), life, and 20 or more years, as of December 31, 1998. Elderly inmates accounted for 7.1 percent of the total inmate population on that day (67,224). Over half of these elderly offenders (51.4 percent) were serving these lengthy sentences. On August 5, 1999, there were 72 elderly men and no elderly women on death row; 16.7 percent of these elderly men committed their capital offenses at age 50 or older. The average age at the time of their offenses for elderly inmates was 42.1 years.[80]

[80] Information compiled by Commission staff from "Facts & Fallacies", Florida Department of Corrections, http://www.dc.state.fl.us/oth/index.html, (August 5, 1999).

Total Number of Florida's Elder (50+ Years) Inmates and Number Serving Terms of Natural Life*, Life and =20 Years as of December 31, 1998								
Age in	**Total**	**%**	**Natural**	**%**	**Life**	**%**	**=20**	**%**
50-54	**2,387**	**50.1**	**116**	**48.9**	**501**	**42.2**	**517**	**50.4**
55-59	**1,182**	**24.8**	**59**	**24.9**	**317**	**26.7**	**267**	**26.0**
60-64	**634**	**13.3**	**29**	**12.2**	**199**	**16.8**	**130**	**12.7**
65-70	**361**	**7.6%**	**21**	**8.9%**	**103**	**8.7%**	**71**	**6.9%**
>70	**202**	**4.2%**	**12**	**5.1%**	**66**	**5.6%**	**47**	**4.0%**
Total	**4,766**	**100.0**	**237**	**100.0**	**1,186**	**100.0**	**1,026**	**100.0**

**"Natural Life" means life without the possibility of parole*

Source: Bureau of Research and Data Analysis, Florida Department of Corrections

The following table illustrates that 58 percent of the elderly inmates incarcerated in Florida's prisons were first time offenders.

Number of Florida's Elder Inmates First Time Offenders as of December 31, 1999		
Age in years	**Number**	**%**
50-54	**1,240**	**44.9%**
55-59	**698**	**25.3%**
60-64	**414**	**15.0%**
65-70	**262**	**9.5%**
>70	**149**	**5.4%**
Total	**2,763**	**100.0%**
Total Number of	**4,766**	
% that are first time offenders		**58.0%**

Source: Bureau of Research and Data Analysis, Florida Department of Corrections

In the table below the presumptive parole release date of inmates age 50 or older are depicted. A "suspended" presumptive parole release date indicates an inmate whose presumptive parole release date was prior to January 1999 but has not been released and is usually considered a release risk. Not all inmates are eligible for parole. Of the elderly inmates which are parole-eligible, over half (54.2 %) have presumptive parole release dates of 2010 or earlier. The remaining elderly inmates (45.8 %) have presumptive parole release dates of more than ten years away or suspended dates. [81]

Presumptive Parole Release Date of Florida's Elder (50+ Years) Inmates as of December 31, 1998							
	Age In Years						
Presumptive Parole Release	**50-54**	**55-59**	**60-64**	**65-70**	**>70**	**Total**	**Percent**
1999-2000	**102**	**55**	**24**	**1**	**8**	**201**	**32.9%**
2005-2010	**64**	**29**	**18**	**1**	**6**	**130**	**21.3%**
2011-2020	**62**	**34**	**15**	**7**	**4**	**122**	**20.0%**
2021-2030	**30**	**18**	**6**	**9**	**2**	**65**	**10.6%**
>2030	**43**	**28**	**12**	**6**	**4**	**93**	**15.2%**
Suspended	**73**	**43**	**24**	**1**	**8**	**163**	**26.7%**
Total	**301**	**164**	**75**	**4**	**24**	**611**	**100.0%**

Source: Bureau of Research Data Analysis, Florida Department of Corrections, adapted by Florida Corrections Commission staff

b. Florida's Medical Care for Elder Inmates

The medical care of elderly inmates is incorporated into the provision of care for all inmates. According to the Department of Corrections Health Service Bulletin 15.03.13, each inmate is assigned a Functional Grade by using a physical profiling system. A functional capacity (or medical grade) is assigned by a physician, dentist, clinical associate, or psychologist based on an assessment of the inmate's overall profile. The inmate's functional capacity serves as the basis for institutional and work assignment. It ensures that an inmate will be assigned to an institution that can meet that inmate's medical needs. Those inmates who suffer from a severe degradation in health as a direct

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[81] The charts are exclusive of death row and do not include missing data.

result of the aging process are deemed "impaired" and noted and tracked in the department's medical classification system in this manner.

Depending on the nature of the medical condition, the inmate is provided those services necessary to meet acceptable standards of care. Among services available to all inmates, including the elderly, are such programs as: assignment to an institution consistent with their overall classification, which includes medical class; health education information related to their health status in which age may be a factor; use of impaired inmate assistant from among trained inmates; assignments of a minimum of two "signing" proficient inmates at any institution for the hearing disabled; ready access to specific clinical services such as hypertension and specialty units such as dialysis; and staging facilities such as the Department's North Florida Reception Center-Hospital for cancer treatments or in preparation for more complex procedures which are scheduled in contracted community care facilities.

There are 124 inmate assistants, 34 of whom are assigned to inmates age 50 or older. Assistants may be assigned to more than one inmate. As a result of medical class and location of inmate assistants, the majority of older inmates are concentrated in several institutions; however, no one institution is officially designated a "geriatric" or "elder inmate" facility.[82]

Facilities with 50 or more Elder (50+ Years) Inmates as of December 31, 1998					
	Facility	**Disabled Accessible**	**Number**	**Total Pop.**	**Percent**
1	**Hamilton CI**	**x**	**131**	**7844**	**16.7%**
2	**Polk CI**	**x**	**155**	**990**	**15.7%**
3	**Union CI**	**x**	**205**	**1,344**	**15.3%**
4	**Walton**	**x**	**158**	**1,083**	**14.6%**
5	**Marion CI**		**157**	**1,132**	**13.9%**
6	**NFRC Main**	**x**	**140**	**1,040**	**13.5%**
7	**Avon Park CI**		**102**	**763**	**13.4%**
8	**Glades CI**		**109**	**876**	**12.4%**
9	**Gulf CI**	**x**	**134**	**1,117**	**12.0%**

[82] Information compiled by Commission staff from "Facts & Fallacies", Florida Department of Corrections, http://www.dc.state.fl.us/oth/index.html, August 5, 1999.

10	**Jackson CI**	**x**	**126**	**1,057**	**11.9%**
11	**Lawtey CI**	**x**	**76**	**647**	**11.7%**
12	**New River West**	**x**	**85**	**735**	**11.6%**
13	**South Bay CI**	**x**	**140**	**1,240**	**11.3%**
14	**Okeechobee CI**		**121**	**1,075**	**11.3%**
15	**Okaloosa CI**		**71**	**648**	**11.0%**
16	**Tomoka CI**	**x**	**99**	**906**	**10.9%**
17	**Baker CI**		**97**	**971**	**10.6%**
18	**Taylor CI**		**107**	**1,171**	**9.1%**
19	**Dade North Annex**	**x**	**86**	**948**	**9.0%**
20	**Zephyrhills CI**	**x**	**56**	**622**	**8.5%**
21	**Wakulla CI**		**65**	**768**	**8.4%**
22	**Cross City CI**		**56**	**668**	**8.4%**
23	**Apalachee CI - West**		**64**	**764**	**8.4%**
24	**Moore Haven CF**		**59**	**705**	**8.2%**
25	**Sumter CI**		**106**	**1,289**	**8.2%**
26	**Hendry CI**		**76**	**957**	**7.9%**
27	**Everglades CI**	**x**	**124**	**1,569**	**7.9%**
28	**CFRC - Main**	**x**	**96**	**1,219**	**7.9%**
29	**Lake CI**	**x**	**75**	**963**	**7.8%**
30	**Columbia CI**	**x**	**81**	**1,060**	**7.6%**
31	**Apalachee CI - East**		**53**	**713**	**7.4%**

32	**NFRC West**		**61**	**865**	**7.1%**
33	**FSP Main Unit**	**x**	**57**	**876**	**6.5%**
34	**Charlotte CI**	**x**	**74**	**1,173**	**6.3%**
35	**Madison CI**		**66**	**1,048**	**6.3%**
36	**Jefferson CI (female)**	**x**	**53**	**891**	**5.9%**
37	**SFRC - Main**		**59**	**1,015**	**5.8%**
38	**Liberty CI**		**62**	**1,075**	**5.8%**
39	**Washington CI**	**x**	**62**	**1,092**	**5.7%**
40	**Martin CI**	**x**	**55**	**1,036**	**5.3%**
41	**Hardee CI**		**54**	**1,040**	**5.2%**
42	**Santa Rosa CI**		**60**	**1,167**	**5.1%**
43	**Century CI**		**50**	**996**	**5.0%**
44	**DeSoto Annex**		**50**	**1,030**	**4.9%**
45	**Total**		**3,973**	**43,074**	**9.2%**

Source: Bureau of Research and Data Analysis, Florida Department of Corrections

The following table shows the medical grade of inmates over age 50. The percentage row reflects the number of these inmates assigned an unrestricted or minimum medical grade. As expected the percentage with a low medical grade decreases with age, and the severity of the medical grade increases with age.

Medical Grades of Elder (50+ Years) Inmates as of December 31, 1998												
	Age In Years											
	50-54		55-59		60-64		65-70		>70		Total	Percent
Medical Grade	No.	%	No.	%	No.	%	No.	%	No.	%		
1-Unrestricted	568	23.9	200	17.0	47	7.5	15	4.2	3	105	833	17.6
2-Minimum	1,147	48.3	567	48.3	277	44.0	104	29.0	48	23.9	2,143	45.2
3-Moderate	575	24.2	339	28.9	247	39.2	180	50.1	84	41.8	1,425	30.1
4-Severe	87	3.7	69	5.9	59	9.4	60	16.7	66	3208	341	7.2
Total	2,377	100.0	1,175	100.0	630	100.0	359	100.0	201	100.0	4,742	100.0
Percent	50.1		24.8		13.3		7.6		4.2			100.0

Source: Bureau of Research and Data Analysis, Florida Department of Corrections

Medical Grades

1 - Medically fit for any assignment

2 - Some limitations may be imposed on assignment

3 - Require certain restrictions in assignment to ensure reasonable availability of care

4 - Require assignment restrictions to insure continuous monitoring of condition(s)

c. Programs for Elder Inmates

Florida and South Carolina are the only two states which have programs for older women.

In response to the national survey, the Department of Corrections indicated that a 100-hour skills program is in place for elderly inmates. The program is offered at both Madison Correctional Institution and Avon Park Correctional Institution which are said to have a high concentration of inmates over the age of 50. In the past, the department reported that special services were available for older males at Lawtey Correctional Institution and Hillsborough Correctional Institution, as well as a special unit for older females at Florida Correctional Institution.[83] Hillsborough Correctional Institution has subsequently been converted into a youthful offender facility. According to the department, Lawtey

[83] "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 14; Florida along with South Carolina are the only two states which have programs for older women.

Correctional Institution had evolved into an institution serving an almost exclusively elderly population. Other elderly inmates were housed at disabled-accessible institutions or the Central Florida Reception Center hospital unit. Special diets were (and still are) designed for older inmates, but a prescription for the diet is required.[84]

On August 19, 1999, staff from the Florida House of Representatives Committee on Corrections and the Florida Corrections Commission visited Lawtey Correctional Institution to observe the programs and facilities for elderly inmates. Prior to the visit, staff had not been informed that the mission of Lawtey Correctional Institution had changed as a result of the reorganization. At the time of the visit, there were no programs specific to the elderly population being offered at this institution, but the facility is disabled-accessible. On the day of the visit, Lawtey Correctional Institution reported having fifteen impaired inmates. Two open bay dorms have been retrofitted for disabled inmates with wheelchair ramps, room for wheelchairs at tables in the day area, and special shower and lavatory fixtures. Other general use buildings, such as the cafeteria, medical unit, and library and educational facility are disabled-accessible. Most recently, a wheelchair ramp was built for access to the PRIDE garment factory. According to the plant manager, two wheelchair-bound inmates had been hired. Impaired inmates are assigned to "utility squads." Staff observed a utility squad sanding toys for the "Toys for Tots" program.

Inmates in wheelchairs or who are blind or deaf are not usually assigned to work camps, road prisons, or forestry camps due to the type of physical labor that is required at these facilities. Accommodations are made for the less seriously disabled at these facilities. The department's one stand alone drug treatment center in Bradenton is disabled-accessible. Fourteen Community Corrections Centers and Work Release Centers are in compliance with the Americans with Disabilities Act:[85]

American with Disabilities Act Compliant Institutions			
Marianna CCC	Dinsmore CCC	Sante Fe CCC	Lake City CCC
Kissimmee CCC	Atlantic CCC	Opa Locka CCC	St. Petersburg CCC
West Palm CCC	Pinellas CCC	Miami North CCC	Bartow CCC

[84] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 17.

[85] E-mail from Martie Taylor, Florida Department of Corrections to Florida Corrections Commission staff, (October 4, 1999).

American with Disabilities Act Compliant Institutions			
Tallahassee CCC	Pine Hills CCC		

Source: Florida Department of Corrections

The department plans to conduct a survey of all its facilities to determine that all the programs, services, and activities it offers are accessible to disabled inmates as required by the Americans with Disabilities Act. A survey of this type was last conducted in 1993.[86]

In the department's *Operational Plan for Female Offenders*, several goals addresses the health and wellness services for elderly females.[87] Specifically , Goal 6.4 states:

By September 1, 1999, the Assistant Warden for Programs, in conjunction with other institutional program staff will recruit volunteers to facilitate monthly support groups and other activities that address issues and needs of female offenders over 50 years of age. Issues and needs should include, but not be limited to:

Depression	Menopause	Health	Stress	Projects (quilts, Toys for Tots, etc.)
Wills and Trusts	Terminal Illness	Nutrition	Goal-Setting	Social Security
Death and Dying	Self-esteem	Exercise	Life Skills	Maintaining Family Connections

B. Initiatives in Other States

For the most part, states do not have specific written policies addressing elderly inmates, but rather base policies on inmates' special medical needs. Few states make policy decisions based solely on age. In one state inmates aged 50-55 receive classification requiring lighter, slower duties and inmates over age 55 are restricted from harder, heavier work and may work reduced hours. Another state allows inmates to retire at age 65.[88]

Several state correctional systems have addressed the issue of increasing age within their prison

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86 E-mail from Martie Taylor, Florida Department of Corrections to Florida Corrections Commission staff, (October 4, 1999).

87 Florida Department of Corrections, *Operational Plan for Female Offenders*. (July 1999)

88 *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments. (1998) p. 31.

population. A survey of the types of programs that have been designed and implemented to meet the needs of older offenders in other states follows.

Alabama
Alabama has a 200-bed Aged and Infirm Unit in Hamilton, which is one of the few in the nation.[89]

Arkansas
The state of Arkansas is currently exploring an initiative with the private sector to establish a single-site geriatric facility.[90]

Georgia
The Men's Correctional Institution at Hardwick houses 165 chronically ill or disabled inmates. A 384-bed assisted living unit has been constructed at the Augusta State Medical Prison. This facility also has a 60 bed hospital and 24-hour medical services access. There are special programs for the elderly, such as gardening, special exercise classes, and access to audio books.[91]

Illinois
Dixon Correctional Center Health Care Unit houses inmates 55 and older, or those with chronic illnesses and other special needs inmates. A special mental health treatment center, psychiatric and a special needs unit exists at Dixon. Special arrangements are made for meals, legal library access, visits to the barbershop, obtaining items from the commissary, and receiving chaplaincy services. Special activities are scheduled. These activities include chess, dominoes, billiards and art classes.[92]

Indiana
Two facilities are designated for the placement of special needs and older offenders. The state has also developed a strategic plan for health care which includes the creation of hospice, recreational and vocational programs, as well as access to gerontologists.[93]

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[89] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments. (1998) p. 15.

[90] "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 15.

[91] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 18; "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 15.

[92] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 22; "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 15.

[93] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 22; "Older Inmates: The Impact of an Aging Inmate Population on the

Kentucky
There are two special units at Kentucky State Reformatory: the Medical Treatment/Mental Health Special Management Unit for inmates with limited mobility, advanced age, and medical conditions, and a Skilled Nursing Facility (SNF) with 58 beds which legally can house geriatric and infirm inmates of both genders. In addition, the infirmary at the female institution is currently being remodeled to include SNF beds. The nursing care facility is believed to be the only licensed nursing care facility inside a medium-security correctional facility in the United States. There is a recreational leader and classification officer assigned to the unit. Also, there are plans to convert a 30-bed unit to house and treat short-term care inmates and a 150-bed mental health unit at the Kentucky State Reformatory.[94]

Louisiana
Four prisons have identified beds designated for the frail, elderly, and infirm: 120 at Louisiana State Prison; 70 at Elayn Hunt Correctional Center; 30 at Dixon Correctional Institution; and 20 at Louisiana Correctional Institution for Women. A detention center is being renovated for aged/physically impaired inmates at Forcht-Wade, close to Louisiana State University Medical Center in Shreveport. Of its 550 beds, 330 will be reserved for the elderly. The Department of Corrections has also developed relations with Department of Gerontology at Northeast Louisiana University. Louisiana recently abolished "medical parole."[95]

Maryland
Most older inmates are provided "special housing" in hospital units, dorms, first floor cells, and single cells. Chronically ill inmates for whom the Department of Corrections can no longer provide adequate care are paroled. Additionally, the Department of Corrections has an agreement with the State Department of Health and Mental Hygiene to house senile or incapacitated inmates in state hospitals or skilled nursing facilities.[96]

Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 15.

[94] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 19; "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 15.

[95] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 20; "Elder Care: Louisiana Initiates Program to Meet Needs of Aging Inmate Population." Jean Wall. Corrections Today. (April, 1998) p. 137; "Prison Complex." World Press Review. (June 1997) p. 31.

[96] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 21; "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 15.

Minnesota
Minnesota Correctional Facility-Stillwater Senior Dormitory accommodates 23 self-sufficient men age 50 or older. Those needing medical monitoring are placed in a 10-bed medical unit. The inmates go to meals before the rest of the population. A special senior social group is provided. [97]

Mississippi
Mississippi State Penitentiary in Parchman has two special units available to older inmates: a 85-bed geriatric unit and another 192-bed geriatric and/or disabled unit.[98]

Missouri
Missouri offers specialized programs for elderly inmates: recreational therapy, educational activities, discussion groups, and exercise programs. A unit at Moberly Correctional Center can house 22 older inmates near the infirmary. There are two additional units for elder inmates with medical problems. Infirmaries are also used to provide Skilled Nursing Facilities level of care. Chronically ill inmates for whom the Department of Corrections can no longer provide adequate care for are eligible for parole. [99]

New Jersey
The New Jersey Department of Corrections is in the process of developing a comprehensive program for elder inmates. In the interim, an agreement with a community Skilled Nursing Facility exists. Minimum security inmates can be placed without the need for security. There are a total of 77 beds on three floors of a local hospital specifically identified for inmates. Security is assigned full time to the hospital. The department is planning a new facility that is slated to include 100 long term-and 40 older inmate beds.[100]

North Carolina
The North Carolina Department of Corrections is renowned as a national model for older inmates issues. The McCain Correctional Hospital has been operating for 13 years; it houses 120 geriatric and 25 paraplegic inmates separate from the regular population. There is a comprehensive activity and therapy program in place. This program includes taking the inmates into the community for

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[97] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice (August 1992) p. 23; "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 15.

[98] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments. (1998) p. 22.

[99] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments. (1998) p. 23; "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 16.

[100] "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 16.

recreational and socialization activities.[101]

Ohio

Hocking Correctional Facility, Nelsonville, Ohio (formerly a tuberculosis hospital), houses the country's oldest prison population. The facility is designated for 400 older medium/minimum security offenders. The average age is 56, but their "physical age" is ten years older. Staff attends a special course concerning loss, which is also offered to inmates. The facility also has a two-part pre-release program specific to older inmates: (1) inmates returning to the workforce; and (2) those who will retire. Security personnel at Hocking regularly participate in sensitivity training to learn to empathize with old, feeble, or hard of hearing inmates who have poor eyesight, arthritic joints, numb fingers, and aching feet.[102]

The Hocking facility also hosts aerobics classes which have been developed in three levels of difficulty for the offender. Chair aerobics are available at the beginning, intermediate and advanced levels. Recreation is tailored specifically for the older offender. Staff receive special training on older inmates' issues and special programming opportunities exist. The local senior volunteer program provides assistance at the facility.

Oklahoma

In March 1998, the Corrections Board opened bidding for a privately run geriatric facility, although funds were not appropriated.[103]

Pennsylvania

The State Correctional Institution at Laurel Highlands is the only institution in the Commonwealth specially designated for the care, custody, and control of long-term care, wheelchair, dialysis and geriatric inmates. Specialized programs are provided to meet inmates' needs; namely, medical care for the long-term ill, life skills program, and recreational activities that are individualized to meet the needs of older or physically challenged inmates, substance abuse programs for general and geriatric populations, psychological assessments and treatment, as well as religious services.

South Carolina

South Carolina opened State Park Correctional Institution for elderly inmates in 1970. The facility was converted from the state's tuberculosis hospital. The state soon discovered that younger inmates

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[101] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 24; "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 16.

[102] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 23; "Prison Complex." World Press Review. (June 1997) p. 30.

[103] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments. (1998) p. 25.

with physical handicaps also function better in the minimum security environment.[104]

With the establishment of State Park CI, certain guidelines and principles were established:

- A definition of handicapped status was established; .
- Handicapped inmates are mainstreamed as long as they function in the general population; and
- All inmates work within their medical limitations. Inmates 65 and over can retire, but cannot earn earned work credits.[105]

State Park Correctional Institution has a male, female, and a mixed gender program for older inmates.[106] While housing men, women, and younger inmates together has its problems, it also provides a more normal environment. Residents are expected to go to meals, sick call, and activities and to get up and stay dressed throughout the day. Staff treat residents with dignity and respect, referring to them as Mr. or Ms.; the inmates are expected to respond in kind.[107] South Carolina has initiated a trial work release program for older, low risk inmates and a release training course to aid them in adapting to life outside the prison environment. There is also a geriatric/handicapped unit at Perry Correctional Institution and a handicap unit at Broad River Correctional Institution. Programing including recreation, education, crafts, horticulture, literacy, counseling and work release programs are geared toward elderly and provided at these institutions.[108] South Carolina and Florida are, reportedly, the only two states which accommodate elderly females separately.

Tennessee

A 50-bed unit at Wayne Correctional Annex houses inmates over the age of 55, with minimum custody and minor medical needs who can do general work. There is also a 100-bed sheltered living

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[104] "South Carolina Strives to Treat Elderly and Disabled Offenders." Judy C. Anderson and R. Daniel McGehee. Corrections Today. (August 1991) p. 126.

[105] "South Carolina Strives to Treat Elderly and Disabled Offenders." Judy C. Anderson and R. Daniel McGehee. Corrections Today. (August 1991) p. 126.

[106] South Carolina is the only state which reported housing its older female prisoners in a special geriatric facility.

[107] "Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates." Ronald H. Aday. Federal Probation. Vol. 58, No. 2. (June 1994) p. 49; "South Carolina Strives to Treat Elderly and Disabled Offenders." Judy C. Anderson and R. Daniel McGehee. Corrections Today. (August 1991) p. 126-127.

[108] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments. (1998) p. 26; "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 16.

unit at Deberry Special Needs Facility which is close to the infirmary. Although all inmates are allowed, most of the elderly prisoners housed there are elderly.[109]

Texas

Texas has a prison hospice program, special needs parole, a special geriatric center that provides extended care, skilled nursing care services, and separate housing for mobility impaired offenders. A 60-bed geriatric facility is located near a regional medical center. In 1997, an additional facility was identified as necessary to provide services as the geriatric population grows. A 50-bed Skilled Nursing Facility is located in a wing of the adjacent hospital. Medical charts are reviewed monthly with the inmate patient seen every three months, or as needed, for chronic illness. [110]

A memorandum of understanding exists between several agencies which establishes a continuity of care and service program for offenders in the criminal justice system who are physically disabled, terminally ill, or significantly ill.

Virginia

The state has geriatric units which offers exercise programs and discussion groups on relevant topics for inmates over age 50 who qualify for lower custody.[111] The Commonwealth of Virginia also provides in its statutes for the conditional release of geriatric prisoners. Any person serving a sentence for a felony offense which was committed on or after January 1, 1995 and who has reached the age of sixty-five or older and who has served at least five years of the imposed sentence -- or who has reached the age of sixty or older and who has served at least ten years of the sentence -- may petition for conditional release.

Washington

The Washington Department of Corrections has a "chronic disease" program in lieu of a geriatrics program in recognition of the discrepancy between chronological age and the health status of inmates. Inmates are seen every 90 days, or as needed. Staff, both medical and custody, have been sent to specialized training in chronic diseases and geriatrics.[112]

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[109] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments. (1998) p. 27.

[110] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments (1998) p. 28; "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 16.

[111] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments. (1998) p. 29; "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 16.

[112] "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 16.

West Virginia

Forty-five inmates over age 50 are housed in a medium-security, protective custody dorm called the "Old Men's Colony." Another special dorm at Huttonsville Correctional Center is adjacent to the infirmary. Specialized programs offered to elderly inmates include: medical care; counseling; exercise; gardening; self help; dietary and pharmacological services; horticulture; life-skills; special education; and religious services. In March 1998, the state began the conversion of a former retardation center into a 450-bed prison for older/infirm inmates.[113]

Wisconsin

Elderly inmates are placed in one of two units for the medically needy. There is an infirmary unit for those who need 24-hour care and a self-care unit for those who need minimal assistance. A $7 million appropriation was granted to the Department of Corrections to turn a former state institution at Chippewa Falls into a prison for aged inmates. The geriatric prison is to house 300 inmates.[114]

Wyoming

The Wyoming State Penitentiary has two special units within the Medium Security Unit for males 40 and older who meet certain screening criteria. The programs for these inmates exist within the general population.[115]

The House survey of the states with the ten highest inmate populations over the age of 55 yielded significant information on how the various states were responding to the challenges of an aging prison population. Several issues were frequently reported as concerns to be addressed in the future. As previously noted, several states are beginning to identify and address the emerging situation regarding the elder inmate population. The next table illustrates these areas of concern.

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[113] *Aging Inmate Population*. Todd Edwards. Southern Legislative Council of The Council of State Governments. (1998) p. 30.

[114] "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 17.

[115] *An Administrative Overview of the Older Inmate.* Joann B. Morton. National Institute of Corrections. U.S. Department of Justice. (August 1992) p. 24; "Older Inmates: The Impact of an Aging Inmate Population on the Correctional System. An Internal Planning Document for The California Department of Corrections." (1999) p. 17.

Specific Concerns Regarding Population Over Age 55 (Ten Highest Inmate Populations)	
State/ Agency	*Response*
Federal Bureau of Prisons 7,244	No response
California 4,385	Adequate housing Isolation Health Care upon release
Florida 2,396	Health Issues Program Activities & Work Transitional Services
Texas 2,380	Health Care Problems & Costs Appropriate Housing & Release Planning Programming needs
New York 2,380	Unavailable
Ohio 1,963	Health Care Costs Physical Plant modifications Programming needs
Pennsylvania 1,871	Continuity of care upon release
Georgia 1,298	No response
Arizona 1,015	No response
Virginia 910	No response

Source: Survey conducted by House Corrections Committee staff (August, 1999)

In addition the survey produced a comprehensive listing of programming activities specifically created for elder inmates and those with disabilities. The California Department of Corrections states in their planning document that these identified activities have been chosen because they can be accomplished at little or no cost. Relying on community volunteers and talent often found within an institution, many of these activities have the potential to generate sufficient funds to support the activity. This table represents the state of California's analysis of programming alternatives.

Programming Activities for Elder Inmates

ACTIVITY	POSSIBLE INSTRUCTORS	POSSIBLE MATERIAL SOURCE	OUTCOMES	POTENTIAL FOR REVENUE GENERATION	POTENTIAL FOR CHARITABLE OUTCOME
Horticulture	**Inmates Master Gardeners Local garden clubs Local colleges Community volunteers Joint Venture**	** X X X X Local garden stores and horticultural societies Other donations Revenue from sales**	**Flowers for facility Flowers for staff Packaged seeds Dried flower arrangements Flower crafts Potpourri Fruits and Veggies Spices Dried gourds Dried Indian Corn**	** X X X X X X X**	**Flowers and decorative arrangements for hospitals, nursing homes, day care centers, etc., fruits and veggies for food banks**
Yarn Crafts	**Inmates Community volunteers Yarn shops Art Facilitators Local colleges Hobby Craft Program**	** X X Staff (leftover yarn) Other donations Revenue from sales**	**Afghans Lap robes Ornaments Dolls Yarn wall hangings Hooked rugs**	**X X X X X X**	**Donate to hospitals, nursing homes, day care centers**
Material Crafts	**Inmates Community volunteers Yardage shops Craft shops Art Facilitators Local Colleges Hobby Craft Program**	** X X X**	**Soft dolls Soft toys Doll clothes Rag rugs Rag baskets Ornaments Quilts Placemats and napkins Aprons Applique Fabric painting Lap robes**	**X X X X X X X X X X X X**	**Donate dolls to children's facilities; ornaments and lap robes to nursing homes**
Holiday Decorations	**Inmates Art Facilitators Local Colleges Community volunteers Craft shops Hobby Craft Program**	** X X X Horticulture program Staff (leftovers) Other donations Revenue from sales**	**Decorations for various holidays Greeting cards**	**X X**	**Donate to hospitals, nursing homes, children's facilities, low income families**

Programming Activities for Elder Inmates					
Wood Craft	**Inmates Art Facilitators Community volunteers Local colleges Craft shops Hobby Craft Program**	**X X X Lumber yards Staff (scrap wood) Wood shop scraps Other donations Revenue from sales**	**Wooden toys Wall hangings Decorative boxes Name plates Picture frames Shadow boxes Plant stands Foot stools Rocking horses**	**X X X X X X X X X**	**Donate toys to children's program**
Art Projects	**Inmates Art Facilitators Local colleges Community volunteers Hobby and craft shops Hobby Craft Program**	**X X X Staff (leftovers) Leftovers from other projects Other donations Revenue from sales**	**Paintings Drawings Mobiles Clay projects Prints Paper art**	**X X X X X X X**	**Donate to hospitals, nursing homes, children's facilities, low income families**

Source: California Department of Corrections (1999).

California's planning document also suggests that studies have shown it to be beneficial to play music from the era most familiar to the inmates. This reportedly has a calming effect, promotes greater participation in activities, and may aid in maintaining order and security.

Other suggestions for suitable activities are:

- low impact exercises for about 20 to 30 minutes a day;
- small group activities;
  - book clubs (access to large print and audio books);
  - reality exercises; and
  - reminiscing exercises using sight, sound, and smell cues.
- card and board games;
- crossword puzzles (in large print)
- jigsaw puzzles
- Occupational, music and art therapy;
- group discussions on pertinent physical and emotional concerns; and

- self-sufficiency exercises for those eligible to return to the community (e.g. how to handle money, how to pay bills, how to cook nutritionally, scheduling and attending medical appointments and victimization awareness).

X. CONCLUDING OBSERVATIONS AND RECOMMENDATIONS

Within the next decade, Florida's prison system is likely to be significantly impacted by the increased financial costs of incarcerating elderly individuals. Failure to begin addressing the problems and costs associated with elderly inmates may lead to a corrections crisis similar in proportion to that of the early nineteen nineties concerning the availability of inmate beds.

The first step is preparing for this change is identification and collection of current data on the costs of caring for the elderly as a subgroup of the total offender population. While baseline data is being collected, the Department of Corrections, in conjunction with the Correctional Medical Authority and the Department of Elderly Affairs, should develop one or more wellness and prevention oriented pilot programs to assess net medical savings as a result of wellness programs, as well as the effectiveness of these programs for the elderly which may indirectly impact the general health and functioning of this group.

In addition to wellness programs, the agencies must work together to develop meaningful behavioral programs and work projects for the elderly. After development of these items, pilot projects should evaluate the effectiveness of the programs developed.

Because of the significant savings in security which may be realized when inmates of certain ages and infirmities are housed together, the department should develop a profile of offenders reasonably expected to require less security. A pilot program could then be initiated which separately houses some of these individuals.

Individuals from the Department to Corrections, the Correctional Medical Authority, and the Department of Elderly Affairs familiar with correctional instructional facilities should compile a list of structural items likely to pose difficulties for the elderly in institutions. In conjunction with the ADA survey the department is commencing of its facilities, these structural items should be inventoried.

Statistics indicated that a significant proportion of the elderly who are first incarcerated at an age greater than 50 are convicted of violent crimes against family members. These individuals also have a low rate of recidivism. The simplest way to control the high medical costs associated with this population may be to keep them out of prison by reducing the incidents of violent behavior in this subgroup. A proactive community based program should be developed by the Department of Elder Affairs and the Correctional Medical Authority after data is collected from these types of individuals who are, or who have been, in the custody of the Department of Corrections. This data should include a psychological analysis of the factors which led to the violent behavior.

There my be a number of individuals within the corrections system who no longer pose a threat to society. A system of measures must be developed with which to identify these individuals. This should be a co-operative venture which includes the Department of Corrections, the Correctional Medical Authority, the Department of Elder Affairs and the Parole Commission. The Legislature

should consider legislation, including but limited to, bills which would expand executive clemency, expand the current law on conditional medical release, and create a geriatric exception to the requirement that eighty-five percent of all sentences must be served.

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