

MANAGING THE ELDERLY IN CORRECTIONS

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“Well, I done got old,
I can't do the things I used to do,
'Cause I done got old,
I can't see like I used to,
Can't walk like I used to,
Can't love like I used to,
'Cause I'm an old man.”²

Buddy Guy

'Life in prison can challenge anyone, but it can be particularly hard for people whose bodies and minds are being whittled away by age. Prisons in the United States contain an ever growing number of aging men and women who cannot readily climb stairs, haul themselves to the top bunk, or walk long distances to meals or the pill line; whose old bones suffer from thin mattresses and winter's cold; who need wheelchairs, walkers, canes, portable oxygen, and hearing aids; who cannot get dressed, go to the bathroom, or bathe without help; and who are incontinent, forgetful, suffering chronic illnesses, extremely ill, and dying.'

Human Rights Watch, *Old Behind Bars*, 2012 p.4

INTRODUCTION

There are few benefits to growing old. As we age, we inevitably deteriorate both physically and mentally, perhaps gradually if we are fortunate, but nonetheless steadily. Social psychological studies tell us that happiest elderly people are those who can remain active, with close connections with family and friends and other social supports, and who can still feel they are contributing in some meaningful fashion. We clearly live in an 'ageist' society and none of us particularly looks forward to getting old, but old age can be negotiated more or less effectively when there is quality healthcare we can access, some level of financial stability we can enjoy, and supportive social networks we can be part of.

Aging in prisons is another experience all together. Most elderly offenders will have lost touch with their families and friends, who are either dead, too old to visit, or have simply moved on with their lives. Health concerns are a daily preoccupation and fear of death, alone in a small cell, the fodder for nightmares. Opportunity to enjoy the small things in life, that become very important things as we grow older, is lost in prison; looking forward to our favorite meal, that special cup of tea, the calla lilies in our garden, or playing peek-a-boo with our grandchild.

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² Blues Ballad by Buddy Guy, Done Got Old Lyrics, from the Album Sweet Tea, 2001.

Aging in prison instead becomes an unceasing grind where one is forced to endure a boring, austere, routinized, noisy and foul smelling enclosed environment. There is no 'choice' to learn to age gracefully in prison. You simply get old, quickly and mostly invisibly.

The issue of managing the elderly in prisons has emerged as one of the most significant and unplanned for crises in corrections. Though it may be of most concern in developed nations, where life expectancy has steadily and significantly increased, the problem is growing quickly in developing nations where long prison sentences are becoming a matter of course. For many jurisdictions worldwide, it is an issue that has simply caught them by surprise as the aging of their prisoner population has begun to be noticed. It is clearly a situation that obliges action in accordance with numerous declarations of respect for human rights endorsed by most nations of the world. The elderly in prison, like all prisoners, have the right to be treated with respect for their humanity and inherent human dignity; to not be subjected to torture or other cruel, inhuman, or degrading treatment or punishment; to receive appropriate medical and mental healthcare; to have reasonable accommodation for their disabilities; and to be provided activities and programs to support their rehabilitation.³ This paper will attempt to:

- Outline the scope of the problem of the elderly offender in corrections;
- Discuss what might be causing this problem; and finally,
- Assess what some of the most significant consequences might be for the delivery of correctional services to this population, and what possible responses (policies, programs or services) might be helpful.

The Scope of the Problem:

Although there is some inconsistency both across countries and in the literature in terms of how the 'older' or 'elderly' offender is defined, typically it is accepted that this should refer to offenders who are at least 50 years old or over (Aday, 1994; Gallagher, 2001).⁴ A useful distinction is to categorize older offenders as falling into one of three groups (Goetting, 1984). The first is those offenders incarcerated after the age of 50, often for the first time, and often described as the later-life offender. These offenders will most often be charged with either minor economic offences (i.e., shoplifting or theft), fraud, or as far as serious offences are

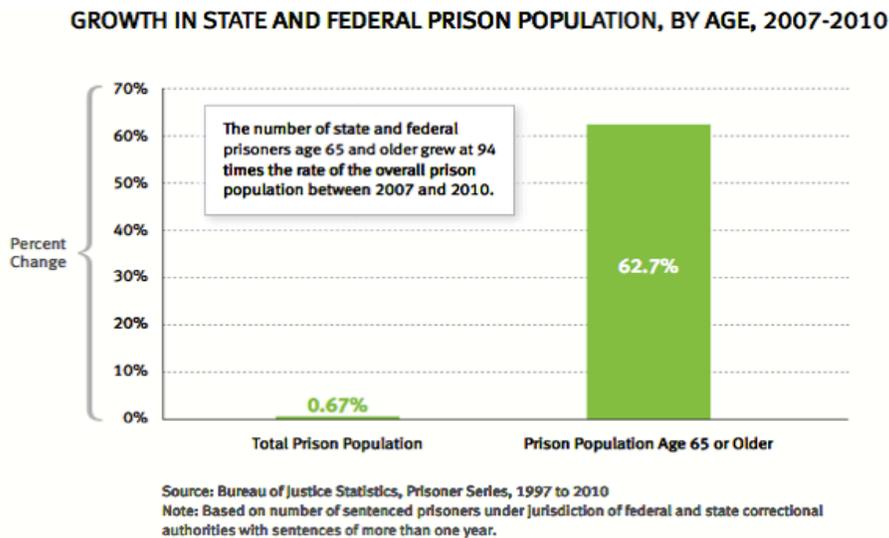
³ See for example, United Nations Standard Minimum Rules for the Treatment of Prisoners, adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of July 31, 1957, and 2076 (LXII) of May 13, 1977; European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, "The CPT Standards, 'Substantive' sections of the CPT's General Reports," CPT/Inf/E (2002) 1, Strasbourg, October 2006; International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, arts. 7 and 10; Convention on the Rights of Persons with Disabilities (CRPD), adopted December 13, 2006, G.A. Res. 61/106, Annex I, U.N. GAOR, 61st Sess., Supp. (No. 49) at 65, U.N. Doc. A/61/49 (2006), entered into force May 3, 2008.

⁴ Following convention in the literature, reference to the 'older' offender will be for those aged 50 or older, whereas 'elderly' offender will refer to those aged 65 or older.

concerned, either a sex offence (e.g., pedophilia) or murder (e.g., of a spouse). A second category of older offenders is the relatively small proportion of ‘career criminals’ who consistently continue to offend and get imprisoned well past the peak age for offending (Aday, 2003). Typically, these offenders would be serving sentences for a whole variety of serious crimes, including possibly organized crime, drug trafficking, or robbery. Finally, the last category of older offenders, which is clearly the largest group within prisons and jails today, are the ‘long-termers’ who were incarcerated prior to age 50 but who have aged in prison because of their long sentences.

It has been documented that approximately 13% of sentenced prisoners in America are aged 50 and older (Guerino et al., 2011). This constitutes the fastest-growing sector of the prisoner population, which is now at least 5 to 8 times as large as it was in 1990 (Human Rights Watch, 2012). As an example, although the population in New York State prisons decreased by over 20% in the last decade, the population of incarcerated individuals aged 50 or older increased by 64% (Bernstein, 2011). Between 1995 and 2010, the number of state and federal prisoners in America age 55 or older nearly quadrupled (Human Rights Watch, 2012). Over a period of only a few years, from 2007 to 2010, the prisoner population older than 65 in America grew at 94 times the rate of the overall prison population (see Figure 1 below).

Figure 1⁵

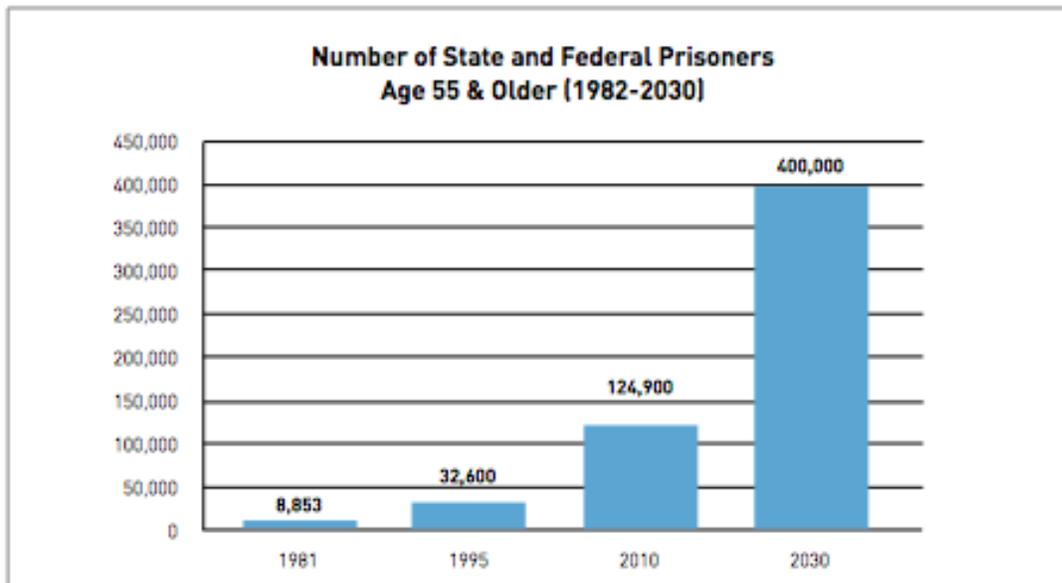


Strikingly, it has been noted that the rate of incarceration for men age 65 and over in America is 142 per 100,000 male US residents of that age, a rate that exceeds the total rate of incarceration for men of any age in most countries (Human Rights Watch, 2012). By the year 2030, it has been forecasted that older inmates will represent over one-third of the U.S. prisoner population (Durham, 1994; Neeley et al., 1997), an increase of 4,400% since 1981

⁵ Taken from Human Rights Watch, Old Behind Bars, 2012

(American Civil Liberties Union, 2012) (see Figure 2).

Figure 2



Figures from Canada in the mid 90s suggested that about 8% of offenders in federal institutions were 50 years of age or older (Grant & Lefebvre, 1994) and that the growth in the concentration of offenders 65 years of age or older had been outpacing all other age groups (i.e., an increase of 49% over only a 3 year period from 1990-93). By 2011-12, it was reported that 20.6% of the incarcerated federal offender population was now aged 50 and over (over 1 in 5). Moreover, the population under community supervision was even older, with 32.6% of offenders in the community aged 50 and over (Public Safety Canada, 2012). Interestingly, almost three quarters (72%) of the offenders 60 years of age and older were found to be serving their first prison term, mostly for either homicide or sexual offences (70.3%) (Grant & Lefebvre, 1994)

Similar concerns about a quickly aging prisoner population have been noted in England and Wales where it was reported recently to the House of Commons that 12% of prisoners were aged 50 and older and the proportion in this age grouping had more than doubled since 2002, significantly outpacing all others age categories (Berman & Dar, 2013). In Australia the proportion of prisoners over 50 has also been reported as more than doubling in the last several decades (Dawes, 2005). And in Japan it has been reported that the number of prisoners age 65 and over increased by 160% between 2000 and 2006, mostly for non-violent offences such as shoplifting and petty theft, a phenomenon attributed to the break down of the traditional family that has led to older persons turning to crime due to poverty and isolation.

So What Is Causing This Problem of the Graying of the Prisoner Population?

“The increasing warehousing of aging prisoners for low-level crimes and longer sentences is a nefarious outgrowth of the “tough on crime” and “war on drugs” policies of the 1980s and 1990s.”
ACLU, ‘The Mass Incarceration of the Elderly’, 2012, p.2

Many parts of the world are facing what has been dubbed a ‘silver tsunami’ -- a growing trend towards aging of the general population. Between 2000 and 2010, for example, the elderly population in America (65 years and over) increased at a much faster rate (15.1%) than the total population (9.7%), a trend that is expected to accelerate. People 65 or older represented only 4% of Americans in 1900, increasing to 12.4% of the population by the year 2000, and expected to grow to close to 20% by the year 2030 (Administration of Aging, 2014). This same pattern is occurring in many countries where the demographic bulge known as the ‘boomer’ generation is now moving into old age. It might seem sensible, therefore, to suggest that the graying of the prisoner population is simply a reflection of this more general phenomenon. However, the facts present quite a different story. Looking at who these aging prisoners actually are makes it quite clear that the aging of the prisoner population is not being caused by the well-established shift in demographics of the general population.

A recent thorough analysis of the trends and patterns of offences committed by the elderly in America over a 25-year period (1980-2004) confirms that demographics alone cannot account for the disproportionate growth of the elderly prisoner population (Feldmeyer & Steffensmeier, 2007).

First, it was found that older offenders (i.e., aged 55 or older) actually contribute only modestly to the nation’s total arrest rate. The elderly show the lowest rate of arrests of any age group and their share of crime accounts for less than 4% of total arrests and less than 3% of ‘serious’ or Index crime arrests.

Second, elderly crime rates have not increased in level or *seriousness* in recent decades and the relative criminal involvement of the elderly is about the same as 25 years ago. For almost all offenses that were examined, arrest rates for the elderly had either remained stable or had fallen over time.

Third, the analysis confirmed the stability over time of the well-known age-crime curve that has been observed in criminology for over a century.⁶ This burn out theory of crime has become one of the most well known observations in criminology (Maruna, 2000; Steffensmeier et al., 1989), and we know, for example, that arrest rates drop dramatically to just over 2% at age 50 and are almost 0% at age 65 (ACLU, 2012).

⁶ The age-crime curve, which seems to be stable across both cultures and historical periods, show rates of involvement in crime rising rapidly in early adolescence, peaking in the late teens or early twenties, and then declining. The dramatic drop off in criminal involvement with age has been related to numerous factors that contribute to an “aging out” of crime at later stages in life. This has been attributed to the biological process of aging as well as the changing roles and perspectives of the elderly. There is a decline in physical strength, energy, and psychological drive with age. The elderly are likely to have fewer opportunities for crime and criminal sanctions and possible incarceration will represent as a more serious threat (i.e., more to lose with less time to death). Finally, aspirations and goals change with age and the elderly may no longer strive for the same level of material fulfillment and recognition as when they were younger. Major sources of reinforcement for crime (e.g., money, sex, status, and antisocial peer pressure) may be absent or relatively weak in old age.

And finally, the findings showed that there was very little change in the profile of the elderly offender who is arrested, with elder arrests continuing to be overwhelmingly for minor offenses (e.g., theft) or alcohol-related offences. The authors concluded that the law-violating behavior of older adults was not more of a pressing problem today than a generation ago, and that indeed there was some evidence suggesting it was less so.

We can conclude that despite the obvious aging of the population in the wider community, the elderly are not committing crimes, being arrested or ending up in prison in significantly larger numbers.⁷ But if that is the case then what explains the rather dramatic and disproportionate growth in the concentration of older and elderly offenders in prisons? Arguably, the main culprits are, on the one hand, punitive sentencing policies and practices that send more offenders to prison for longer terms, and on the other hand, severely restrictive release policies for long-term offenders, either for parole, or even for offenders who are infirm or quite disabled and dying.

The well-documented recent report from the American Civil Liberties Union, *Mass Incarceration of the Elderly (2012)*, highlights the following:

- The elderly prison population is increasingly made up of individuals who were sentenced when they were younger but given lengthy prison terms (20 years or more) that effectively lead to their remaining in prison well into old age. In 1979, only 2% of aging prisoners fell into this category nationwide. Data shows that this percentage has increased up to ten fold in many American jurisdictions.
- Many older individuals who would have been sentenced to short periods of incarceration for repeat crimes of a minor nature are now caught in the net of ‘habitual offender’ and three-strikes legislation.
- The percentage of aging prisoners who were first imprisoned after they turned 50 is actually declining.

Over a 25-year period, from 1984 to 2008, the number of offenders serving life sentences in federal prisons in America increased tenfold. Even in the more recent decade from 1998 to 2008, the number of state and federal prisoners serving life sentences in America more than quadrupled (ACLU, 2012). The Sentencing Project⁸, a well respected non-governmental research and advocacy group, has documented that 1 out of every 9 prisoners in America are currently serving life sentences, and even since just 2008, the rise in sentences of life without parole has been much steeper than for life with parole (22.1% rise in LWOP; 7.6% rise in LWP).

⁷ It is generally recognized that demographically the highest crime-risk group is males from their teens through to their late 20s. Crime rates began to increase in North America as the large wave of a so-called ‘boomer’ generation passed through their high crime-risk years from about 1960 to the mid 90s. As this boomer generation aged, crime rates began dropping steadily since the early 1990s, particularly since the follow on demographic groupings entering their high crime-risk years (i.e., the baby bust and boomer echo) are much smaller in size than was the boomer generation.

⁸ See <http://www.sentencingproject.org>

The ACLU review summarizes the situation as follows: “Our prison population has not grown so old by accident. The proliferation of severe sentencing policies—the enactment of mandatory minimum, three-strikes, and truth-in-sentencing laws along with the general increase in sentence lengths—has led to a massive explosion in the aging prisoner population” (p.45).

The deterrent effect of these severe sentencing practices has been seriously questioned repeatedly (Wright, 2010). Nonetheless, all over the world, political mileage continues to be had with ‘tough on crime’ rhetoric and the common refrain of calling for lengthier prison terms in the supposed interest of increased public safety. But the reality is that punitive sentencing is only of chimeric value in terms of public safety. In Canada, for example, our Conservative government recently saw fit to pass a ‘Safe Streets & Communities Act’ embracing a range of American-like practices to lengthen prison terms for many offenders. This occurred despite the fact that crime rates had steadily decreased to the lowest level in over forty years. When challenged about the need for such measures, our Justice Minister dismissively declared that: “We don't use statistics as an excuse not to get tough on criminals”.⁹

Getting tough on criminals has led to many perhaps unintended consequences; the perpetuation of institutionalized racial discrimination on a grand scale in America and elsewhere (Alexander, 2010), inhumane conditions of overcrowding, and skyrocketing costs of incarceration that deplete public funds that could be allocated to education and/or other essential social or health care services (Vera Institute of Justice, 2012; Sentencing Project, 2013). More or less globally, corrections is now struggling as well with how to deal with a growing wave of elderly adults, many of whom are in need of specialized care, in facilities that were not at all designed for that purpose (Stone et al., 2011).

The next section of this paper attempts to summarize a number of the most significant consequences for correctional services and outline some possible ways for corrections to respond more humanely and effectively.

The Aging Prisoner Population: Significant Consequences and Possible Responses

As the proportion of older and elderly offenders grows steadily, correctional services confront a difficult dilemma. With correctional budgets already stretched to the limit, do they more or less let things be and thereby run the risk of not only seriously disadvantaging this group of individuals, but violating their fundamental human rights. Or, do they further stretch these strained budgets to develop specialized programs and services for these older offenders and possibly disadvantage younger offenders as a result.

It has been estimated that taxpayers pay more than twice as much per year to incarcerate an aging prisoner compared to a younger one (ACLU, 2012). The estimated 16 billion dollars

⁹ Our Public Safety Minister was also quoted as saying he didn't believe crime statistics because he *knew* that ‘unreported’ crime was on the increase – rather humorous if it wasn't also sadly reflective of how ‘facts’ can be so totally dismissed by politicians.

required to incarcerate older offenders in America, for example, is more than the Federal Department of Education funding for state elementary and secondary school improvements. While there is clearly an imperative to look at sentencing reforms and diversion strategies for stemming the growth of the number of elderly in prisons (HRW, 2012; ACLU, 2012), the fact remains that corrections will need to attend, for the foreseeable future, to managing, and finding ways to reduce the cost, for at least the most essential services for humane treatment of an increasingly aging prisoner population.

1. Managing the Health Care Needs of the Elderly Prisoner

Even only the most basic and minimal level of care for elderly prisoners has been estimated to cost roughly two to three times that for a younger prisoner (ACLU, 2012). Aging prisoners are more likely ~~to suffer from a variety of medical conditions~~, require more contacts with healthcare providers, and will typically need longer and more frequent hospitalizations. In America, a Bureau of Justice Statistics national survey of prisoners' medical problems indicated that more than two-thirds of prisoners age 45 and older were experiencing medical problems and over 20% had underwent surgery after they were incarcerated (Maruschak, 2008). Loeb & Steffensmeier (2006) have nicely outlined a broad range of conditions that can lead to physical deterioration of the elderly prisoner.

- Decreased sensitivity to heat, cold and pain (so they may need extra clothing and bedding);
- Disinclination to eat (no taste, bad teeth and/or denture problems, swallowing problems and gastrointestinal difficulties, decreased sense of smell and taste) leading to weight loss;
- Pressure injuries and falls which may be exacerbated by stairs, slippery floors and mats;
- Increased problems with heart disease, either related to high blood pressure or to age related changes in the heart muscle, lungs or blood vessels;
- Decreased amount of activity;
- Increased amount of medications they will be consuming;
- Age related changes in the nervous system (for example, tremor or shaking of the hands and body, dementia, stroke, parkinsonism);
- Decreased circulation in the extremities, which can result from illnesses such as diabetes or life style choices like smoking;
- Poor sight and hearing;
- Decreased muscular strength and physical fitness;
- Bone and joint related disorders such as arthritis and osteoporosis;
- Urinary tract problems ranging from infections to prostate problems to incontinence (either bladder or bowel);
- Cancers of various types.

Several factors in particular stand out in accounting for the much higher cost of health care for the elderly in prisons, most of which are beyond the control of correctional agencies.

- It is well established that the elderly in prison suffer more rapid decline in cognitive and functional capacity, or what is often referred to as 'accelerated aging' (Fattah & Sacco, 1989; Human Rights Watch, 2012; Williams et al., 2012). This can be attributed to multiple causes including a tendency to pursue unhealthy lifestyles (poor diets, little exercise) and engage in high-risk behaviors prior to imprisonment (smoking, drug and alcohol use); inadequate preventive health care; a greater rate of infectious disease; and the compounding effects of the deprivations and stressors of prison life.

- Prisons in general are designed for the young and able-bodied and not for individuals requiring various special services and devices, such as walkers, wheelchairs, and hearing or breathing aids. Without access to these medical aids, health conditions deteriorate even more quickly. More so than in the community, the elderly in prison also suffer from falls, accidents or various kinds of victimizations, which also add to high health costs.
- Correctional and healthcare professionals in prisons are under-trained vis-a-vis geriatric care and lack the technical expertise for early intervention of various age-related illnesses. Problems such as hearing loss, vision problems, arthritis, diabetes, asthma, hypertension, and dementia consequently exacerbate unnecessarily during confinement and costs to address them increase.
- Prisons often have to send aging prisoners to outside hospitals for emergency or specialized medical treatment and this incurs the added costs of transportation, the specialized treatment itself, and the salary costs of the officers (often with overtime) to supervise the prisoners undergoing treatment. It has been estimated that these 'external care expenditures' can constitute up to 70% of total health care costs for the elderly offender.
- And finally, at the extreme, taking care of some aging prisoners with chronic conditions (e.g., heart disease, emphysema), as well as hospice care for the dying, will require substantial costs simply to meet even very basic needs.

Correctional agencies increasingly need to pursue innovative strategies to deal with these spiraling costs of health care for the elderly offender. Many jurisdictions are turning to the establishment of geriatric or nursing-home type programs ranging from specially designed facilities for the aged and infirm to special units within a larger prison setting. Grouping prisoners with similar health care needs is not only more cost effective but it allows for the design of a more age-sensitive, safer and healthier environment for the elderly that can help avoid further deterioration and encourage preventive self-care (e.g., special diets, access to appropriate medications, geriatric walking programs, low-impact sports activities ... etc.). With an interdisciplinary staff compliment trained in geriatric-specific correctional care, these specialized units often also make very effective use of family and prisoner peer supports, and community in-reach and advocacy group volunteers and mentors (Maschi et al., 2013). Programs are offered as well to help prisoners deal with their emotional reactions to health issues, the strain of prison life, and conflicts or disengagement with family and children that can be a powerful additional strain on physical health.

As long as sentencing practices continue to resort to lengthy prison terms despite the limited gains for public safety, the aging of our prisoner population will press on, and the concomitant costs of providing essential health care services will present a growing challenge to corrections. A double-sided strategy is needed where on the one hand, correctional environments for the elderly are created where physical and mental health is not exacerbated (i.e., prevention), and on the other hand, practical solutions are found where care can be provided in a cost-effective manner (i.e., intervention). A number of examples of these kinds of double-sided and integrated models of practice for managing the elderly in corrections will be outlined later in this paper.

2. Coping and Adaptation to Prison Life for the Elderly

'We assert that the poor social and environmental conditions of confinement, particularly for older persons, are in fact a type of elder abuse and neglect.'

Maschi et al., 2014, p. 56

There has been considerable criminological and psychological focus on the causes and consequences of 'prisonization', and the challenges of coping with, or adapting to imprisonment. This dates back to the early, classic sociologic studies of prison life (Clemmer, 1940; Sykes, 1958) and other more recent and more psychologically attuned studies of the impact of imprisonment (see for example; Cohen and Taylor, 1972; Liebling & Maruna, 2005; Zamble & Porporino, 1988). Adjustment or maladjustment in prison is clearly multiply determined by both individual and setting characteristics. However, there is also some significant degree of continuity in coping from community to prison, where those individuals who are relatively well adjusted (socially and psychologically) in the community prior to incarceration continue to cope relatively well during imprisonment (Zamble & Porporino, 1988). There has been rather limited study of the psychological impact of imprisonment on the elderly in particular. But what evidence does exist suggests that there is no *continuity* in adjustment or coping for the elderly prisoner. Regardless of how well they may have coped with life prior to imprisonment, the prison experience for the elderly (and especially when it is lengthy) has profound and pervasive psychological repercussions.

As we have already noted, elderly prisoners are a heterogeneous group where some have aged in prison, others have been incarcerated late in life, and yet others are recidivists who may have had numerous terms of imprisonment and may now be facing either a lengthy or relatively short prison sentence in old age. Some will have histories of victimization or co-occurring mental health and alcohol or substance abuse issues to contend with, while others may be mostly concerned only with health issues. Many long-termers will have a respected position within the prison sub-culture, while the newly incarcerated may feel alienated and out of place. Some individuals who have aged in prison may have adapted, and even over-adapted, to the routines and depersonalization of the prison experience, falling into institutional dependency (Aday, 2003). Others may be experiencing the early trauma of entering a strange world where fear of violence and loss of control is persistent. A recent thematic analysis of some of the varied types of 'psychological' stressors experienced by the elderly in prison is informative, based on an extensive survey of close to 700 elderly prisoners in one American state jurisdiction (see Table 1; from Maschi et al., 2014)

Table 1. Types of Stressors for the Elderly in Confinement

<p><i>Health as a stressor</i> Physical and mental pain/distress and receiving services (DISTRESS)</p> <p><i>Social cultural context</i> Separation and loss (DISENFRANCHISED GRIEF) Missing family and friends, too much time in cell (ISOLATION AND LONELINESS) Safety: assault, gang members, witnessing assault, mean guards Being a victim/witness of abuse (FEAR) Administration-sudden changes (ANXIETY) Loud noise, no peace, young people (ANNOYED)</p> <p><i>Anticipatory stress</i> Dying in prison, life after prison, family wellness, work ability (WORRY)</p>
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Indisputably, the physical environment of most prisons will be similarly oppressive for most elderly prisoners, especially if they are also frail or disabled (e.g., poor lighting and ventilation, being housed too far away from dining rooms and toilet facilities, sleeping in bunk beds, limited recreational or work opportunities). But the emotional and psychological coping and adaptation needs of the elderly prisoner will vary substantially depending on how much time they may have served, how much time they may have remaining to serve, their health conditions, available social support networks, and their status within the prison hierarchy. By necessity, an effective correctional response to these differences requires some level of individualized case management and sensitivity to the particular needs of the person, both in time and place. Yet the elderly in prisons, particularly if they are relatively few in number, can tend to be forgotten and ignored, both by correctional officers in their day-to-day interactions, and in terms of the design of more general institutional regimes and operations (i.e., routines, regulations, time-tables etc.). Some groundbreaking ethnographic research of the elderly's experience of imprisonment in the UK has coined the phrase '*institutional thoughtlessness*' to refer to this reality (Crawley & Sparks, 2005).

At the institutional level, there is typically a requirement for the elderly to fit into and accommodate to existing routines and practices, not the other way around. Because they are generally less of a problem, more cooperative and less disruptive, the needs of older prisoners are left inadvertently unattended. Even in some very subtle ways, this can significantly add to the elderly prisoner's feelings of helplessness, dependency and indignity. Crawley & Sparks (2005; 2005a) give some examples that are commonplace in correctional environments.

- Not being allowed sufficient time to complete activities or to get to and from specific locations;
- Forced to watch communal television in the corridor while sitting on hard, un-upholstered chairs;
- Being denied additional clothing or bedding in cold weather;
- Having to queue for long periods to obtain medication;
- Having to climb stairs while carrying food trays;
- No access to toilet facilities during exercise periods;
- Having to shower in slippery, tiled cubicles that were not equipped with grab-rails or anti-slip mats;
- Feeling abandoned or discarded because of limited access to unit officers;

Suffering through the indignities of prison life is a special challenge for the elderly offender. But perhaps even of more fundamental impact is what Crawley & Sparks (2005) refer to as the need to manage a 'spoiled identity'; the loss of a sense of purpose or coherence in life which for many can lead ultimately to 'a disengagement with all social activities and routines, including personal care' (Crawley, 2005, p. 360). Crawley (2005) comments eloquently on this particular pain of imprisonment for the elderly offender.

"The fact of being in prison at this point in one's life is seen as making a failure, or fraud, of the whole of that life. This can be experienced as irreparable—there is not enough time left to make good or start again ... We found that many prisoners are very much engaged with reminiscence, seeking solace in the recollection of happier, more successful times ... For others, however, retrospection offers few consolations. The gulf between the old life and the prison life is too great, the loss of status, position, and identity too complete. In such cases, prisoners speak of their previous life as having been erased." (p. 359)

Working to prevent psychological harm and deterioration for the elderly prisoner has to follow a number of fronts. We know that prisons will generally function more humanely (and effectively) when there is a proper balance of some key dimensions ... an orderly, safe, and fair internal environment; an active regime with provision of opportunities for personal development (+ moral growth); respectful and courteous staff-staff and staff-prisoner interactions; timely response to prisoner concerns, and decent treatment by highly motivated staff (Liebling, 2011). The same principles apply in managing the elderly prisoner. But uniquely in caring for the elderly, there is need for other practice innovations and special focus. The following are a few examples.

Social work and psychology practice in corrections needs to become more geriatric-specialized (Kratcoski, 2000) and more actively involved in advocacy to address the special needs of the elderly offender (Maschi et al. 2014). Closer attention should be paid to critical periods in the lives of the elderly prisoner, when despondency and depression can set in even more acutely (e.g., the early transition into the prison subculture for the late-life offender; pre-release panic for the long-termer; following the death of a fellow prisoner ... etc.). Monitoring the changing moods and patterns of adjustment of the elderly can allow for early supportive intervention, perhaps exploring the benefits of less *change-oriented* and more *acceptance-oriented* therapeutic models. For example, therapeutic approaches could focus on alleviating the internal struggle of thoughts and feelings related to the inevitability of life in prison (Ruiz, 2010).¹⁰

Rather than slotting the elderly into existing educational and recreational programming, new programs should be developed that are focused more particularly on the needs and interests of elderly prisoners (e.g., rather than literacy or traditional upgrading, educational programs that focus on fostering new life interests or hobbies or help explore latent artistic or creative talents; recreational programs that allow for ease of participation of the elderly such as geriatric walking programs and low impact sports activities; reliance on community volunteers to engage the elderly prisoner in age-appropriate arts and crafts activities, theatre, literature or music appreciation ... etc.).

Self-help and mentoring or peer-support groups for the elderly can be re-motivating, validating and empowering, where common and long-standing concerns of life in prison can be shared and explored with peers who 'see and feel' the same things (the pain of reminiscing, loss of freedom, health, energy, work roles, identity, family ... etc.). Powerful interpersonal bonds can be created that may last for years.

For the long-termer, the notion of the prison career can be more fruitfully explored (a life-long job in prison) and forecasting that an individual will be serving a lengthy prison term should invoke early case planning and training for that prison career to take shape. Many of these

¹⁰ For Example, Acceptance Commitment Therapy (ACT) differs from traditional cognitive behavioral therapy (CBT) in that rather than trying to teach people to better control their thoughts, feelings, sensations, memories and other private events, ACT teaches them to simply focus on the present and 'just notice', accept, and embrace the coming and going of their thinking, especially anxious or traumatic events, but without struggling with them.

offenders can find meaning and identity in their work in prison -- in vocational training shops or arts & crafts classes as instructors, as literacy promoters or teachers, in prison maintenance work, as librarians, bookkeepers, clerks, and a variety of other prison jobs. Other late-life elderly offenders may already have pursued careers (e.g., accomplished perhaps as teachers, attorneys, accountants, priests, businessmen ...etc.), and may bring with them various talents (e.g., as musicians, artists, gardeners, educators). Not capitalizing on these capabilities and talents in some fashion within the correctional environment is a sad waste of available resources.

Not all staff members will have the sensitivity, patience and compassion to deal with the elderly prisoner. Rather than forcing staff to deal reluctantly with the elderly, selection and training for specialized roles should be developed, line correctional staff working in special units for the elderly should be carefully screened and other staff can be developed as 'gerontology' specialists.

Correctional environments that can deal more effectively with the elderly prisoner will not emerge by accident. They need to be planned for and carefully designed and pay respect to the evidence we have about how imprisonment can affect the elderly. Not all older prisoners will want to be surrounded *only* by other older individuals. Some may resist being located in specialized facilities that may be geographically distant from families. There are also some well-accepted correctional advantages to mixed housing of offenders, where older offenders, for example, can serve as a 'calming ' influence over younger ones. But giving 'choice' to the elderly offender may be what is most empowering.

It may not be possible to make prison environments actually healthy for the elderly, but at least we can mitigate some of the impact and make them less unhealthy. Resources will continue to be a problem but examples of specialized housing and programs for the elderly offender are growing. As of 2008, for example, at least 13 US states had responded to the needs of older offenders by creating specialized units, six had dedicated prisons, nine had dedicated medical facilities, five had dedicated secure nursing-home facilities, and quite a significant number had developed hospice programs (Sterns et al., 2008). One of these specialized, multi-faceted and very geriatric-sensitive programs is described in more detail in *Appendix A* of this paper, the 'True Grit' program near Reno, Nevada (Harrison et al., 2012).

3. Supporting the Terminally Ill and Dying Elderly in Prisons

Between 2001 and 2009, illness-related deaths accounted for 9 out of 10 prison deaths in America and prisoners age 55 or older accounted for over 40% of all prison deaths (Noonan & Carson, 2011). It has been estimated that more prisoners on death row will soon be dying each year of natural causes in America than will be actually executed.¹¹ In Canada over the 10-year period 2003-2013, 536 offenders died in federal custody and two-thirds of these deaths were

¹¹ See (<http://www.economist.com/blogs/economist-explains/2014/02/economist-explains-0>)

attributed to natural causes (OCIC, 2013). In the UK, the number of prisoners dying of natural causes was recently reported as reaching record numbers.¹²

Issues surrounding the management of the severely and terminally ill offender will continue to pose a significant challenge for correctional services, both in terms of maintaining community and human rights standards for 'quality of care' of prisoners before they succumb to death, and ultimately, in finding ways to provide adequate and humane hospice care for the dying prisoner (Linder & Meyers, 2009).

Even in well-resourced correctional jurisdictions, concerns are raised routinely about the quality of care provided to seriously ailing prisoners, often leaving unanswered the question as to whether a death was preventable or premature. A recent study by the Office of the Correctional Investigator in Canada, for example, concluded that the Mortality Review Process followed by Corrections Canada was inadequate and that in numerous cases of death by natural causes there were questionable diagnostic practices, incomplete records, lax information-sharing, and delays or lack of follow-up on referral or treatment recommendations. Typically, correctional officials did not investigate the circumstances of natural deaths beyond recording the cause as either unexpected or sudden, and these in-custody deaths failed to generate significant findings or recommendations for a 'lessons-learned' exercise that could be conducted to improve practice (OCIC, 2013).

Correctional services obviously need to work steadily to raise health care provision to community-equivalent standards. Two conditions that are at least somewhat treatable, heart disease and cancer, account for close to 50% of illness-related deaths in prisons in America. Some elderly offenders will die unexpectedly regardless of the quality of care they receive (e.g., from heart attacks or strokes). But others will linger into slow deaths where hospice care becomes the only alternative. And this is an area where some quite innovative 'best practice' has emerged in recent years.

There is, of course, the alternative of 'compassionate release' for the terminally ill offender. But in America, as in many other nations, the restrictions are considerable. In addition to requiring difficult to obtain medical confirmation of near death prognosis, to be considered for compassionate leave offenders have to be of low security classification, demonstrate future financial stability, and have an established dwelling to return to. Aging relatives are often unreceptive about caring for a dying offender and nursing homes are unwilling to assume the liability for accommodating ex-offenders.

Prison Hospice programs have become the only alternative for many offenders and though the tragedy of unnaturally dying in prison in pain and suffering has at times become the focus of media sensationalism, other thoughtful presentations highlight the ways in which these

¹² See <http://www.telegraph.co.uk/news/uknews/law-and-order/9544445/Record-number-of-prisoners-dying-in-old-age.html>

programs can quite deeply affect and benefit both the dying prisoner and the living caregiver.¹³

The first prison hospice programs were established in America in the late 80s in the states of Missouri and California (Ratcliff, 2000). Ten years later, the National Institute of Corrections (NIC) identified 28 prison hospice programs (NIC, 1998). More recently, the National Hospice and Palliative Care Organization (NHPCO) in America estimated that 75 state and federal prisons and county jails were offering a formal prison hospice program (Hoffmann & Dickinson, 2011). The National Prison Hospice Association (NPHA) and the Guiding Responsive Action for Corrections in End-of-Life (GRACE) Project have also developed ‘standards of practice’ and ‘operational guidelines’ respectively, to facilitate the implementation of hospice in prisons.¹⁴

A recent survey of 69 well established prison hospices in America noted that these programs have varying capacity for hospice care of anywhere from one to 50 prisoners and that the programs operate quite closely in accordance with community standards; typically managing patient care with Interdisciplinary Teams of a physician, nurse, mental health worker and chaplain who meet regularly to reevaluate the patient’s care plan; providing hospice care to prisoners from various security classification levels; providing extensive hospice-specific training to caregivers, medical staff, and correctional officers; and permitting frequent visits by incarcerated and non-incarcerated family members. Unique to prison hospice programs, however, is the extensive use of fellow prisoners as caregivers. Over 95% of these prison hospices reported employing trained inmate caregivers. Acknowledged generally as the backbone of the prison hospice movement, compared to their volunteer counterparts in community hospices, these inmate caregivers are screened more intensely, go through more stringent training requirements, perform a wider variety of duties, and work much longer hours. Table 2 below is of interest in documenting the variety of ways that inmate caregivers actually contribute (Hoffmann & Dickinson, 2011).

Table 2: Duties Regularly Performed by Inmate Caregivers

Duties	%
Read to patients	98
Feed patients	80
Write letters to family for patients	80
Provide spiritual support to patients	73
Help to train new inmate caregivers	70
Change bed linens	68
Keep logbook of patient’s condition	63
Bathe patients	55
Dress patients	55
Educate general inmate population about the hospice	45
Provide lay counseling to patients	30
Administrative duties for hospice staff	13

¹³ See, for example, the recent quite touching academy award nominated documentary “Prison Terminal: The Last Days of Prisoner Jack Hall” following the final months in the life of a terminally ill prisoner(<http://www.prisonterminal.com/index.html>)

¹⁴ See National Prison Hospice Association. Prison hospice operational guidelines.

<http://www.npha.org/.../Prison%20Hospice%20Guidelines%20revised3.doc>; and Guiding Responsive Action for Corrections in End-of-Life. <http://www2.edc.org/lastacts/archives/archivesMay00/standards.asp>.

There are clearly some challenges to contend with in expanding the use of prison hospices (Hoffmann & Dickinson, 2011). First, managing the pain of dying patients can be seen as conflicting with security concerns about prisoners' abuse of drugs in the prison black market. Careful monitoring has to be instituted to ensure that medication is actually consumed by hospice patients. A second challenge relates to a central tenet of hospice care which is that family members should be actively involved in the care-delivery process. Ways to involve families, and community volunteers, as much as possible and/or desired have to be found. A third challenge is the paradigm shift required to reconcile the seemingly contradictory philosophies of corrections and hospice (i.e., punishment vs. care). Hospice programs may have to struggle to gain the support and trust needed from correctional administrators, correctional officers and other prison staff, to effectively deliver care to terminally ill inmates. And finally, a particular issue faced by prison hospices is whether offenders will agree to the cessation of curative treatment as a condition of admission, considering that the incarcerated individual may seriously doubt whether the prison administration and medical staff have their best interests at heart.

The prison hospice is an innovation born out of necessity that is now accepted internationally not just as 'good' practice but also as humane and ethical practice. It is rare that correctional programs can serve the dual purpose of care and support for the client as well as personal growth and both rehabilitative and redemptive potential for the caregiver (Maull, 2005; Wright & Bronstein, 2007).

4. Reintegration of the Elderly Offender Back to the Community

Some elderly offenders will unfortunately die in prison. But the majority will eventually be released even if quite late in their lives and quite ill or disabled. There are some rather unique issues for correctional services to deal with in this regard. Unlike with younger offenders, where re-entry programming and community supervision has to focus quite deliberately on 'risk management' (i.e., to minimize the risk of reoffending), the issue of risk management with the elderly is of a completely different nature. It is well established that the elderly ex-offender is only very minimally at risk for reoffending, and even when it does occur, it is typically of a rather minor nature (e.g., violation of a parole condition). One study of offenders released from New York state prisons, for example, found that only a very small percentage of elderly offenders were returned to prison within three years for a violent offence (only 3.4 % of those who were between 55 and 64 when released and none of those who were 65 or older) (Human Rights Watch, 2012).

Risk management for the elderly ex-offender is more a matter of preventing risk for homelessness, loneliness and depression, suicide, return to alcohol or substance abuse, unhealthy lifestyles and lack of access to medical care that will shorten life, and a host of other personal and social issues that will make for a rather sad quality of life in old age.

Older offenders, especially those well past the age for typical employment potential, and often

lacking living family members to assist them upon release, will need to secure some level of social assistance and/or specialized housing (e.g., assisted living). Long termers may need practical assistance in finding housing or employment after release, but more importantly in many ways, they will need to learn to negotiate the new world around them, a world quite different from the one they might remember. They may lack important social and practical skills for living, express nervousness about re-establishing ties with family, feel disconnected and unwelcomed in the communities they return to, and generally see little meaning or purpose for living.

Successful community reintegration for the older offender can be excruciatingly challenging when there is a compounding of factors, like one grenade after another tossed their way -- serious health and/or mental health issues to contend with, lack of any family or peer support, no financial resources, inability to access social welfare benefits, no available transportation, and no place to live.

Fundamentally, it is unlikely that the varied needs of the typical elderly offender can be met as an adjunct or afterthought in the normal course of most community corrections programs. It has been referred to as a 'mission seemingly impossible' (Haberman, 2001). Some level of specialization and focus is required and there are now some growing examples of a more geriatric-sensitive approach for reintegration of the elderly offender. The following is a sampling of some of these in a number of different countries.

Hocking Correctional Facility (Ohio, USA). The Hocking Correctional Facility (HCF) in Ohio was established specifically to address the prison and community reintegration needs of older prisoners. Offering one-stop wrap-around services, it includes a pre-release program that provides offenders with information on social security or welfare benefits, job-seeking skills, housing-placement services, employment training, property maintenance, self-care and geriatric-informed psycho-educational classes, and general education courses. Staff members are trained to deal effectively with geriatric populations, including chronic illnesses and death and dying issues. Community reintegration is focused on ensuring that older offenders have the necessary resources for living, including an approved placement in a nursing home if necessitated by declining health.

SEOP (San Francisco, USA). Funded by the U.S. Office on Aging, the program is located in a senior center for adults aged 50 and older who are incarcerated or about to be released. It provides medical, financial, social, mental health, and employment services. Wraparound services are provided that include basic needs, health literature, pre- and post-release counseling, case management, and counseling and support groups (Maschi et al., 2013).

RECOOP (England). This UK program specializes in the care, resettlement, and rehabilitation of older offenders and ex-offenders. Program components include support services, advocacy, advice on financial, housing, employment and health care needs, life skills and mentoring (Davies, 2011).

RESTORE 50 plus Program (England). This is an innovative approach for community reintegration of the elderly offender that adopts a supportive 'offender responsibility model' managed by older ex-prisoners in collaboration with correctional staff, where peers provide mentoring and extensive social support services (Davies, 2011).

RELIEF (Canada). Established in 1999, this program grew out of a collaborative initiative among offenders, community volunteers and corrections staff in British Columbia, Canada. The 'Reintegration Effort for Long-term Infirm and Elderly Federal Offenders' program was designed to facilitate the transition of elderly and infirm older adults from prison to the community. Six self-contained, six-bedroom houses are dedicated to housing clients and caregivers of the RELIEF program, and all living, recreational and programming space is at ground level and walker

and wheelchair accessible. The program goes further in adopting an innovative peer support model in that ex-prisoners are screened to receive hospice training and subsequently serve as caregivers for elderly and infirm offenders (Stewart, 2000). Supervision, general care, and access to medical care is provided by these trained offenders working together with other professional staff and specialized community medical services. Similar initiatives, and other assisted housing projects, are now being pursued in other locations throughout Canada.

CONCLUSION

Perhaps a good place to end this review of the issues surrounding management of the elderly in corrections is to briefly summarize some of the major recommendations that have flowed out of recent thorough analyses of the problem. The American Civil Liberties Union report *'Mass Incarceration of the Elderly'* (2012) highlighted the need for a broad revision of harsh sentencing practices that have caused the problem in the first instance, including recommending the presumptive granting of conditional release to elderly offenders who pose little risk to public safety. The Human Rights Watch report *'Old Behind Bars'* implores correctional officials to pursue a range of strategies, including:

- Undertaking a comprehensive analysis of older prison populations to determine whether, and to what extent, they are being provided with adequate housing, medical care, and programs that respond to their unique needs and vulnerabilities;
- In consultation with older incarcerated men and women, review custody and security rules and their implementation to ascertain which impose unnecessary hardship on older inmates;
- Providing training for corrections officers working with older persons, including training in changing physical and mental conditions, and appropriate means of communication;
- Routinely monitor older prisoners to ensure they are not being victimized, and take the potential for victimization into consideration in their housing decisions; and
- Ensure that a senior official has the specific responsibility for monitoring, assessing, and pressing for improvements in confinement conditions for older prisoners.

And finally, a recent UNODC report, the *'Handbook on Prisoners With Special Needs'*, offers an exhaustive set of recommendations for management of the elderly prisoner within the correctional environment (Atabay, 2009). The report should be required reading for all correctional officials and the recommendations dealing with the elderly offender are reproduced in Appendix B to this paper.

It is undoubtedly the case that limited resources, resistance to changing longstanding policies and procedures, lack of government support, as well as insufficient 'urgency' regarding the need to address the particular vulnerabilities of older prisoners, will all lead to some stalling of efforts in developing a set of geriatric-informed correctional practices.

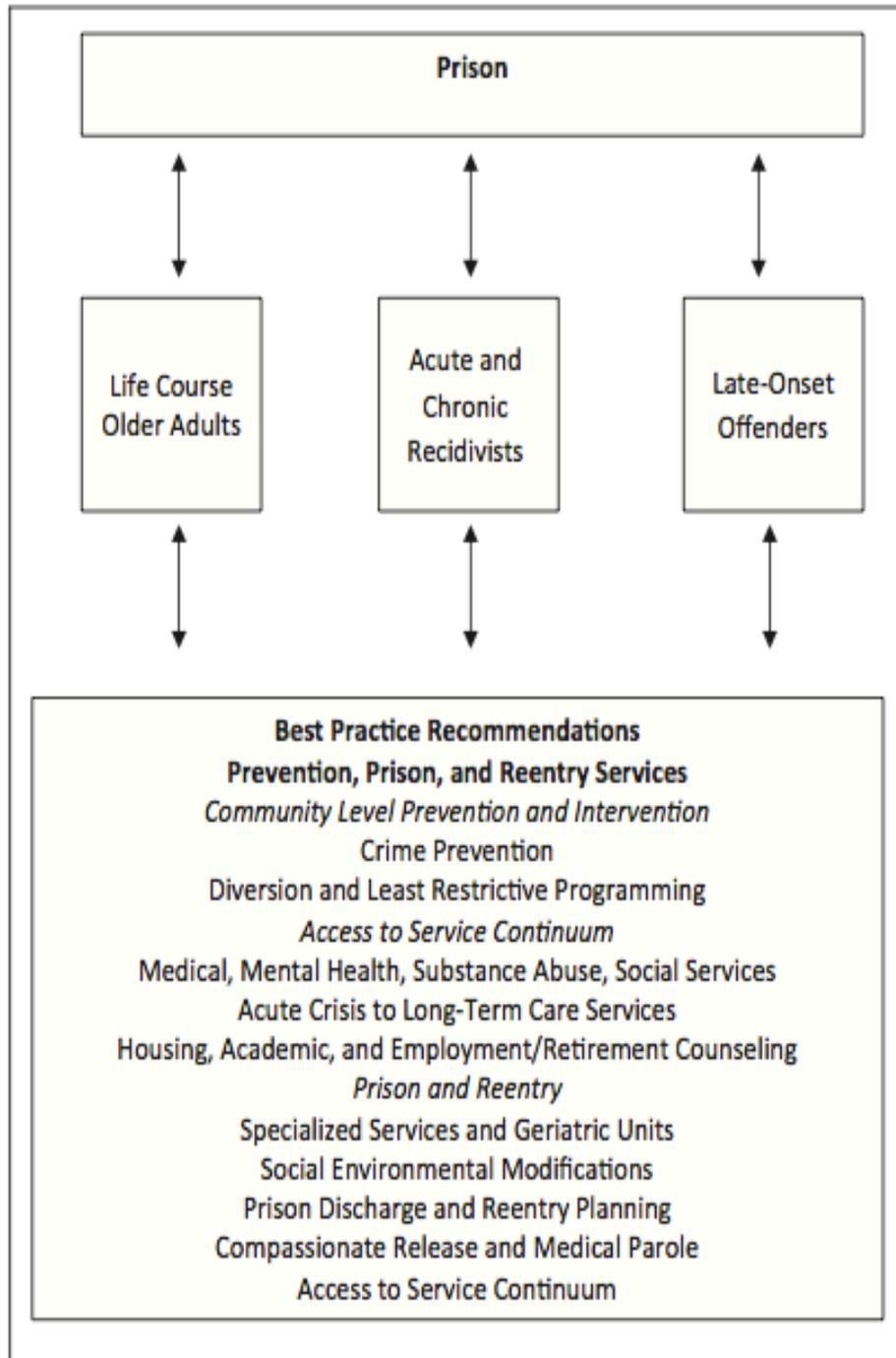
The elderly offender is still treated as distinctly marginal and remains more or less peripheral to policy and advocacy within most correctional jurisdictions. Where innovative practices have emerged, it is typically because of the local efforts of determined correctional professionals, often in partnership with the voluntary sector. Despite their increasing numbers, elderly offenders have not yet attained visibility as a national or international policy issue in

corrections. But the evidence is now available and the issues have now been well formulated and presented by numerous researchers (Aday, 2003; Crawley & Sparks, 2005, 2005a; Lemieux et al. 2002; Maschi et al., 2014), the media (<http://www.prisonterminal.com/index.html>), high profile human rights groups (HRW, 2012; ACLU, 2013), and even government reports (Atabay, 2009; Kennedy, 2008).

Maschi et al. (2013) present a useful model for thinking about the kind of differentiated approach and areas of focus required to deal more effectively with the elderly offender in corrections (see Figure 3 below). As with other complicated issues facing correctional services, however, sporadic or spotty innovation that occurs here and there will not be able to address fully the challenge of managing the elderly in corrections. An overarching and integrated framework is needed, supported by politicians, policymakers, practitioners, researchers, the non-governmental sector and the public at large. Reforms are needed both for reasons of humanity and cost-effectiveness in supporting public safety. They should encompass needed legislative change in sentencing practices, new policy formulation, development of geriatric-sensitive programming and services, prison design, staff training initiatives, and community partnerships to aid in the very real challenge of reintegration of the elderly offender. The evidence on which to base all this is now there. All that is needed is for the sense of 'urgency' to deal with the issue to begin spreading.



Figure 3: A Framework For Best Practice Programming for The Elderly Offender



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APPENDIX A

'TRUE GRIT': DESCRIPTION OF A MODEL CORRECTIONAL PROGRAM FOR THE ELDERLY OFFENDER

Because the problem of the elderly in prison is perhaps most severe in America, a number of US states have recently revamped their policies and approaches for dealing with this population. The state of Missouri, for example, has designed Enhanced Care Units 'to keep offenders as functional as possible while providing appropriate health and housing services to accommodate their special needs'. The units have only single level bunks, organized activities to keep offenders busy and oriented, assistance from other offenders trained as helpers, special assistance with meals, and daily rounds by health services staff. In the state of Texas, there are special geriatric units in different state prisons to provide accommodations for offenders who are age 60 or older. The units allow for longer periods of time to dress, eat, move from place to place, and shower. A specialized medical facility for the elderly is also available that provides physical, occupational, and respiratory therapy, special wheelchair accommodations, temperature-adjusted environments, dialysis, and services for prisoners with hearing and vision impairments (HRW, 2012).

The following description of a model correctional response for dealing with the elderly in prison is borrowed from the work of Tina Maschi and her colleagues (2014), a group of American researchers who have both studied and advocated extensively for a more humane response to the plight of the elderly in corrections.

The *'True Grit'* program in the State of Nevada in America offers an excellent example of a well integrated and focused correctional response to the management of the elderly prisoner's physical and mental health. The program was established to deal with the entire range of issues confronting the elderly in prison; including physical disabilities, chronic health problems, substance abuse, sexually deviant behavior, post-traumatic stress disorder, depression, terminal illness, chronic pain, and end-of-life issues, and/or concerns with community reintegration. It admits select offenders age 55 or older who are exposed to a structured living environment (SLP) where there is "a comprehensive program of structured physical, mental, emotional and spiritual activities with a set routine and within which each member is required to participate, to the best of his abilities, on a regular basis" (Harrison et al., 2012).

The True Grit Program components -- The SLP has a variety of interactive modules or aspects that tie it together. An important facet of the program is that all members are housed together in a separate unit; younger inmates are excluded. When medically necessary, program members may be transferred to at Regional Medical Facility but return to the SLP upon medical discharge. As necessary, dying inmates are afforded end-of-life care in the infirmary, provided by staff, volunteers, and compassionate care visits from other SLP members. Recreational activities are a major segment of the program. Crocheting, knitting, beading, and latch-hook rug-making provide activity that is not only cognitively stimulating, but affords excellent physical therapy for arthritic hands and fingers. Beginning with no resources, the program's musical activities have expanded to include five vocal ensembles and four instrumental groups. Recent donation of guitars and sound amplification equipment by a prisoner-rehabilitation organization (Jail Guitar Doors) allows former professional musicians in the program to enable amateurs to improve their skills. The Do-Wop Band, True Grit Choir, Spanish ensemble, True Grit Pops, and Country/Western groups rehearse regularly, and perform whenever the opportunity presents itself. Because a busy mind may not decline as rapidly as an idle one, True Grit has many cognitive therapy activities, including an ethno-drama theater arts group; a creative writing group; a cultural arts group; and a Spanish language study group. Literary skills are enhanced by production of True Grit Notes, written and edited by members, and an extensive microwave cookbook featuring meals that can be prepared using limited supplies available in prison. Most of the performances by the ethno-drama group deal with problems unique to aging in prison. Unchained Verse is an on-going anthology of poetry created by the members and mentored by a volunteer retired college

professor. This exercise enables men to express thoughts and emotions that they might otherwise never verbalize. A Navy veteran volunteer works with inmate veterans to write memoirs or produce artwork relating to their military experiences.

Substance abuse/addictions groups -- Traditional 12-step groups including Alcoholics Anonymous, Narcotics Anonymous, and Sexual Compulsives Anonymous meet regularly, facilitated by volunteer sponsors.

Wellness and life skills/activities of daily living -- Once each week SLP members gather for seminars on various aspects of health and wellness, life skills such as cooking, menu-planning and healthy life choices, or other relevant activities. Group members present a layperson's view of a medical condition or discuss topics such as human sexuality and the aging process.

Pet therapy/end-of-life care -- Pet therapy plays an extensive role within True Grit. Volunteers from Intermountain Therapy Animals visit the prison on a weekly basis, providing the members with the opportunity to experience unconditional affection. The volunteers from this organization provide animal-assisted therapy in the areas of physical, occupational, speech and psychotherapies, as well as special education. The dogs assist regularly in the pain management group; several have been in the infirmary with dying inmates during their last days.

Physical fitness -- The men assemble regularly in the gymnasium or ball field for group and individual physical activities. Depending on the weather these may include wheelchair softball, basketball, or volleyball; aerobics, tennis, measured-distance walking, weight lifting, stationary bicycle, billiards, Ping-Pong, horseshoes, or dancing. The latter is usually combined with one or more musical sessions. Although no credentialed music or dance therapist conducts these sessions, they achieve the desired goal of enhancing the men's physical and mental fitness.

Peer support groups/Vet-to-Vet -- More than half of True Grit's members are veterans. Volunteers from chapters of the Vietnam Veterans Association, both within and outside the prison, conduct weekly peer support groups with elderly veterans, modeled on the Department of Veterans Affairs Vet-to-Vet program. Volunteers assist members with writing their combat-related memoirs, and a number are producing sketches and paintings related to their military experience.

Spiritual activities -- In addition to institutional religious activities conducted by prison staff and volunteers, there are a number of lay leaders within True Grit. They carry out various spiritual rituals on a regular basis. One particularly moving ceremony is the memorial service conducted after an SLP member dies in prison.

Correctional mental health activities -- Formal correctional programs facilitated by both staff and community volunteers are available to members of True Grit. These programs include victim awareness, stress management, anger management, conflict resolution, relationship skills, health-related recovery, commitment to change, trauma and recovery, addictions prevention education, sex offender treatment of prisoners (STOP), Inside/Outside Dads, and special populations programs. Many of these programs, when completed successfully, provide the members with meritorious credit toward reducing the length of their sentence.

Discharge planning -- Volunteers provide members with information and referrals concerning their eventual release from prison. This includes collaboration with non-profit organizations, halfway houses, resources for potential employment, and other assistance. Organizations such as the Department of Veterans Affairs have also been helpful in preparing SLP members for release and successful return to the community.

Maintaining True Grit in the face of diminishing resources:

In Nevada, the Department of Corrections continues to face a significant budget crisis, resulting in the reduction of non-correctional staff, such as mental health professionals, as well as lack of funding for new projects. Despite this, True Grit has grown and been successful because the costs for the state have been minimal. This is due primarily to extensive use of volunteers and generous donations of supplies and material from community organizations. The

first volunteers were a group of dogs and their handlers, part of the Intermountain Therapy Animal organization. Volunteers now include college professors and other educators, psychologists, nurses, and retired military personnel. Community organizations and private donors also enable diversion activities, cognitive-behavioral interventions, musical activities, the library, the physical fitness program, and the wheelchair repair program to operate successfully. As an example, a community service organization in Reno regularly donates used durable medical equipment, including wheelchairs, to True Grit.

Preliminary evaluation results:

The program is currently being evaluated for its impact. Preliminary analysis of the qualitative data from True Grit participants suggests that they view the program as an invaluable part of their lives, helping them cope with daily prison stress while allowing them to offer restitution for their crimes. Preliminary quantitative analysis suggests that participants who were released have a 0 % recidivism rate.

Caveats and pitfalls:

True Grit is a multi-faceted, multi-disciplinary programmatic approach to meet the bio-psycho-social and spiritual needs of older adult prisoners, with the primary goal of rehabilitation of the individual and assistance with reentry into society. However, despite being broadly recognized and promoted, True Grit has not been without problems. First and foremost, not all security or correctional officers or professional staff support or agree with the program. There has been resistance in some quarters to fully implementing True Grit. Uninformed members of the general public tend to resist what some have labeled “coddling” of prisoners. Unless a cadre of volunteers and an outside support system of donors are organized, funding for older adult prisoner programs may be difficult to implement. With support from administration and continued educational efforts, both inside and outside prison, however, most resistance for True Grit has been diminished

APPENDIX B

UNODC RECOMMENDATIONS: HANDBOOK ON PRISONERS WITH SPECIAL NEEDS

1. To Sentencing Authorities

- To pursue a criminal justice policy under which long-term sentences are imposed only if they are necessary for the protection of society.
- To take into account the age of offenders, their mental and physical health, prospects of receiving adequate care in prison, when passing judgment, to ensure that sentences do not comprise disproportionately harsh punishments.
- To consider older prisoners who have committed non-violent offences for non-custodial sanctions and measures as a matter of principle, as their care can much better be provided for in the community.

2. To Prison Authorities, Probation and/or other Social Welfare Services

Management policies and strategies

- To develop special policies and strategies to address the needs of this vulnerable group of prisoners.
- To involve the input of a multidisciplinary team of prison specialists, working in coordination with specialists and service providers from the community, particularly in the area of medical care.
- To include issues such as staff training, placement of older prisoners within the prison system, improvement of services, coordination with civil society, early conditional release, release on compassionate grounds and resettlement in the policies and strategies to be developed.

Staff

- To ensure that all staff that has any involvement in the supervision and care of older prisoners receive training to enable them to work constructively and effectively with this group of prisoners.
- To encourage prison service staff to work with organizations of civil society, as well as health and welfare services, in order to cover all the needs of older prisoners, while laying the basis for their continuum of care in the community following release.

Access to justice

- To assist older prisoners in accessing legal counsel, legal and paralegal aid services from the outset of their detention and to provide additional support to older prisoners with mental or physical disabilities, as required, to ensure that they are not discriminated against in their access to justice and treatment in the criminal justice system.

Assessment and allocation

- To ensure that a proper assessment is undertaken to determine the very varied needs of older prisoners on admission, taking into account the low risk status of most older offenders;
- Due to the rapidly changing status of older prisoners, particularly in terms of health, to undertake reviews on a regular basis to modify programmes, as well as to reconsider security classification levels.

Accommodation

- To place the majority of older prisoners in the general prison population, taking into account their special accommodation requirements and their need for tranquillity and association with peers.
- To accommodate a small number in special units, only if absolutely necessary to provide specialist care on an ongoing basis, and if it is in the interest of the prisoners' mental well-being and health care. Preference should be given to releasing such prisoners on compassionate grounds to be treated in the community, wherever possible (see below).

Health care

- To ensure that the medical, nutritional and psychological health care needs of older prisoners are met, with the engagement of a multidisciplinary team of specialist staff.
- To establish close cooperation with community health services to ensure that specialist care is provided by outside medical services, as necessary, and that prisoners whose needs cannot be met in prison are transferred to civilian hospitals.
- To provide special programmes addressing mental disabilities, such as depression and fear of dying, as well as individual counselling, as necessary.

Contact with the outside world

- To place older prisoners as close as possible to home in order to help them maintain contacts with family members. In addition, where resources allow, to organize family visits for those who are too old to travel.
- To grant regular prison leave as an integral element of prison regime, enabling older prisoners to spend time with their families and thereby to maintain contact and reduce the sense of isolation.
- To encourage organizations of civil society which work with older persons to include prison visits and projects in prisons within their programmes.

Prisoner programmes

- Where older prisoners are integrated with the general prison population, to make modification to existing programmes to enable all groups of prisoners, including older prisoners, to participate, as well as to introduce special programmes that address the needs of older prisoners.
- Special vocational training programmes may include skills training in a selection of arts and crafts, while areas can be set aside in prisons for older prisoners to read, play cards and board games or just to associate with each other.
- Other special programmes could include instruction on health care for older prisoners, counselling related to growing old, fear of death, isolation and substance abuse, tailored physical activity and special education courses that meets the needs of this age group. Specialized counselling may also include those designed for prisoners with terminal illness and those who have received life sentences without parole.
- To be guided by older prisoners' own wishes and abilities in determining the level of outdoor exercise they participate in, and to provide some support and flexibility, as necessary, in arrangements in order to enable older prisoners to take exercise or participate in outdoor recreational activities.
- Other prisoners' assistance in helping care for older prisoners may be sought, after careful screening, assessment and training.

- To take steps to engage community services and NGOs working with older persons in the community in designing and delivering programmes and activities for older prisoners.

Preparation for release and post-release support

- To develop individualised preparation for release programmes taking into account the special needs of prisoners who have grown old in prison and those who have no family support, in order to help re-establish links with the community, including with health and welfare agencies.
- To work in close coordination with probation services where they exist and with other agencies of civil society and NGOs, to ensure that maximum possible support is provided to older prisoners during the difficult period of re-entry into society.

Early conditional release, compassionate release and amnesties

- To consider developing a different set of parole eligibility criteria relevant to the needs of long-term and older prisoners, to minimize the disadvantages they face in the consideration for early conditional release.
- To release on compassionate grounds older prisoners who are in need of constant specialist nursing care, and who do not pose a risk to society, transferring them to an appropriate institution in the community.
- To encourage and facilitate contacts between older prisoners and legal aid services at the appropriate stage, in order to assist such prisoners in gaining early conditional and compassionate release.
- To ensure that older prisoners, and particularly older women, are one of the groups of prisoners prioritised for release under amnesty laws, following a careful risk assessment.