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CORRECTIONAL Health Care

Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates

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Correctional Health Care

Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates

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Foreword

As the median age of inmates in our jails and prisons steadily increases and the incidence of chronic illness and disabilities grows ever larger, the issue of how best to manage services and care for older inmates and those with chronic and terminal illnesses becomes more prominent.

The National Institute of Corrections (NIC) recognizes that correctional practitioners and correctional health care providers are seeking comprehensive and useful knowledge about current, innovative, effective, and economical practices that address the special needs of these populations.

NIC commissioned this publication to guide prison administrators in managing aging and infirm inmates. This report reviews the most recent relevant literature, provides examples of promising approaches from six states, and clarifies how the nation's correctional agencies are meeting the operational, programmatic, and health care challenges associated with meeting these inmates' needs.

This report is exploratory in nature. It is not intended to provide absolute answers or a single comprehensive model that all corrections agencies might follow. Rather, it respects the different laws and traditions that govern state and territorial corrections and attempts to provide examples and guidance from corrections systems that have addressed these issues successfully. It is up to individual correctional administrators and medical practitioners to consider these examples and to determine what best works for them.

As this is a work in progress, we at NIC would appreciate and welcome the input of corrections practitioners who are facing similar challenges. We will endeavor to incorporate your ideas and suggestions in future work in this area.

Morris L. Thigpen
Director
National Institute of Corrections

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Many individuals contributed to this project. We give special recognition and thanks to our expert consultants, Dr. B. Jaye Anno, Dr. Ronald Shansky, James E. Lawrence, and Camelia Graham, for their guidance, expertise, involvement, and dedication to our efforts. They are substantially responsible for conducting the research and producing the text that follows.

Special thanks to the following six Departments of Corrections that allowed us to visit their prisons: Michigan Department of Corrections, Minnesota Department of Corrections, New York State Department of Correctional Services, Ohio Department of Rehabilitation and Correction, Oregon Department of Corrections, and Pennsylvania Department of Corrections. Thanks also to the individuals who facilitated the six site visits, including Twyla Snow (Michigan Department of Corrections), Nanette Schroeder (Minnesota Department of Corrections), Joan Smith (New York State Department of Correctional Services), Kay Northrup (Ohio Department of Rehabilitation and Correction), Dr. Steve Shelton (Oregon Department of Corrections), and Superintendent Frederick Rosemeyer (Pennsylvania Department of Corrections).

We would also like to acknowledge Judy Bisbee and John Blackmore of the Criminal Justice Institute for their diligent efforts in supporting the work of the project team.

George and Camille Camp, Co-Principals
Criminal Justice Institute
February 2004

Executive Summary

During the past decade, the number of elderly and infirm inmates in state prison systems has increased dramatically. The aging of U.S. prison populations is due, in part, to the effect of baby boom demographics on the general population and to crime and sentencing trends of the 1980s and 1990s. As the inmate population has increased, correctional administrators have encountered new challenges in managing the requirements of older inmates and those with special physical and medical needs.

The most significant challenges facing corrections systems include the following:

- **Management and Housing of Inmates With Special Needs.** As the number of elderly and seriously ill inmates increases, administrators must weigh the advantages and disadvantages of various means of managing them, such as the use of mainstream housing versus construction or remodeling of special housing units or facilities. Cost implications, programming concerns, and classification and screening methodologies are critical factors that must be assessed.
- **Special Accommodations, Facilities, and Programs for Inmates With Special Needs.** The challenge of providing activities and services that meet these inmates' special needs requires a new dimension of thinking. As the inmate population ages, administrators need to consider special architecture, such as grab bars in cells, showers, and toilets; elevated toilet seats, stools, or benches in showers; and improved access to toilet facilities. Institutional medical and dietary professionals also must rethink their services to ensure that the special needs of these inmates are addressed.
- **Cost Containment in Providing for Inmates With Special Needs.** The most serious challenge facing correctional administrators with regard to the elderly and infirm inmate population is containment of health care costs.
- **Epidemiological Considerations.** The stress imposed by incarceration can exacerbate the health problems of elderly and infirm inmates. Institutionalization increases the likelihood that contagious disease will spread and may increase chronic disease symptoms.
- **Preparing Correctional Staff To Respond to the Requirements of Special Needs Inmates.** Medical and correctional staff should be trained to identify issues posed by the presence of elderly and chronically ill inmates.
- **Functional Assessment of Special Needs Inmates.** The key to addressing the above challenges is selecting and using the most appropriate and effective functional assessment instruments. Prison classification and screening instruments generally have not sufficiently accounted for the special needs and issues of older and disabled inmates. Identification of screening and classification instruments that address these concerns can help administrators manage these populations and determine whether additional programming, housing, and medical services are needed. Functional assessment will assist correctional managers and health care planners in understanding and anticipating the overall array of procedures, services, programs, and accommodations that will be required.

A functional assessment is a screening tool that is used to identify behaviors or physical, mental, or emotional disabilities that may cause a patient (or inmate) difficulty in day-to-day activities or mental health issues in getting along with others. Functional assessments help caregivers identify circumstances regularly associated with a physical or emotional difficulty. In addition, they provide information that lays the groundwork for decisions concerning medical treatment or the most appropriate institutional living environment.

It is important to note that three prison populations—the elderly, chronically ill, and terminally ill—overlap considerably. They might be considered subcategories of a single special needs population of inmates who, as a result of their illness or disability, require enhanced services. For this report, the population is divided into three categories: aging and elderly, chronically ill, and terminally ill. The functional assessment, encompassing all three categories with respect to policymaking and programming issues, has become increasingly important as a tool to ensure effective, efficient, and humane programming for inmates as they enter the system.

In the pages that follow, consideration has been given to the functional assessment; specific program, housing, and treatment considerations; and correctional policy considerations for these populations. The authors believe these areas require the most attention and change if special needs inmates are to receive appropriate care that meets humane and constitutional standards.

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Introduction

Chapter 1

Chapter 1

Introduction

Introduction

In October 2000, the Criminal Justice Institute (CJI) and the National Institute of Corrections (NIC) established a cooperative agreement to advance knowledge about promising approaches for the effective management and treatment of elderly inmates and those with chronic and terminal illnesses.

To conduct this project, CJI assembled a multidisciplinary team of medical and correctional experts and practitioners, including Dr. B. Jaye Anno, health care researcher, Consultants in Correctional Care; Dr. Ronald Shansky, correctional medical care consultant and former medical director of the Illinois Department of Corrections; James E. Lawrence, director of operations for the New York State Commission of Correction; and Camelia Graham, M.S.P.H., epidemiologist, AIDS Administration, Maryland Department of Health and Mental Hygiene.

Project Goals

The four major project goals were to identify the following:

- Current practices, policies, and procedures that relate to the management and treatment of elderly inmates, inmates with chronic diseases, and/or inmates with terminal illnesses.
- The impact of current policies, procedures, and practices on elderly inmates, inmates with chronic illnesses, and/or inmates with terminal illnesses.
- Effective practices and interventions in the care and management of elderly inmates, inmates with chronic illnesses, and/or inmates with terminal illnesses
- Ways to assist jurisdictions in improving treatment and associated protocols.

Approach/ Methodology

To scan the field for current policies and practices relating to the needs of elderly inmates and those with chronic and terminal illnesses, the project team relied on various surveys and assessments. Of special relevance was CJI's 2001 survey of existing practices in departments of corrections in the United States and its territories. The project team used these survey results to identify six departments of corrections that offered a range and breadth of care and programs worthy of further examination.

To explore current practices in managing special needs inmates, Dr. Anno, Dr. Shansky, and Mr. Lawrence visited six state departments of corrections that had instituted programs of comprehensive care in Michigan, Minnesota, New York, Ohio, Oregon, and Pennsylvania.

Before the visits, the team developed a program component checklist and needs assessment instrument (see appendix C) to document key program elements in a consistent manner and to determine how each jurisdiction addressed formative and operational issues in implementing its program strategies.

The team members used this information to inform and validate their findings and suggestions and to enrich the content of this report with examples of practical applications.

OUTCOME

The project culminated in the production of this monograph, which addresses issues concerning the effective management and treatment of elderly inmates and those with chronic and terminal illnesses. The focus of the monograph is as follows:

- Identification of management and treatment protocols that reflect effective and humane practices and care for these populations.
- Exposition of effective management and care practices that take into account screening techniques, treatment and intervention, classification and case management, transition planning, discharge planning approaches, specially designed correctional programs and services, training of correctional staff and clinicians, and provision of services to culturally diverse populations and inmates of different gender.
- Explanation, with examples, of how comprehensive correctional programs and services are organized and delivered for elderly and seriously ill inmates.
- Identification of various treatment modalities and evidence of their effectiveness in addressing the special care needs of these populations.
- Identification of innovative practices that expand our knowledge about effective care, management, and treatment approaches for these populations.

SUMMARY

This report is designed to serve as a resource guide for correctional agencies researching management and treatment for elderly, chronically ill, and terminally ill inmate populations. It does not present a comprehensive model that can be adopted by all agencies, nor does it impart prescriptive, definitive advice. Rather, it is meant to provide guidance and information about promising approaches to help correctional managers and planners address these inmates' special needs.

What We Know About Elderly, Chronically Ill, and Terminally Ill Inmates

Chapter II

Chapter 11

What We Know About Elderly, Chronically Ill, and Terminally Ill Inmates

Introduction

When considering dangerous, violent, and predatory inmates, one does not usually envision an elderly man hobbling down a prison corridor with a cane or walker. However, in reality, some of the most dangerous and persistent criminals who were sentenced to life in prison without parole 30 years ago are now old, debilitated, frail, chronically ill, depressed, and no longer considered a threat to society or the institution.

During the past decade, the number of elderly and infirm inmates in state prison systems has increased dramatically. From 1992 to January 1, 2001, the number of state and federal inmates age 50 and older increased from 41,586 to 113,358, a staggering increase of 172.6 percent (Camp and Camp, 1992–2001) (see exhibit 1).

In 1992, inmates age 50 and older represented 5.7 percent of the prison population. By 2001, they represented 7.9 percent (Camp and Camp, 1992–2001) (see exhibit 2).

The aging of American prison populations is due, in part, to the same baby-boom demographics that cause concern about the future of Social Security and long-term elder care outside prison. In the criminal justice system, however, the demographic changes affecting the general population have been compounded by crime and sentencing trends. A middle-age bulge in most large state prison populations reflects the advent of "three strikes" felony sentencing, which calls for third-time felony offenders to serve mandatory sentences of 25 years to life, and the punitive sentencing measures associated with the war on drugs of the 1980s and 1990s. Furthermore, 14 states and the Federal Bureau of Prisons have eliminated parole, which for many years served as a vehicle of early release for well-behaved inmates and as a population pressure release valve in times of overcrowding. State laws requiring truth in sentencing, enacted as a result of the Violent Crime Control and Law Enforcement Act of 1994, offered prison construction grants and other incentives to

EXHIBIT 1.
State and Federal Inmates Age 50 and Older (1992–2001)

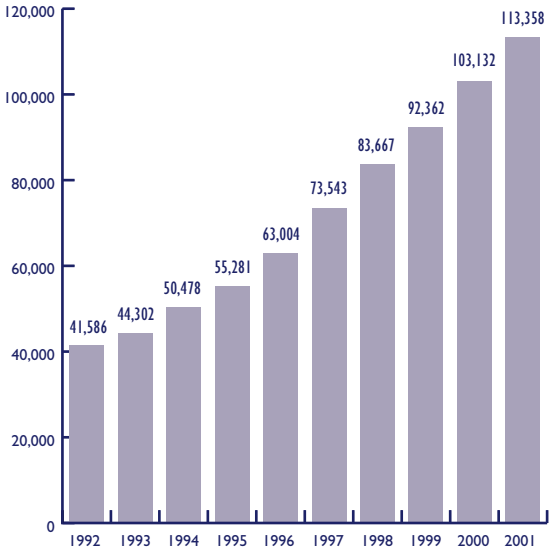
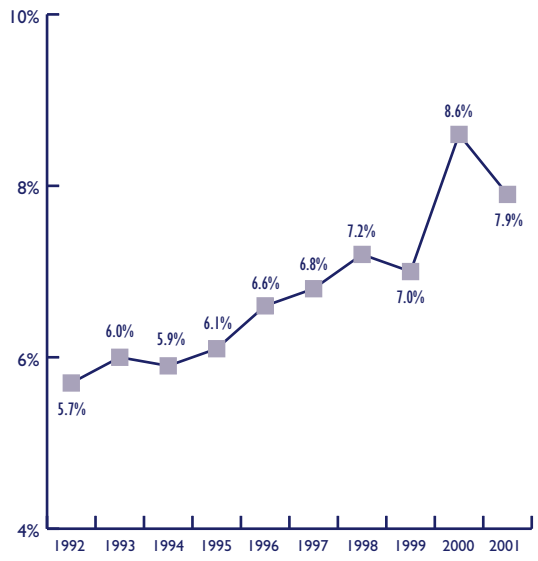


EXHIBIT 2.
Percentages of Inmates Age 50 and Older (1992–2001)



states that required violent criminals to serve at least 85 percent of their sentences.

WHAT WE KNOW NOW

The specialized medical needs of older inmates, including those with chronic illnesses and terminal diseases, have been well documented.

In a National Institute of Corrections (NIC) report on special needs inmates, LIS, Inc., surveyed state correctional agencies and found that more than half of the state departments of corrections (DOCs) had located the delivery of medical services at one site. Similarly, in 23 DOCs, inmates with terminal illnesses were being cared for at a single location. Fifteen DOCs were placing elderly inmates in a single facility. Other findings included an increased use of telemedicine, fees for services paid by inmates, and the use of managed care and private providers (National Institute of Corrections Information Center, 1997).

Elderly Inmates

As the population of Americans age 65 and older continues to increase, families, health care providers, social services agencies, government managers, and policymakers, including those who plan for and manage correctional institutions, face new challenges with respect to managing the needs of the elderly and those with special physical and medical requirements.

A recently published federal report estimated that, in the year 2000, "35 million people age 65 or older [were] in the United States, accounting for almost 13 percent of the total population. By 2030, it is projected that one in five people will be age 65 or older [and that] the size of the older population is projected to double over the next 30 years, growing to 70 million." (Federal Interagency Forum on Aging-Related Statistics, 2000).

Just as the number of elderly individuals is growing in the United States, the number of geriatric inmates is steadily increasing. This is the result of overall demographic trends and increased frequency of incarceration of older offenders due to sentencing laws enacted in the past 25 years, especially statutes requiring long-term determinate sentencing for predicate felons and other classes of specially targeted offenders, such as substance abusers (Glaser et al., 1990).

At this time, no consistent definition of what "elderly" means in correctional systems exists in the United States. Some administrators recommend that age 50 be the chronological age defining the elderly in prison. While 50 may seem young to be classified as elderly in the free world, several important factors seem to speed the aging process for those in prison. These factors include the amount of stress experienced by new inmates trying to survive the prison experience unharmed; efforts to avoid confrontations with correctional staff and fellow inmates; financial stress related to inmates' legal, family, and personal circumstances; withdrawal from chronic substance abuse; and lack of access to

adequate medical care prior to incarceration. All contribute to inmate stress, which, in turn, accelerates the aging process.

As part of a 2001 survey, the Criminal Justice Institute (CJI) asked representatives of state correctional agencies whether they had a specific definition for when inmates in prison are considered to be elderly. Of the 49 respondents, 22 said that they did have a definition of the elderly in prison; the average first qualifying age was 55 years. Eight defined elderly as 55 years of age and older, seven defined elderly as 50 years and older, four defined elderly as 60 years and older, one defined elderly as 62 years and older, and two defined elderly as 65 years and older. Some states did not have a chronological age cutoff but, instead, defined elderly based on degree of disability. Another based its definition on chronological age with the explicit provision that the inmate must have a debilitating disease or disability to be considered elderly (Criminal Justice Institute, 2001).

In 1999, the Ohio Department of Rehabilitation and Correction predicted that inmates age 50 and older would represent close to 25 percent of its general population by the year 2025 (Ohio Department of Rehabilitation and Correction, 1999). According to the CJI survey, as of December 31, 2000, an average of 1,835 inmates per jurisdiction were age 50 and older (Criminal Justice Institute, 2001).

Of the 49 systems assessed by CJI, only 15 had special housing areas designated for elderly inmates; of those, 7 special housing areas were available only for elderly inmates with special medical needs or for those who were otherwise eligible for hospice care. Only one agency reported that it had special housing for elderly inmates solely upon their request (see appendix A). The lack of personal protection for elderly inmates, who may be frail and therefore vulnerable to the threats of assault by younger predatory inmates, contributes to the emotional stress and physical deterioration they routinely experience, especially among those who may be already vulnerable owing to chronic or terminal illness and who have few options for change in their environment.

A review of the literature confirms the increasing numbers of elderly inmates, the link between aging inmates and those with chronic illnesses and behavioral problems, and the role of gender with regard to illness within the aging inmate population. For example, Lindquist and Lindquist found: "Jail and prison inmates experience disproportionately high levels of chronic and acute physical health problems . . . [and] . . . gender and age are the most consistent demographic predictors of health status and medical utilization, with females and older inmates reporting higher morbidity and concomitantly higher numbers of medical encounters" (Lindquist and Lindquist, 1999). With regard to higher morbidity rates among inmates, the number of inmates dying from natural causes increased from 946 in 1990 to 2,105 in 1999, an increase of 123 percent. As prisoners' length of stay increases, these problems are likely to intensify in that "self-reported health problems increase with inmates' duration of incarceration" (Lindquist and Lindquist, 1999). "The results suggest a need for medical care in correctional settings to adapt to the medical needs of older inmates and women," Lindquist and Lindquist conclude, "in addition to improving treatment for chronic conditions and preventive services" (Lindquist and Lindquist, 1999).

In a 1997 article, Smyer, Gragert, and LaMere reported: "Aging inmates form a distinct cultural subgroup." They also concluded that aging within the prison setting differs from aging outside the prison environment and that programs and services must take those differences ("loss of family, employment, and sexual identity") into account (Smyer, Gragert, and LaMere, 1997).

Management issues associated with elderly inmates

Management problems associated with elderly inmates, although not unique to prisons, are intensified in the prison setting and include the following:

- Vulnerability to abuse and predation.
- Difficulty in establishing social relationships with younger inmates.

- Need for special physical accommodations in a relatively inflexible physical environment.
- Need for special programs in a setting where special privileges are disdained as counterproductive to discipline and orderliness.

Furthermore, in an environment of scarcity, elderly inmates consume a disproportionate amount of health services. Their greater need for peace, quiet, and privacy—highly desirable commodities for all inmates—puts them in conflict with the general population. The elderly require help in coping with the fast pace, noise, and confusion of modern life, whether or not they are residents in a crowded correctional facility. The elderly frequently feel unsafe and vulnerable around younger people. Fear-based abrasive relations between young and old are becoming increasingly prevalent in prisons and in society in general (Aday, 1994a).

The few reliable longitudinal studies of elderly inmates that have measured group-specific and overall health and functional status reveal accelerated signs of aging and deterioration of health among state inmates age 50 and older. Most prevalent were increased rates of incontinence, sensory impairment, impaired flexibility, respiratory illnesses, cardiovascular disease, and cancer. These conditions are exacerbated by lifelong histories of substance abuse, including alcoholism and smoking, which are common to inmates. The most common chronic illnesses reported are arthritis, hypertension, ulcer disease, prostate problems, and myocardial infarction. These patterns are not substantially different from those of the overall population but are concentrated in distressed and needy subpopulations (Colsher et al., 1992). These and other prevalent problems of inmates older than age 55, most associated with lifelong medical and social histories of high-risk sexual practices and other unhealthy behaviors, accelerate their aging processes to an average of 11.5 years older than their chronological ages after age 50 (Aday, 1994a). Ordinary cognitive impairments of age aside, decreased sensory acuity, muscle mass loss, intolerance of adverse environmental conditions, dietary intolerance, and general vulnerability precipitate collateral emotional and mental health problems. Elderly inmates experience a reduction in human interaction and tend to withdraw owing to a lack of privacy and a loss of self-esteem. They are frightened, anxious, and dependent, particularly on prison staff. Some report the fear of dying in prison. Many others report fearing release from prison more than dying in one. This creates excessive stress for elderly inmates living in large state prison populations, often producing illness and debilitation as manifestations of decompensation (Morton and Jacobs, 1992, pp. 6–7).

A typology of elderly inmates first established by Delores Craig-Moreland and William McLaurine (Neeley, Addison, and Craig-Moreland, 1997; Morton and Jacobs, 1992) and substantiated by a variety of experts includes three distinct groups:

- **First-time offenders.** Inmates who have committed their crime after the age of 50. Their crimes are likely to be serious, considering they have been imprisoned for a first-time offense at an advanced age. They are likely to have problems adjusting to prison since they are new to the environment, which will cause underlying stress and probable stress-related health problems. Furthermore, they are "easy prey" for more experienced predatory inmates.
- **Recidivists**. Habitual offenders who have been in and out of prison for most of their lives. They often have substance abuse issues that can lead to chronic diseases, such as asthma, heart problems, circulatory problems, and kidney or liver problems.
- **Long-term servers.** Inmates who have earned long sentences and have "aged in place." Inmates who have aged in place are generally the best adapted to prison life because they have been in prison since their youth and have adjusted to it. It is difficult to say what health problems this group may be likely to develop, since their environment remains largely the same.

Nationally, about 50 percent of elderly inmates are first-time offenders incarcerated after age 55. Prison recidivists have long criminal histories and a sequential record of imprisonment. They are well adjusted to incarceration. Long-term inmates have extended, uninterrupted histories in prisons and are heavily institutionalized. Moreover, they have few community ties, limited coping strategies, and, consequently, feelings of diminished self-worth.

Newly incarcerated offenders have emerged recently as a subcategory in the first-time offender classification. Their criminal conduct is often a function of changes associated with aging. Loss of ordinary social inhibitions, inflexibility, and paranoia often translate into aggression; consequently, this is a violence-prone group. Their criminal behaviors are often situational and spontaneous, so they rarely see themselves as criminals. Their most common offenses are aggravated assault and murder. First-time incarcerated older inmates are frequently severely maladjusted and especially at risk for suicide, explosiveness, and other manifestations of mental disorder. Since their behaviors are not well tolerated by other inmates, their victimization potential is high. Consequently, they often appear to be withdrawn (Aday, 1994b).

Recidivists generally adjust better to prison because multiple prison reentries over time interspersed with community placements have given them more realistic expectations and greater coping skills. Their behavior problems tend to be chronic and are often related to histories of substance abuse. They are violent or mentally disturbed less often than older first-time offenders. Given demographic trends, recidivists are destined to constitute a larger portion of the elderly inmate population (Morton and Jacobs, 1992).

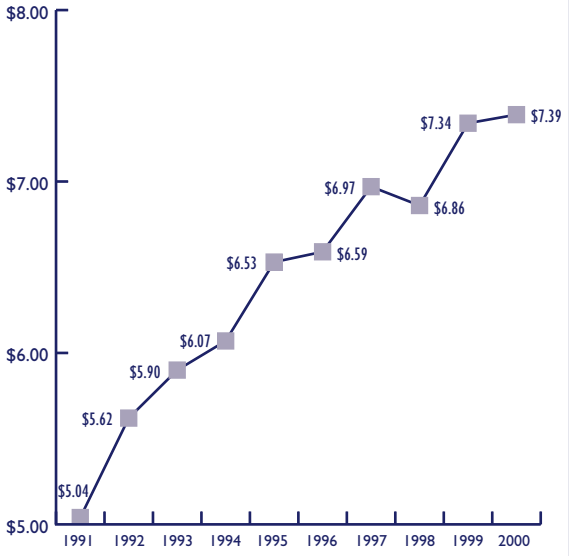
Cost implications of providing services to elderly inmates

The growing number of elderly inmates with chronic and terminal illnesses affects correctional administrators in several ways. The annual cost of incarcerating this population has risen dramatically to an average of $60,000 to $70,000 for each elderly inmate compared with about $27,000 for others in the general population (Beiser, 1991). From 1997 to 2001, health care spending in U.S. prison systems increased 27.1 percent, from $2,747,843,808 to $3,493,047,306. From 1992 to 2000, the average daily cost per inmate for health care rose from $5.62 to $7.39, an increase of 31.5 percent (Camp and Camp, 1992–2001) (see exhibit 3).

Chronically Ill Inmates

The Bureau of Justice Statistics (BJS) report *Medical Problems of Inmates, 1997* (Maruschak and Beck, 2001) indicates that 326,256 state (31.0 percent) and 20,734 federal (23.4 percent) inmates reported having a physical or mental problem that required attention from their correctional facility. Approximately 12 percent of state inmates and 11 percent of federal inmates reported an overall physically impairing condition, and just more than 48 percent of state inmates (21.0 percent male and 27.2

EXHIBIT 3.
Average Health Care Cost per Inmate (1991–2000)



percent female) reported having medical problems brought about by causes other than injury. The greatest percentage (30.4 percent) of state inmates reporting medical problems were those who had been in prison for 72 months or more.

In 2000, 18.4 percent of Federal Bureau of Prisons inmates were reported to have been under care for serious chronic illness: "[A]t midyear 2000, the Federal system had 5,639 (4.4%) inmates with asthma, 4,616 (3.6%) in a diabetic clinic, 3,358 (2.6%) in a cardiac clinic, and 10,011 (7.8%) in a hypertension clinic" (Maruschak and Beck, 2001). Approximately 17 percent of inmates housed in state facilities self-reported specific conditions, including HIV/AIDS (1.7 percent), heart disease (1.1 percent), circulatory problems other than heart disease (2.4 percent), respiratory problems (1.4 percent), cancer (0.2 percent), neurological problems (0.7 percent), skeletal problems (2.6 percent), kidney/liver problems (0.9 percent), and diabetes (0.9 percent) (Maruschak and Beck, 2001).

The authors of the BJS report *HIV in Prisons and Jails, 2000* (Maruschak, 2002) indicate that 2.2 percent of state inmates and 0.8 percent of federal inmates were known to be infected with HIV, the virus known to cause AIDS. Although the number of AIDS-related deaths in state prisons has decreased significantly, from 1,010 deaths in 1995 to 174 in 2000, the overall incidence of AIDS in state prisons has remained much higher than that in the free world—nearly four times the rate in U.S. communities. About 52 in every 10,000 inmates had confirmed AIDS compared with 13 in 10,000 persons in the U.S. general population.

BJS reported that, when questioned about medical assessments they had received since admission to prison, 96.2 percent of respondents said they had been tested for tuberculosis exposure, 86.7 percent said they had had a blood test, and 85 percent said they had had a medical examination for any reason since their admission (Maruschak and Beck, 2001). Only 59.7 percent were checked to see whether they had a medical issue at the time of their admission, and only 82.3 percent of inmates responded that they had been asked questions about their health or medical history at the time of their admission (Maruschak and Beck, 2001).

In the 2001 CJI survey, when correctional agencies were queried about how chronic medical problems are discovered in agencies, 48 of 49 agencies (98.0 percent) responded that chronic illnesses are detected through the reception health screening, reception health appraisal, or sick call and 46 of the 49 responding agencies (93.9 percent) said that chronic illnesses are discovered during annual health appraisals. All 49 agencies (100 percent) reported that chronic illnesses are discovered by self-referral.

Terminally Ill Inmates

Most systems define inmates as terminally ill if they are known to have a fatal disease and have fewer than 6 months to live.

According to the Guiding Responsive Action in Corrections at End-of-Life (GRACE) Project of the Volunteers of America, largely because of the decrease in AIDS deaths nationally since 1995 with the introduction of protease inhibitors, the number of deaths in U.S. prisons has declined since 1995 (GRACE Project, 2001). According to the most recent statistics from the National Center for HIV, STD, and TB Prevention at the Centers for Disease Control and Prevention, deaths due to AIDS in the United States have declined from 51,117 in 1995 to 15,245 in 2000 (Centers for Disease Control and Prevention, 2001).

Deaths due to other causes in prison, however, have approximately doubled (GRACE Project, 2001). Data are limited on the causes of death in U.S. prisons. One agency stated that causes of death other than AIDS included overdose, execution, suicide, homicide, cancer, heart attack, liver disease, congestive heart failure, and other (GRACE Project, 2001). The research literature provides no clear indication as to which of the "other" causes are most responsible

for the increased death rate or why the rate has increased so precipitously.

Generally, the current approaches to dealing with terminally ill inmates are release and provision of prison-based services (GRACE Project, 2001). "Release" usually occurs in the form of compassionate release, when a dying inmate is released before completing his or her sentence to be allowed to die outside prison walls. "Services" typically refers to palliative care or "end-of-life services" provided within the institution, which are designed to make the last days or months of terminally ill inmates' lives somewhat more comfortable. The most widespread service response has been the initiation of prison-based hospice programs that provide palliative care services "including pain management, spiritual support, and psychological counseling" (National Institute of Corrections Information Center, 1998).

According to the 2001 CJI survey, compassionate release provisions were available in 43 (87.8 percent) of the 49 responding agencies. The average annual number of requests for compassionate release was 18, and the average number granted was 8. The highest number of requests was 115 in Texas, which also granted the highest number (49). Compassionate release procedures vary from state to state, and there is no common definition of the criteria for the compassionate release of dying inmates.

When asked whether hospice care was available for terminally ill inmates, 25 (51.0 percent) of the 49 responding agencies said it was. Five agencies (20 percent) offer hospice services in a separate unit; 22 (88 percent) operate the hospice as part of their infirmary; 4 (16 percent) operate the hospice as part of a housing unit; and 8 (32 percent) operate a hospice as a part of an outpatient program. Only 11 agencies (44 percent) assign staff who have no other responsibilities than to their hospice unit.

There appears to be rapid recent growth in the number of hospice programs for terminally ill inmates. A 1998 NIC survey reported that 11 states and the Federal Bureau of Prisons had hospice services. In 2001, the GRACE Project found 19 states with formal end-of-life programs for terminally ill inmates. The CJI survey found 25 agencies that operated hospice programs.

In the chapters that follow, we examine how prison systems have responded to the need for early assessment of special needs. We also discuss program, housing, and treatment considerations for elderly, chronically ill, and terminally ill inmates. Finally, we discuss policy implications in managing special needs inmates.

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Effective Evaluation for Identifying the Special Needs of Inmates

Chapter III

Chapter III

Effective Evaluation for Identifying the Special Needs of Inmates

Introduction

Correctional managers are now being asked to meet the needs of a growing population of elderly inmates and inmates who exhibit a variety of complex medical and mental health problems. They must properly identify these inmates' needs at the time they enter the prison system. This will result in more effective and efficient care for special needs inmates and also will reduce court challenges and liability risks for the prison system.

This chapter describes what prison systems across the country have done to ensure early identification of these needs. It characterizes the variety of needs that require special attention, describes the impact of these special needs on the institutions, and explains how the corrections systems have effectively responded to special needs inmates. The chapter concludes with a discussion of the measures prison systems have adopted to ensure that accommodations ordered by a physician to meet a patient's needs continue to be provided when an inmate transfers between institutions.

Entry Into the System

In most prison systems, a member of the medical staff, ordinarily a nurse, performs an intake history or screening exam shortly after the inmate arrives at a reception center. This health care screening attempts to identify whether the inmate suffers any physical disability, has current illnesses, is currently taking medications, or has allergies. The staff member then asks a series of questions regarding symptoms or diseases that is designed to provide the basis for developing an appropriate treatment plan. Typically, female inmates are also asked a separate set of questions that attempts to identify such gender-specific problems as pregnancy, gynecological problems, or breast problems. Additional questions may relate to contagious diseases, hospitalization, substance use or abuse, and mental health problems.

This initial screening is designed to identify individuals whose medical needs must be addressed immediately, usually on the same day as the screening. Thus, an inmate arriving in a wheelchair would be referred to a physician who would conduct an immediate assessment to develop a plan for responding to the inmate's needs. In most systems, individuals who do not appear to have a problem requiring urgent attention are referred for a complete medical history and physical examination, usually within the first 7 to 14 days of incarceration.

In addition to taking the history and conducting a physical exam, prison medical staff evaluate newly arrived inmates for tuberculosis (TB). A nurse performs a TB skin test that is read between 48 and 72 hours later. This allows prison medical staff to quickly identify individuals who may have acquired a TB infection for which prophylactic treatment is indicated. In some instances, individuals with active TB are identified. In addition to the TB screening, most prison systems perform a test for syphilis at intake, and many systems also test for gonorrhea at the time of the physical exam. Some systems also routinely perform HIV tests at intake. A few systems

test for hepatitis as well. Complete blood counts and blood chemistries are also performed on entry to the corrections system in some jurisdictions.

Ideally, the clinician uses data collected from the initial screening, TB skin test, and other blood tests, along with the information gathered during the history and physical exam, to identify the inmate's health care needs.

PITFALLS IN THE PROCESS

The responsiveness of the health care portion of the reception process may be undermined if any of the following problems occur:

- The medical history and physical exam are performed and inmate planning begins before data from the other intake tests are received and evaluated. If patient data are to be used effectively to plan for the inmate's needs, delaying formulation of the long-term plan until all requisite data are in place makes sense. There are notable exceptions, however, such as the need to screen immediately on admission, to evaluate those rating positive on the screening for suicidal intentions, and to respond to other circumstances indicating that an inmate might present risk of harm to himself or herself or others.
- During the medical history and physical exam process, the data are not collected effectively or the feedback loop is not completed. An example would be when, in sequence, an inmate completes a self-history inventory, then a nurse later adds more history, and finally the physician performs a physical exam but fails to review the data from the inmate's self-history or the nursing history.
- A nurse collects the medical history for the inmate in a location where confidentiality is not ensured, thus inhibiting candor on the part of the patient. Inmates tend to be cautious in disclosing information where it may be overheard by other staff or inmates and potentially used against them.

Any of these problems will result in the development of an inaccurate or incomplete plan for the inmate. When a self-history is conducted and the inmate has checked multiple items in his or her history as positive, often a physician does not follow up on the items. These situations can interfere with the inmate receiving needed and effective treatment and can create serious potential liabilities for the corrections agency.

At the completion of the history and physical exam, the physician is responsible for developing a treatment plan that includes diagnostic and therapeutic interventions based on the data collected. In addition, at this point the physician usually identifies the inmate's particular needs. Those needs may be relevant to housing assignment, needed prosthetics, work assignments, or educational activities. Corrections systems have developed the following two effective strategies to develop plans that address inmates' special needs:

- **Physician lists specific needs.** Many departments have the physician list particular needs (such as "Patient with a seizure disorder needing a low bunk" or "Patient in a wheelchair needing a handicap-accessible housing arrangement") for individual inmates. This can inform the formal classification system and enable placement staff to prioritize placements. For this strategy to work well, the placement staff must know what environmental and professional resources are available at each prison in the system.
- **Coding system.** Other departments employ variations of a system used in the military that provides decisionmaking categories (such as physical capabilities, upper extremities, lower extremities, hearing, vision, and psychiatric considerations) for which the examining physician must rate the inmate as "normal," "moderate needs," or "severe restrictions." Correctional counselors then use this system to determine appropriate inmate placement.

In one variation of the coding system described above, the Ohio Department of Rehabilitation and

Correction (ODRC) uses a medical classification grid with the following classifications:

- **Class 1:** Medically stable inmates who require only periodic care and do not require any chronic care clinic or infirmary monitoring.
- **Class 2:** Medically stable inmates who require routine followup and chronic care. This would include those with diabetes, hypertension, HIV disease, and other problems.
- **Class 3:** Inmates who require frequent, intensive, skilled medical care who can maintain their own activities of daily living (ADLs). Inmates in this category include individuals on dialysis, those with severe lung disease, unstable seizure disorder patients, paraplegics, hemiplegics, and inmates with other health problems.
- **Class 4:** Inmates who require constant medical care and who need medical assistance with ADLs.

ODRC has identified institutions that are eligible to receive inmates from each classification. Based on the classification scoring grid and information provided to the counselors, determinations also are made with regard to educational activities, job assignments, etc. The health care capability of a prison is factored in with these other issues to determine the placement for each inmate. Elderly inmates with more severe problems are sent to a specific institution. Other elderly inmates may be mainstreamed in the general population based on their physical capabilities.

CORRECTIONS-SYSTEMS VERSUS FREE-WORLD FUNCTIONAL ASSESSMENTS

In both the free world and corrections systems, the medical history and the physical examination are critical elements in determining and responding to functional needs. One difference is that many hospitals or health care organizations employ a survey developed by the Rand Corporation, the SF–36, that allows patients to complete a self-assessment questionnaire with regard to their general health and their functional capability.[1] Such self-assessment instruments are less commonly used in prison settings. The SF–36 includes 11 questions that attempt to determine how the patient perceives his or her own functioning and also how that current perception differs from the patient's past perceptions. Another purpose of the SF–36 is to determine whether the patient's perception of his or her health status corresponds with the health care provider's perception. This instrument is particularly helpful in identifying patients who are perceived as overutilizing or underutilizing health services.

Owing to an understandable skepticism prevalent throughout the corrections environment, prison medical staff tend to rely more heavily on objectively observed data than on data provided exclusively by the patient. This skepticism is based on concerns that inmates will not be forthright in responding to questionnaires and that they may attempt to gain preferential treatment or undermine security by giving exaggerated or untrue responses. Although the primary focus of corrections is security, corrections officials are also obligated by tenets of law and humaneness to provide an environment that meets inmates' needs. In the free world, the focus is on understanding the patient well enough to create conditions that will enable the patient to be as healthy and fulfilled as possible.

Despite these differences in focus and priority between how free-world and prison-based functional assessments are conducted, it might be useful for a prison system to pilot the SF–36 functional assessment survey with a group of inmates. This would help confirm or discontinue the widely held belief in corrections that inmates tend to overutilize health services, especially through the sick call process. Insight could be gained by comparing SF–36 results and health care direct assessments with inmates' use patterns. If those scoring high on the SF–36 are also high users of services and if health care staff are not identifying a physiological basis for many of the service requests, it would be productive to bring together a multidisciplinary team consisting of medical and mental health staff to determine the basis for this apparent disconnect. The Health Services Division of the Oregon Department of Corrections conducted a study several years ago to understand utilization patterns and compare them with professional evaluations. The study demonstrated that one-third of inmates used services consistent with medical staff expectations, one-third underutilized services, and one-third overutilized services. The study also found that the overutilizers believed they were less healthy than the medical staff believed.[2]

NEEDS REQUIRING SPECIAL ACCOMMODATION

A number of conditions require special accommodation, including mobility impairment, sensory-neural impairment, chronic illness, mental illness, terminal illness, and certain types of women's health problems.

Mobility Impairment

Inmates with mobility impairments pose a challenge for correctional facilities. Such impairments include a reduced ability to ambulate due, most commonly, to spinal cord injury, neurological problems, severe arthritis, or complications of chronic diseases such as diabetes. Mobility-impaired individuals include not only those who require the use of a wheelchair but also amputees and others who need to walk with the aid of an assistive device such as a crutch, cane, or brace. Depending on the severity of the disability, an inmate may require housing in a room or cell that has been modified to accommodate that disability. Modifications might include a wider door to allow for wheelchair access, grab bars around the toilet and in the shower, a sink and toilet of the appropriate height, a shower chair, and handheld shower fixtures. Since the enactment of the Americans with Disabilities Act (ADA) in 1990, federal guidelines have identified the appropriate types of accommodations required in prisons. To comply with ADA requirements, most prison systems now cluster inmates who require wheelchairs in newer or specially modified institutions. In addition, many inmates with mobility impairments require other devices. Many no longer have bladder or bowel control and therefore require catheters and other equipment. Some prison systems assign inmate workers to assist mobility-impaired inmates in moving around the prison environment. Mobility-impaired individuals also may need specially selected work assignments or the opportunity for educational activities in a modified class environment.

Sensory-Neural Impairment

Inmates suffering from sensory-neural impairments also may require special housing. This category includes inmates who cannot see, hear, or speak or who experience significant difficulty in performing these activities. These individuals may need to be housed in sheltered environments. Some prison systems have assigned inmate workers to assist those suffering from sensory-neural impairments so that they can function in the prison environment.

Operational ramifications

Patients suffering from mobility or sensory-neural impairments present widespread operational ramifications and pose significant challenges to institutional managers and staff. Modifications may be

required in the dining area to allow suitable access for mobility-impaired individuals. Sensory-neural-impaired individuals, such as those who are deaf or hard of hearing, may require special phones or other assistive devices. Many of these inmates will require access to specialists (e.g., occupational therapists, physical therapists, physiatrists, ophthalmologists, audiologists), which must be arranged by the health care program. Departments of corrections may also need specially modified vans to transport individuals with severe mobility impairments.

Several successful class action suits have been brought on behalf of inmates who have not received the accommodations they need to adequately adjust to their environments. Thus, it is clearly in the interest of each correctional agency to engage planners and clinicians in efforts to identify the types of disabilities individuals have on intake and to plan accordingly to address their needs adequately, whether they are to be housed in special facilities or accommodated in the general population (Anno, 2001).[3] Much of the institutional response has been driven by regulation and lawsuits, all too often in a makeshift fashion.

Chronic Illness

The National Commission on Correctional Health Care (NCCHC) report *The Health Status of Soon-To-Be-Released Inmates: A Report to Congress* projects the numbers of inmates who experience such common chronic diseases as hypertension, diabetes, seizure disorder, asthma, and HIV disease (National Commission on Correctional Health Care, 2002). After examining data received from correctional institutions, the authors of the NCCHC study suggest that these diseases may, in fact, be underdiagnosed. NCCHC has published clinical guidelines that provide educational information derived from national consensus panels of experts and detail useful strategies for diagnosing, monitoring, and treating individuals with these diseases.[4]

Many prison systems now have well-organized chronic disease programs in which patients are referred to a chronic clinic for a specific disease. Individuals with multiple chronic diseases have all of their diseases treated at the clinic where they have been referred for treatment for their most severe disease. Prison systems without organized chronic care clinics are likely to have more grievances and litigation. In addition, costs for hospitalizations and specialty services are likely to be greater owing to the higher morbidity rates that result from inadequately treated chronic diseases.

Despite clear evidence in the literature that morbidity and mortality are reduced when desired clinical outcomes are achieved, some prison systems with organized chronic clinic programs do not encourage their providers to focus each chronic disease visit on the desired clinical outcomes. Several sources of this evidence are cited below:

- American Diabetes Association. 2003a. "Clinical Practice Recommendations 2003." *Diabetes Care* 26 (suppl. 1) (January).[5] Guidelines are issued each January. Archives provide information for each year. (See *http://care.diabetesjournals.org/content/vol26/suppl_1/*.)
- American Diabetes Association. 2003b. "Management of Diabetes in Correctional Institutions." *Diabetes Care* 26 (suppl. 1) (January): S129–S130. The American Diabetes Association has been producing this supplement for about 5 years.
- Diabetes Control and Complications Trial Research Group. 1993. "The Effect of Intensive Treatment of Diabetes on the Development and Progression of Long-Term Complications in Insulin-Dependent Diabetes Mellitus." *New England Journal of Medicine* 329 (14): 977–986.
- National Institutes of Health. 1997. *The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure*. Bethesda, MD: National Institutes of Health, National Heart, Lung and Blood Institute. November, NIH 98–4080.

• Puisis, Michael, and John M. Robertson. 1998. "Chronic Disease Management." In *Clinical Practice in Correctional Medicine,* ed. Michael Puisis. St. Louis, MO: Mosby, 51–66.

In May 2002, NCCHC received a demonstration grant from the Robert Wood Johnson Foundation to develop a correctional health care, outcome-based measurement system that will provide feedback to correctional systems to measure the percentage of inmates with hypertension, diabetes, asthma, seizure disorder, or HIV disease who are under good, fair, or poor control at any time. For this demonstration project, NCCHC will be working with the states of Michigan and Georgia and will encourage those states to assess their patients based on standardized and agreed-upon definitions of good, fair, and poor control for each disease. The data from the patient encounters will be forwarded to NCCHC. Each correctional system will receive a quarterly report indicating the percentage of inmate patients with each disease under good, fair, or poor control at each institution within the system. Agency managers and clinicians at each prison system will then use the data to identify the prisons in which the highest percentages of patients are under good control and to identify practices that can be employed to improve the outcomes at other prisons within the system. NCCHC hopes ultimately to create a permanently funded system that will make this resource available to all prisons on a voluntary basis.

The Michigan Department of Corrections, as part of its chronic clinic program, has developed a unique disability clinic for individuals who have serious mobility or sensory-neural impairments. This disability clinic employs definitions of good, fair, and poor control for inmates with mobility or sensory-neural impairments. This allows the primary care provider to see these patients on a regular basis (every 3 months) and to intervene with these inmates if it is found that their problems are not under good control. In Michigan, if someone with a disability has several other chronic conditions, the disability clinic is the main clinic in which all the other diseases are addressed.

Most chronic clinic programs begin with a physician writing an order to enroll the patient in the chronic clinic program. At the first visit, comprehensive data related to the specific disease and its potential complications are collected. A patient with hypertension or diabetes will have information gathered with regard to cardiovascular risk factors, smoking, etc. Once these data are collected on the initial visit (and this may include blood tests and other ancillary studies), the physician is then able to develop a plan for each patient. To have a successful chronic clinic program with positive patient outcomes, it is incumbent on the physicians to work very closely with the patients, as it has been shown that shared responsibility between patient and provider is correlated with success in achieving positive treatment outcomes.

Most well-run chronic care clinics in corrections settings rely heavily on registered nurses. Registered nurses perform valuable functions in patient education, medication counseling, and assurance that appropriate tests are performed before a scheduled chronic care clinic visit. A well-organized chronic clinic program in which good outcomes are achieved is almost certain to reduce such costs as emergency room visits and hospitalizations. This is an example where an initial investment in developing an organized chronic care program with well-trained professional staff benefits both the inmate and the agency.

Mental Illness

Several jurisdictions have reported that roughly 15 percent of all prison inmates suffer from some variety of mental illness (Council of State Governments, 2002). Most of these individuals have personality disorders; in addition, a significant minority of individuals have schizophrenia or affective disorders. The initial intake history, physical exam, and screening evaluation are designed to detect histories of mental illness and to identify individuals whose behavior requires some kind of intervention. Beyond the intake evaluation, many prison systems provide various psychological tests to further delineate mental health and mental retardation problems. Most

systems employ formal psychological testing to detect developmental disabilities. Many systems also use such psychological tests as the Minnesota Multiphasic Personality Inventory (MMPI), Draw-A-Person test, or Finish Sentence test. Individuals with an identified mental illness then receive a more comprehensive mental health evaluation. This evaluation determines whether the inmate requires an acute mental health inpatient bed, a chronic mental health bed, or maintenance on an outpatient mental health caseload. The mental health evaluation is also important in determining whether the individual is at risk for suicide. If it is determined during the intake process that an individual is at risk for suicide, the inmate generally will be placed under suicide observation until the situation has been stabilized.

Individuals who are being followed in an outpatient mental health program or in a program for the chronically mentally ill should be provided with as much relevant programming as possible. They may participate in educational and some vocational activities. It is important, however, to identify and track their problems and status so that they do not become lost to followup and, therefore, fail to benefit from followup interventions. When these inmates are lost to followup, the likelihood of decompensation is greatly increased.

Another category of individuals with mental health problems that must be addressed includes those who have personality disorders, including self-mutilators; individuals with borderline personality disorders; and others who are aggressively mentally ill. Inmates with these problems disrupt both the prison population and the health care program. Historically, psychiatrists have attempted to avoid responsibility for responding to these types of patients because their diagnoses do not always meet the definition of serious mental illness. On the other hand, if mental health professionals do not participate in providing a structured program for these inmates, then custody officers are in essence abandoned to their own devices in attempting to respond to them. This is unfair to the custody officers, inappropriate for the inmates, and ultimately disruptive to the prison environment. Individuals with these types of problems function much better in a structured behavior management milieu in which positive and negative consequences of behaviors are part of the program rules. These rules go beyond the traditional custody rules. An example is entering into a behavioral management contract with a self-mutilator who, when he cuts himself, may be put into restraints for a defined period of time. If the negative behavior is avoided, on the other hand, privileges may accrue. Such inmates need to understand the consequences of their self-destructive behavior, and the consequences need to be meted out in a predictable way.

Individuals thought to have mental retardation, defined as having an IQ below 70 and significant deficits in everyday living skills, should reside in a dedicated environment. This type of setting will allow them to receive the assistance of competent others and help them function adequately and avoid the need for confinement to ensure their safety.

Terminal Illness

Most systems define inmates as terminally ill if they are known to have a disease determined to be fatal and have less than 6 months to live. In the CJI survey, the two most often mentioned program responses for terminally ill inmates were hospice programs and programs for compassionate release, both discussed earlier in this report. Whatever the response, it is important that inmates with terminal conditions be identified as soon as possible. Some individuals with terminal illnesses are able to function quite adequately in the mainstream population until shortly before their death. Still others may require a more protected inpatient housing arrangement. In general, the terminally ill inmate should participate in the decision as to whether or not to remain in general population housing; most inmates prefer to stay in the general population to the extent that they are physically capable. Regardless of where the inmate resides, the sooner these individuals and their problems are identified, the sooner an appropriate plan can be made for their housing and functioning within the prison environment.

Women's Health Problems

It is well recognized that women, both in the free world and in corrections, use health services far more frequently than their male counterparts and that they have distinct health care requirements. Women's institutions require more physician hours per 100 inmates than prisons that house men. Thus, it is incumbent on a prison system to provide adequate resources to ensure that women's problems are addressed in a timely, effective, and efficient manner. During the intake process, it is important to identify any problems related to pregnancy, menstruation, mental and emotional problems, and history of abuse. Because women who are incarcerated are at very high risk for both sexually transmitted diseases and certain types of cancer, it is important to include testing for sexually transmitted diseases, such as gonorrhea, chlamydia, and syphilis, as part of the reception process and to conduct a pelvic examination and Pap smear to identify cervical cancer.

TRACKING INDIVIDUALS WITH SPECIAL NEEDS

In many prison systems, grievances and litigation have occurred because problems identified at one institution are not followed up at a second institution. Problems and delays may occur, for example, when medical equipment or supplies that are needed for an inmate's accommodation and ordered by a physician at one institution must be reordered by another physician when that inmate is transferred to a new institution.

The Michigan Department of Corrections has developed a model program that attempts to reduce these types of problems. Michigan's system begins during the reception process when a Special Needs Identification Screening Form is completed in the reception area. This form identifies individuals' limitations with regard to a number of physical problems. It also identifies particular appliances that individuals may need to be adequately accommodated, along with any ongoing treatments, restrictions, or special needs (e.g., provision of a low bunk or housing in a low gallery) that may be required. The reception physician completes the form. In addition, the department has developed a form called the Special Accommodation Notice. This form, prepared in quadruplicate, identifies needs for housing, work assignment, medical equipment and supplies, transportation, therapeutic diet, communication assistance, and any other needs that the physician may indicate. This form goes in the unit health record with copies going to the inmate's master file, to the counselor, and to the inmate. This form is universally recognized at all Michigan correctional institutions, and all accommodations that are checked on this form must be adhered to unless a new, updated form is generated that calls for changes in the accommodations ordered. Since the implementation of this form, problems of inmates being denied necessary accommodations after moving from one institution to another have been dramatically reduced. In addition, at one Michigan institution, the G. Robert Cotton Correctional Facility, this information is maintained in a computer file, which also identifies the inmate's location within the prison. This automated system is now being planned for use throughout the Michigan prison system. On a printout from the G. Robert Cotton Correctional Facility, one can immediately identify inmates who use wheelchairs as well as those who must have bottom bunks, must be on the ground floor, must be in a single cell, or are hearing impaired.

In addition, Michigan correctional physicians fill out a Medical Detail Form to identify inmates who are expected to need an accommodation for fewer than 6 months. The physician indicates the accommodation and the expiration date (see appendix B, "Site Visit Report: Michigan Department of Corrections").

CONCLUSION

By identifying special needs early and then providing an organized approach to meeting these special

needs, prison systems will be able to more satisfactorily handle the variety of problems that they must address. Clearly, this will minimize grievances, decrease litigation, and create a more accepting inmate population. With such policies and procedures in place, it will be much easier to manage a prison with all of its complicated human interactions. Although the challenges are great, substantial rewards may be derived from designing and implementing a comprehensive approach to identifying and responding to inmates' special needs that begins at the time they are processed through reception.

NOTES

1. SF–36v2™ Health Survey Scoring Demonstration; *http://www.sf36.com/demos/SF-36v2.html*.

2. Personal communication from B. Jaye Anno to Steven Shelton, Medical Director, Oregon Department of Corrections.

3. See, for example, *Armstrong* v. *Terhune* (California Department of Corrections); *Armstrong* v. *Davis*, 124 F.3d 1019 (9th Cir. 2001).

4. Additional information regarding NCCHC clinical guidelines may be obtained from its Web site at *www.ncchc.org*.

5. The American Diabetes Association produces an annual supplement to *Diabetes Care* that contains clinical practice recommendations. Guidelines are updated and issued each January. Archives provide information for each year. (See http://care.diabetesjournals.org/content/vol26/suppl_1/.)

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Program, Housing, and Treatment Considerations

Chapter IV

Chapter IV

Program, Housing, and Treatment Considerations

Introduction

A number of individuals who are chronically ill, elderly, or terminally ill require special accommodation in their housing and program assignments. Owing to their physical condition, they often need specialty care in addition to basic health services. In this chapter, treatment, programs, and accommodation for inmates with special needs are explored in detail. Examples are given of how these special populations are managed in the six state prison systems that were visited. Although the terms "elderly," "chronically ill," and "terminally ill" are not mutually exclusive, for practical reasons they are discussed separately below.

Elderly Inmates

Strong encouragement to live healthier lifestyles, coupled with advances in medical treatment, have contributed to longer lives for more people. In the general population outside prison, recent census data indicate that people older than age 65 represent the fastest growing segment of the U.S. population. At the turn of the 20th century, only 4 percent of the U.S. population was older than age 65; at its close, this figure had more than tripled. Projections for the year 2050 place the number of Americans older than age 65 at 20 percent of the population (Robert Wood Johnson Foundation, 1998).

A similar trend can be seen among the incarcerated. Although they still represent a minority of prison admissions, offenders older than age 40 represent the fastest growing segment of the inmate population in many states. This is true for two reasons: first, more offenders in this age group are being sentenced to prison; and, second, mandatory sentences, longer sentences, and more restrictive release policies mean that more inmates are growing old behind bars (Anno, 2001).

It is difficult to state with any precision how many elderly inmates are in U.S. prisons at any given time, partly because there is no universally accepted definition of the term "elderly." The Federal Bureau of Prisons defines as elderly those inmates who are older than 50 years of age; however, different states use ages 50, 55, 60, or even 65 as their lower limit to define elderly inmates (see the CJI survey results in appendix A). In the six prison systems visited for this report, two had no definition of elderly (New York and Pennsylvania), Ohio and Oregon defined elderly inmates as age 50 and older, Minnesota used age 55 as the lower limit, and Michigan used age 60 and older.

Regardless of the lower age limit used to define elderly inmates, correctional health professionals generally agree that the onset of geriatric conditions usually occurs at a younger age among inmates than among the general population. This difference is largely attributable to inmates' relatively greater poverty and to their lifestyles, which are less healthy than those of the general population. Most inmates are poor and from racial, ethnic, and cultural minority groups that do not receive optimum health care services. Most of them use or have used tobacco, alcohol, and illicit drugs. Many have engaged in risky

sexual practices and have had multiple sexual partners. These factors, taken together, make inmates as a group "among the least likely to have had access to preventive care or regular health services and among the most susceptible to serious illness, violence, and debilitating conditions" (Anno, 1997, p. 291).

Treatment Needs

It is clear that older inmates have considerably greater health care needs than younger inmates in the general prison population. Many suffer from chronic illnesses, including heart disease, hypertension, diabetes, and chronic obstructive lung disease. They also are subject to a number of conditions that accompany the normal aging process, including loss of vision, impaired hearing, sleep disturbances, incontinence, mental confusion, and gastrointestinal disorders. Osteoporosis (loss of bone density) is another risk factor for older people, especially for women. In fact, the cost of providing health care to older inmates has been reported as three times the cost for the typical adult inmate (Faiver, 1998).

Because of their increased risk of having one or more chronic diseases as well as the debilitating conditions that may accompany the aging process, older inmates should be placed in institutions that offer a full range of health services, including availability of health care staff and emergency care 24 hours a day, 7 days a week, and access to such specialty services as geriatrics, pulmonology, cardiology, and nephrology. Additionally, some older inmates may be too frail or weak to attend to their own activities of daily living (ADLs) (e.g., eating, bathing, toileting). Increasingly, larger departments of corrections (DOCs) are developing nursing home environments to care for their frail elderly who require such assistance. In smaller DOCs that do not have an extensive older population, the frail elderly typically are managed in an infirmary.

Elderly inmates also often need a number of adaptive devices that enable them to be more functional. All or almost all of the DOCs surveyed indicated that they provide walkers and canes, hearing aids, dentures, eyeglasses, supportive devices, warmer clothing, and extra blankets to the older inmates who need them. Geriatric chairs and beds were provided by more than half of the DOCs surveyed (see appendix A).

Housing Options

A number of older inmates are healthy and do not require special housing. They can be placed in any housing area that is appropriate to their custody classification. Others may require placement in a nursing home environment or in an infirmary, as noted above. There is a third group of elderly inmates, though, who are not sufficiently debilitated to require nursing home placement but who still need a sheltered housing area that can accommodate their special needs. Older inmates may have difficulty relating to younger, more aggressive inmates. Additionally, they are more prone to being victimized by younger inmates. Also, according to Faiver:

> The physical plants commonly found in correctional facilities were designed for young and physically active inmates. Living units and support service buildings frequently are scattered over wide areas, and inmates must walk long distances for meals, medical services, and other activities. Architectural barriers, such as steps, narrow doorways, and lack of handrails or grab bars, present additional problems which older inmates encounter. Poor ventilation and inadequate climate control can be extremely hard on the elderly. . . . (Faiver, 1998, p. 130)

As a consequence, some correctional systems now provide separate living facilities for the elderly, the handicapped, or others who may benefit from a more sheltered environment. Examples include facilities in Minnesota, Oregon, Pennsylvania, and Ohio (see site reports in appendix B).

The Linden Unit at Minnesota Correctional Facility, Faribault, Minnesota

The Minnesota Department of Corrections (MDC) offers special housing for older inmates. Although elderly inmates in Minnesota (defined as anyone 55 years of age or older) may remain in the general prison population if they choose to do so, they also may choose to live in a dedicated housing unit at the Minnesota Correctional Facility (MCF) at Faribault. MCF-Faribault, a medium-security facility for adult males, has established the Linden unit, a special housing unit for inmates with chronic health problems who are 55 or older and for younger inmates with disabilities (such as those who are blind, deaf, or confined to wheelchairs). The Linden unit has 103 beds. At the time the site visit for this report was conducted, 80 beds were filled with special needs inmates (both elderly and disabled). The other beds were used by inmates from the general prison population. According to the nursing staff, general population inmates are moved out if beds are needed for special needs inmates, but they are required to keep the beds filled. The Linden unit has licensed practical nurses who provide coverage 16 hours a day. Nursing coverage is available 24 hours a day in the main clinic area. Inmates housed at Linden must be able to perform their own ADLs, including eating, bathing, and toileting. If inmates require assistance with their ADLs or 24-hour nursing care, they are transferred to the Transitional Care Unit (infirmary) at MCF-Oak Park Heights. There is no "keep on the person" medication program in Minnesota. The nurses pass all medications individually to ensure better compliance.

The features and accommodations of the Linden unit, including the recreation equipment, dining area, and telephone booths, are handicapped accessible. There are TTY machines for the deaf, and interpreters are provided for all adversarial hearings. Special needs inmates stay in two-person rooms (not cells). Hospital beds with railings are available as needed. General population inmates assigned to this unit reside in dorms.

Inmates who are wheelchair bound or severely disabled may be assigned a personal care attendant (helper), who helps the inmate clean the room, push the wheelchair, and perform other activities. The personal care attendant may not assist with ADLs because, as noted above, inmates at Linden must be able to perform their own ADLs.

Inmates assigned to the Linden unit usually do not mix with general population inmates in other housing areas. They have their own dining area, weight room, craft room, and recreation area with a pool table. Little other programming is available. Job assignments are limited to janitor, kitchen worker, or personal care attendant. During the summer, a horticultural program is provided, and inmates may plant a garden. Inmates who are 55 and older who choose to live at Linden cannot work because the DOC considers them to be "retired" (see appendix B, "Site Visit Report: Minnesota Department of Corrections").

Unit 13 at Oregon State Correctional Institution

The Oregon Department of Corrections defines anyone older than age 50 as elderly. However, it has no special programs or housing specifically for elderly inmates. Unit, program, and work assignments are based on the functional abilities of individual inmates older than 50.

At Oregon State Correctional Institution (OSCI), however, a 61-bed dorm (called Unit 13) offers a more protected environment for elderly, disabled, and mobility-impaired male inmates. Eighteen inmate orderlies work in this dorm (12 as janitors and 6 who assist with ADLs, such as providing "wheelchair taxi service" as needed). Hospital-style beds equipped with extra padding, bedding, trapeze features, etc., are provided as needed. Toilets, sinks, and showers are handicapped accessible. At special times, Unit 13 inmates can use a therapeutic gym equipped with a pool table configured at a lower height to accommodate those in wheelchairs. An elevator ramp is available adjacent to the stairway leading to

the gym. Unit 13 has its own barbershop and sewing program to reduce the amount of movement these inmates must make. It is important to note that Unit 13 is not an inpatient unit. Although nursing care is available at OSCI 22 hours a day, the inmates assigned to Unit 13 do not require ongoing nursing services. If they do, they are transferred to the nursing home at the Snake River Correctional Institution.

The Oregon system provides several other accommodations for inmates with specific disabilities. Several units have wheelchair taxi service available; this is a paid job for the inmates who provide the service. Blind inmates may be assigned a "seeing eye" cellmate. Closed-captioned television and specially equipped phones are available for the hearing impaired. Although only the newer units are ADA compliant, most prisons in the system have at least some cells that are handicapped accessible (see appendix B, "Site Visit Report: Oregon Department of Corrections").

State Correctional Institution at Laurel Highlands, Pennsylvania

In 1996, the Pennsylvania Department of Corrections established a special prison for elderly inmates and others who require long-term care or assisted living. DOC's management recognized that housing elderly and infirm inmates at multiple sites required duplicating services, which increased costs and lowered quality. Hence, a decision was made to convert the Somerset State Hospital (which had been closed as a result of the mental health system's deinstitutionalization policy) to a special prison unit known as State Correctional Institution (SCI) Laurel Highlands. In an innovative development, a decision was made not only to convert the state hospital to a correction/geriatric/assisted living facility but also to convert the existing staff to that purpose. Department of Welfare employees, mostly registered nurses, licensed practical nurses, and certified nurse assistants, were screened and then offered correctional health positions with the understanding that a new program for elderly inmates would be developed. This not only saved jobs but also created a positive work ethic and morale that continue to contribute to the program's success.

SCI Laurel Highlands has 437 inmates, including long-term care inmates (capacity 107) managed at the skilled nursing/high-acuity level; the Personal Care Program (capacity 140), which is a self-care/assisted living program; and a general population work cadre that assists staff in maintaining the facility. Expenses average approximately $65,000 per inmate per year versus $27,000 per inmate per year elsewhere in the Pennsylvania system.

Admission to SCI Laurel Highlands is based on a functional assessment. The referring institution completes an eight-page application. A senior nurse from Laurel Highlands often goes to the referring institution to assist in this process. The facility is able to accommodate adult males of all security classifications. Nursing staff are available around the clock (see appendix B, "Site Visit Report: Pennsylvania Department of Corrections").

Hocking Correctional Facility, Ohio

In Ohio, all wardens receive training on the aging process and its impact on inmates. In five institutions, elderly inmates are housed together in distinct units; one of these is the Hocking Correctional Facility (HCF). HCF is a medium-custody facility holding older adult males. As of November 5, 2001, HCF had a population of 403. The inmates' ages range from 37 to 90 years; the mean age is 61 years. More than 90 percent of the population at HCF is older than age 50.

At HCF, a program called 50+ and Aging addresses the physical, psychological, and social needs of older inmates. Programs and services, including chair aerobics, adult basic education, and GED classes, are provided. All HCF inmates have job assignments designed to meet their needs, including positions such as elevator operator and other sitdown jobs. A case manager assists inmates in a variety of areas, including applying for Social Security benefits, completing Medicaid and Medicare applications, writing wills, securing postrelease placement, and obtaining

housing and meal services. Recreational activities geared to older inmates are offered, such as bingo, wiffleball, shuffleboard, horseshoes, putt-putt, board games, and a three-level (beginner, intermediate, and advanced) walking program.

In addition, the mental health department at HCF has developed an Associate Aide Program to assist inmates who suffer from memory loss and other mental conditions. Inmates who are interested in serving as an aide complete an application and are then interviewed and screened. The aides are required to attend annual training that reviews the duties they are expected to perform and those they are prohibited from performing. In general, the aides' responsibilities include serving as an escort to appointments, meals, commissary, etc., until locations and routes are learned and reminding their assigned "associates" of upcoming appointments, the importance of personal hygiene, and other concerns (see appendix B, "Site Visit Report: Ohio Department of Rehabilitation and Correction").

Program Considerations

The most important consideration in determining program assignments for older inmates is their physical limitations. Factors such as hearing and vision loss, reduced physical strength, and the inability to stand for long periods of time affect the types of work assignments that may be appropriate. Similarly, these same factors may affect the types of recreational activities that are appropriate for the elderly. Special accommodations may be required in educational programs as well, such as use of large print books and other materials.

Despite their physical limitations, older inmates need to stay physically active and mentally alert as long as possible. They can benefit from a number of adult education courses and self-help programs, particularly those that will help them more successfully reenter the world outside prison. As Faiver notes:

> Douglass et al. pointed out the importance of considering the plight of long-term inmates who return to a world that rejected them and that they rejected. The older, discharged prisoner usually faces substantial difficulties upon reentry to the community, as highlighted by a 1988 study of elderly homeless persons in Detroit. It showed that the probability of homelessness for the elderly was as strongly associated with prior prison experience as with mental hospitalization (about 30 percent). (Faiver, 1998, p. 132)

One facility that provides significant educational programming for the elderly is the Ohio Reformatory for Women in Marysville, Ohio. It has approximately 12 different educational and recreational programs that deal with problems and issues relevant to elderly or special needs female inmates. These include educational and support programs, such as "The Aging Process," which presents information on what to expect and how to come to terms with the aging process; "Topic Talk," a guided discussion group that encourages women to take more control of their lives; "Helping Others Together (HOT)," which allows inmates to assist fellow inmates who are incapable of performing ADLs; "Heart to Heart," an educational support program for women who are chronically ill; and "Topics of Powerful Significance," which addresses health issues, codependency issues, substance abuse, and other topics. A special recreation program is suited to the limitations of special needs inmates, and a garden club encourages the women to get involved in outdoor horticultural activities. Inmates also are given information to assist them with prerelease planning on such relevant topics as Social Security, Medicare/Medicaid, estates and wills, advance directives, funeral planning, and community-based services (see appendix B, "Site Visit Report: Ohio Department of Rehabilitation and Correction").

CHRONICALLY ILL INMATES

By definition, chronic illnesses are either ongoing or recurring. Individuals with such chronic conditions as asthma, AIDS, heart disease, diabetes, hypertension, and hepatitis C and those with certain permanent physical conditions (e.g., paraplegia) need to be monitored closely to maintain their health status or to slow the progression of their disease or condition.

The first step in developing an effective program is to identify the number of inmates in any given system with specific chronic conditions. Although this seems obvious, the health care staff in many DOCs still cannot state with precision how many inmates they have at any given time with specific chronic conditions. A 1998 survey conducted by the National Commission on Correctional Health Care (NCCHC) and the National Institute of Justice of the 50 state prison systems, the District of Columbia, and the Federal Bureau of Prisons found that of the 41 systems responding, only 19 (46 percent) were able to identify the number of inmates in their systems with specific chronic diseases (Hornung et al., 2002).

Identification of chronic diseases and conditions should occur at intake, at the time of repeat health assessments, or whenever a clinician suspects the onset of a disease based on the patient's clinical symptoms. It is helpful to develop a database of inmates with chronic conditions so they can be tracked centrally for planning purposes and they can receive attention and relevant programs regardless of their unit of assignment.

Treatment Needs

People with chronic conditions generally are among the sickest of the prison population. Consequently, they should be placed in facilities that have the highest level of health care services available, including around-the-clock emergency services, nursing care, infirmary care, and specialty care.

Each DOC should have clinical protocols for specific chronic conditions (based on national guidelines) that provide direction to practitioners in managing their patients' care. A number of professional specialty societies (e.g., the American Diabetes Association) and government agencies (e.g., the Centers for Disease Control and Prevention, the National Institutes of Health) offer regularly updated, evidence-based protocols for managing such diseases as asthma, diabetes, tuberculosis, HIV, and hepatitis C. In addition, NCCHC has developed sample clinical protocols for six chronic diseases based on national guidelines.[1]

Each chronic care patient should have an individualized treatment plan that specifies the types of medication prescribed; any restrictions on exercise, diet, or work assignments; the type and frequency of laboratory and other diagnostic testing; any special therapies needed (e.g., respiratory therapy, physical therapy); and the frequency of followup for reevaluation of the patient's condition and adjustment of the treatment plan as necessary (Anno, 2001; National Commission on Correctional Health Care, 1997). The frequency of followup is dependent on the extent to which the patient's disease is controlled under the current treatment regimen. A number of correctional health practitioners recommend that most chronic care patients be seen by a provider, such as a physician, physician's assistant, or nurse practitioner, every 3 months.[2] A provider can see more stable patients every 6 months, with an intervening nurse visit. Less stable patients should be followed more often, as dictated by their clinical condition.

Establishing chronic care clinics where such patients are scheduled for routine revisits to the health unit can help ensure they receive needed care. Some DOCs group their patients with the same disease together, so that, for example, diabetics are seen on the third Tuesday of the third month, asthmatics on Wednesdays, etc. In Minnesota, at the time of the site visit conducted for this report, the medical director was working on developing clinical

protocols and planned to implement chronic care clinics at each of the prisons. The plan is that all of the institutions for adult males will have the same schedule for chronic care clinics to ensure that inmates who are transferred to a different facility do not miss their appointments (see appendix B, "Site Visit Report: Minnesota Department of Corrections").

In the Oregon system, on the other hand, inmates with the same diagnoses are not all scheduled to be seen at the chronic care clinic on the same day. Instead, they receive individual appointments. Staff there found that many inmates have multiple problems and do not fit neatly into one diagnosis. In addition, the Oregon health care staff felt that such scheduling would undermine patient confidentiality, in that other inmates could easily ascertain a patient's diagnosis simply by tracking who attended which clinics on which days (see appendix B, "Site Visit Report: Oregon Department of Corrections").

Regardless of how chronic care clinics are organized, several correctional health experts recommend that flowsheets be used at each encounter to track the patient's progress (Puisis and Robertson, 1998; Spencer, 1999). Flowsheets record basic data regarding laboratory test results, medications, vaccinations, weight, blood pressure and/or glucose readings, vital signs, etc., based on the specific disease entity being followed. They enable the provider to see at a glance what has been done and how well the patient is doing on his or her current treatment regimen, and they serve as a reminder to the provider when additional tests or exams need to be ordered.

Patient education is another important component of chronic disease management. Counseling and self-care instruction by providers, dietitians, or health educators can be of great assistance to these inmates, both within the correctional facility and when they return to the community. Diabetics, for example, can be instructed on how to select an appropriate diet, monitor their glucose, and administer their own insulin. Although health care staff still must monitor some of these activities for security reasons, the inmates will have received valuable information that they can use to care for themselves throughout their entire lives. Teaching inmates to assume some responsibility for managing their chronic conditions also can improve their adherence to a treatment regimen while they are incarcerated (Anno, 2001).

Housing Options

As noted above, owing to the serious nature of many chronic conditions, inmates diagnosed with such conditions should be housed in prisons with the highest available level of health care services. They also should have ready access to an acute care hospital, as these are the patients most likely to have a medical crisis. Within an institution, many chronic care patients will have other housing needs that should be considered. For example, frail inmates and those with seizure disorders will require a bottom bunk. Those suffering from heart disease, certain respiratory conditions, or difficulty in ambulating should be housed on a lower tier to avoid the need to climb stairs. If the facility is not smoke free, certain chronic care patients, particularly those with respiratory ailments, require placement in nonsmoking cells or dorms. Patients with certain spinal cord injuries must be housed in air-conditioned areas. Mobility-impaired inmates should be placed in a barrier-free facility, or at least in a housing area that is handicapped accessible. As noted below, health care providers should develop a mechanism to inform classification staff of inmates' special housing considerations.

Program Considerations

Inmates with chronic diseases often have special requirements that should be taken into account before work, school, and other program decisions are made. Typically, correctional agencies have a systemwide classification board that makes initial unit assignments and reviews transfer requests, and unit classification committees that determine work, housing, and program assignments. For these groups to

make effective decisions, they must have some information about inmates' medical and mental health status. The dilemma for health professionals is how to provide classification staff with important information about inmates' health conditions without violating the inmates' right to confidentiality. The solution is relatively simple: a form that summarizes any medical restrictions regarding housing, work, or program assignments without revealing the inmate's precise condition or diagnosis (Anno, 2001).

The form should include, for example, any restrictions in terms of facility assignment (e.g., medical facility, barrier-free facility, extended care facility), unit housing assignment (e.g., single cell, special housing), bunk assignment (no restriction or lower bunk only), or row assignment (no restriction or ground floor only). It also should address specific work restrictions, such as sedentary work only, limited standing, no walking more than a specified number of yards, no lifting more than a specified number of pounds, no temperature extremes, no exposure to environmental pollutants, etc. Such a form should be completed for each inmate at the time of admission to the prison system (based on the initial health assessment) and updated periodically when an inmate's condition improves or deteriorates. One copy should be sent to the classification committee and another copy retained in the inmate's health record.[3]

TERMINALLY ILL INMATES

Given the fact that aging and chronic illness are both progressive, it is inevitable that a number of inmates with these conditions will reach a terminal stage. While there is no consensus about how "terminal" is defined, the concept of a prognosis of less than 6 months to live is gaining increasing acceptance. Treating a terminally ill individual in prison is difficult at best. Inmates are usually isolated from their friends and family on the outside precisely when they need them most. In addition, compassion for the dying means that correctional health care staff, as well as other correctional staff, must make a change in the way they relate to the terminally ill—one that transforms them from inmates to patients to human beings.

There are other concerns as well. Inmates seldom trust that the correctional system is acting in their best interests. That is why it is so important that they be given the opportunity to participate in decisions regarding end-of-life care in a voluntary, uncoerced manner. Dying patients should be provided with information on available treatment options, including any remaining curative procedures, as well as palliative care and hospice services. They also should have the opportunity to issue advance directives such as living wills, health care proxies, and "do not resuscitate" (DNR) orders (Dubler and Heyman, 1998).

In the sections that follow, the special needs of this growing subset of inmates are discussed, along with examples of how different prison systems manage this population.

Treatment, Housing, and Program Needs

Terminally ill inmates need to be placed in facilities with the highest level of available health care services. While they are still receiving curative treatment, such patients require medication for pain and discomfort and frequent access to specialty services; they tend to cycle in and out of infirmaries and hospitals. As their condition worsens, they often will require around-the-clock nursing services. Inevitably, they reach a point where medicine can offer little help. The primary health goal then shifts from one of curing illness to palliative care, which entails keeping the patient comfortable and pain free, and also helping the inmate adjust to imminent death. Because terminally ill individuals may experience increased anger and depression and are at increased risk of suicide, the involvement of clergy, mental health professionals, and others who can offer supportive counseling is essential (Anno, 2001).

Although the usual prison work and school programs are seldom options for them, terminally ill inmates need to be kept humanely and comfortably occupied. The availability of books, music, and, above all, companionship are important components that can elevate a dying patient's mental outlook.

Just as hospice services are becoming an increasingly common option for terminally ill people in the community, the same is true for people dying in prison. In the assessment conducted as part of this project, half of the responding DOCs reported that they offered hospice services (see appendix A). Four such programs are described below. For staff contemplating the initiation of a hospice program, the *Standards of Practice for End-of-Life Care in Correctional Settings*, developed by the Guiding Responsive Action in Corrections at End-of-Life (GRACE) Project of the Volunteers of America, can be helpful (GRACE Project, 2000).

Minnesota Correctional Facility, Oak Park Heights

Owing to its small size, MDC does not have a hospice unit. Instead, terminally ill inmates (males only) are managed in the Transitional Care Unit (infirmary), the Mental Health Unit at MCF-Oak Park Heights, or in community facilities under a conditional release process. Hospice care is included as part of MDC's contract with Correctional Medical Services (CMS). CMS contracts with Health East Hospice, which is a part of Saint Joseph's Hospital in Saint Paul. When a terminally ill inmate chooses hospice care and will remain at MCF-Oak Park Heights, a nurse and a social worker from Health East Hospice staff meet with the inmate and his family to discuss their services. The hospice staff explain the options available to the patient and, based on the patient's wishes, help the patient execute advance directives, which can include DNR orders, "do not intubate" orders, maximum pain relief, and other options. Hospice staff also work with the facility's nursing staff and the patient to develop a plan of care. Thereafter, they visit the patient at least once each week.

No specific written criteria need to be considered for hospice care in Minnesota. "Terminal illness" is not defined by time, level of functioning, the patient's specific diagnosis, or the inmate's current offense. Instead, the only criterion is a physician's recommendation that the patient receive a consultation with hospice staff.

MCF-Oak Park Heights normally allows 16 hours of visitation each month. Special visitation arrangements are made for the hospice patient's family over and above the regular visits, however, including bedside visits when the individual is no longer ambulatory. Decisions regarding visits by other inmates are made on a case-by-case basis. Religious counseling is available if the hospice patient requests it. Memorial services led by religious leaders are held when the patient dies.

Palliative care is available for terminally ill inmates and for those with other painful conditions. Intravenous narcotics are not used; only patches, pills, and injectable liquids are permitted. All narcotics are administered under directly observed therapy. If a patient is in the general population rather than the Transitional Care Unit, only oral narcotics are permitted.

Staff indicated that administrative and custody staff at MCF-Oak Park Heights never exhibited any concern about or resistance to the hospice or palliative care programs. According to the warden, "Medical staff make the medical decisions, and we figure out how to implement them" (see appendix B, "Site Visit Report: Minnesota Department of Corrections").

Coxsackie Correctional Facility, New York

The Coxsackie facility currently operates the only hospice program offered by the New York State Department of Correctional Services (NYSDOCS), although others are planned for other regional medical units (RMUs) operating in the prison system. The hospice program is located within the Coxsackie RMU and is managed as part of the RMU contract by Correctional Medical Services. It is not a discrete

unit with a specific number of beds but, rather, a series of services provided to individuals designated as terminally ill who have chosen hospice for their end-of-life care. As many as 12 hospice patients have received services at one time. Last year, the program served 28 male inmates. Hospice services have been available at Coxsackie since 1997 through a contract with a community hospice program, but CMS staff themselves have provided these services only since October 2001.

The Coxsackie hospice program uses the National Hospice and Palliative Care Organization definition of 6 months or less to live as its definition of terminal illness. Staff members have developed worksheets for several diseases and conditions to assist physicians in determining who may be terminally ill. Unlike consideration of medical parole, the type of crime the inmate committed is not a factor in determining eligibility for hospice services.

All RMU staff undergo training in hospice philosophy and programs. The RMU director of nursing is a certified case manager and a hospice and palliative care nurse. A certified hospice volunteer from the community provides assistance. The program also benefits from the services of four hospice aides, who are inmates paid to work in these positions. These aides receive 40 hours of preservice training. Their primary role is to provide companionship for the dying patient (e.g., reading, talking, writing letters, listening). They do not assist in any way with patient care activities but are permitted to touch the patient (e.g., hold his hand, rub his back) if staff approve of such contact. This is a compelling and compassionate feature of this hospice program, particularly because correctional health care staff are repeatedly warned not to become emotionally involved with their patients or to touch them in anything other than a professional manner. Allowing the aides to have such contact provides the necessary "human touch" that is so important at the end of life. When death is imminent, the aides hold a 24-hour vigil to ensure that the inmate does not die alone.

All inmates are required to issue advance directives when they are admitted to the RMU. These are on file if the inmate becomes terminally ill and elects to receive hospice services. Inmates are not required to issue DNR orders to receive hospice care but, if they do not, the staff questions whether they really understand the hospice philosophy.

Visits are available to all RMU patients on Saturdays and Sundays. Arrangements can be made for midweek visits when necessary, and bedside visits are permitted when the patient is in critical condition. Terminally ill patients receive extra snacks and nutritional supplements, and staff try to fulfill special requests if possible.

Palliative care is available to terminally ill inmates as well as to those with other painful conditions. Both intravenous and by-mouth medications (including narcotics) are available for symptom control. Patient-controlled analgesia (PCA) pumps (devices that allow patients to control the dosing of pain medications) are seldom used, and the physicians in this program avoid prescribing patches because of their abuse potential.

According to the health care staff, the primary barrier to implementing the hospice program was the resentment of line correctional officers who were "morally opposed" to criminals receiving such services. The key to eliminating this barrier has been to educate correctional staff that the basic rule of treating inmates "professionally, but not compassionately," shifts at the end of life (see appendix B, "Site Visit Report: New York State Department of Correctional Services").

Oregon State Penitentiary, Salem

A hospice program for men in the prison system is located at the Oregon State Penitentiary (OSP). Currently, there are no terminally ill women in the Oregon prison system, but a room has been prepared at the Oregon Women's Correctional Center should the need arise, and health care staff there have received hospice training.

At OSP, hospice patients are kept in the general population as long as possible because that is their "home." When they become too ill, they are moved to the infirmary, which has a 21-bed ward, two single rooms, and two traditional secure cells. The hospice patient can elect to be housed in one of the separate rooms or in the ward, depending on whether he wants privacy or company.

The only criteria for receiving hospice care are that two practitioners must have determined that the inmate has less than a year to live and that the inmate elects to receive hospice services. The inmate's diagnosis, level of functioning, and type of crime are not considered. No staff are dedicated to hospice care (in part, because few inmates require these services), but OSP health care staff have received training from a community hospice expert. The program also utilizes pastoral counseling and 22 inmate volunteers, each of whom has received 44 hours of training in hospice philosophy and services. Criteria for their selection include an absence of disciplinary reports over the past year, but there are no restrictions on who may volunteer in terms of the seriousness of the crime committed. The volunteers are supervised by a nurse coordinator, who also gives them their assignments. When death is imminent, the hospice volunteers organize a 24-hour-a-day vigil.

Individuals who elect to receive hospice care are not required to sign advance directives, including DNR orders, but most do. Inmate law clerks in the law library have copies of these forms for terminally ill inmates who wish to use them.

Hospice inmates in the general prison population follow the regular visitation rules. Those in the infirmary can have bedside visits, including visits from other inmates that the patient has identified as "family." If the patient is dying, children under the age of 18 may visit. On one occasion, a dying patient's dog was permitted to visit. Other amenities in the infirmary include special food and drinks, a television with a VCR player, a CD player for music, and access to the health services' telephone where the patient does not have to call collect.

Palliative care is available to terminally ill inmates as well as those with other painful conditions. Patches and pills are available to individuals in the general prison population and PCA pumps are available to those in the infirmary. Most of the narcotics taken in pill form are crushed and floated in water, and all are directly observed when taken. Staff admitted that the patches had the potential of posing contraband problems but said those with patches were checked daily.

Staff indicated they were satisfied with their current end-of-life care services but would like to do more in the way of bereavement services after a patient dies, especially for institutional staff and the inmate's prison family. They hold a memorial service in the chapel when someone dies, but the infirmary staff would like to take a further step and organize a bereavement group.

Staff stated that the costs of hospice care are paid for out of the regular health services budget. They feel that hospice may save money because inmates are not dying in the hospital where care and services would be more costly.

The health care staff found no real barriers to implementing the hospice program. Once they received approval from the director of the DOC, the rest of the correctional staff fell in line. They felt that it was a real advantage that health services in the Oregon DOC are a separate division and that they report to the systemwide medical director rather than to a warden (see appendix B, "Site Visit Report: Oregon Department of Corrections").

Corrections Medical Center, Ohio

The Ohio prison system has a six-bed hospice unit located at the state's Corrections Medical Center. Two separate three-bed rooms in a ward area are considered to be hospice rooms. Eligibility criteria for the hospice unit include a prognosis of less than 6 months to live and discontinuation of any curative efforts. No criteria are related to level of functioning, type of crime, diagnosis, or any other factors. An inmate's decision to reside in the hospice unit must

be fully voluntary. On average, four patients are residing in hospice beds at any given time. There is no outpatient hospice program.

Owing to the small number of patients, no staff members have been dedicated to the hospice unit. Nursing staff are available nearby, as are other staff from the Corrections Medical Center. Inmate volunteers are also used as part of the hospice program. Stephen Ministries provides all inmate volunteers with training geared to listening. After completing this training, medical staff screen the inmate volunteers for their appropriateness for this position; the screening includes consideration of the volunteers' behavior while incarcerated. Those selected to serve as volunteers are matched with the hospice patients according to personality type. The volunteers function primarily as companions to the dying. They are prohibited from providing any care. They may interact with the families of patients and participate in predeath vigils.

Terminally ill inmates in Ohio may issue advance directives, including DNR orders, but these are not required for the inmate to receive hospice care. Generally, family input is sought before the inmate issues an advance directive. Staff report that family members occasionally try to coerce the inmate to issue a DNR order.

Once an inmate is in the hospice program, each person on the inmate's list is permitted to visit the inmate up to three times each week. When death is imminent, there is no limitation on visitation. Nonhospice patients at the Corrections Medical Center are allowed a total of four visits each week. If a general population inmate is terminally ill, the number of visits permitted is based on his or her security level, either once or twice a month. Other inmates may visit hospice patients only if they are volunteers or live in the same unit, although exceptions are made for blood relatives who are also inmates.

Because staffing is minimal at the end-of-life program at Columbus, the program operates at a low cost. It is funded from regular revenues plus the efforts of volunteers and donations. The program does receive some donations for appliances and special food. A refrigerator is provided in the hospice unit, and additional food and drink are available to these patients at all times.

Although hospice staff are generally satisfied with the end-of-life services they are able to provide, they would like to add a music therapist to the program. They also would like to be able to use a massage therapist for hospice patients but anticipate that correctional staff would offer resistance.

The primary institutional barrier encountered when the current hospice program originated was the correctional staff's opposition to relaxing the rules on visitation for a subset of the prison population. For the hospice patients, however, these changes have made a substantial difference. Hospice has also allowed for much greater family involvement in caring for the dying inmate patient (see appendix B, "Site Visit Report: Ohio Department of Rehabilitation and Correction").

Early Release Options

Although 43 of the 49 DOCs surveyed in the CJI study reported the availability of a compassionate release program for seriously ill inmates (see appendix A), the time required to process the paperwork as well as political considerations as to the type of crime the inmate committed limit it as an option. Only a few terminally ill inmates in most states are granted compassionate release (see Dubler and Heyman, 1998). Still, for inmates who meet a state's criteria for early release, the option should be aggressively pursued. Care should be taken, however, to ensure that the dying inmate has an adequate release plan that considers the interest and involvement of family and friends on the outside. Responsible release policies mandate that provisions be made for continuing care of the terminally ill in community settings (Anno, 2001, p. 206).

The process for initiating an early release request differs from state to state, as do the eligibility criteria. Those for four of the six states visited are described below.

Minnesota

If someone is gravely ill or cannot be medically managed within the MDC system, Minnesota provides for conditional medical release. In this case, the inmate is placed in an appropriate community health facility to receive needed care. The basic criteria for an inmate to be considered for conditional medical release are that the inmate has a grave health condition that is not likely to improve, is incapable of self-care, and does not pose a risk to public safety. If these conditions hold, it must be determined that the inmate's health needs can be better met by a community facility than in a prison. With conditional medical release, an inmate can be placed in the community during his or her incarceration term but can be brought back into the prison system if his or her health improves to the point that it can be managed within MDC facilities.

A request for conditional medical release of a specific inmate is initiated by health services personnel and forwarded to the Hearings and Release unit. If approved by that unit, the request is sent to central office personnel (including the commissioner). The process is not cumbersome and can be completed in a week or so if necessary (see appendix B, "Site Visit Report: Minnesota Department of Corrections").

New York

An inmate's health status or medical needs can serve as the basis for early release from NYSDOCS through either a request for executive clemency or medical parole. A Bureau of Executive Clemency runs the former; the NYSDOCS deputy commissioner for health services manages the medical parole program. Requests for medical parole for terminally ill inmates are usually initiated by the nurse administrator at the inmate's current facility of residence and forwarded to the deputy commissioner for approval and processing. The legislature and NYSDOCS commissioner have developed specific criteria for medical parole, including the following:

- The inmate must be serving an indeterminate sentence.
- The inmate must have a terminal health condition.
- The inmate must be "so debilitated or incapacitated as to be severely restricted in his or her ability to self-ambulate and to care for him or herself."
- The inmate must not be serving a sentence for "murder in the first or second degree, manslaughter in the first degree, any sex offense . . . or any attempt to commit any of these offenses."[4]

Individuals who qualify for medical parole are usually released to a subacute setting, although sometimes they are released to home with hospice care. The process generally takes about 2 months (see appendix B, "Site Visit Report: New York State Department of Correctional Services").

Ohio

ODRC has a medical parole policy that establishes procedural guidelines for the medical assessment of inmates for whom death is imminent. This medical parole policy delineates criteria for consideration of inmates' early release as if on parole. Imminent death in Ohio is defined as a predicted life expectancy of less than 6 months. A physician initiates the request for medical parole at the facility and forwards the request to the warden's office. The warden then directs the heads of social services and mental health each to generate a summary of the inmate's condition. Based on the accumulated data, the warden makes a recommendation to the regional director, who determines whether to approve or disapprove the request. If approved, the regional director forwards his or her recommendation along with the medical director's statement, a placement investigation request, and a background report to the ODRC director. The director then asks the Adult Parole Authority to conduct an investigation into an appropriate community placement, identify the terms and conditions to which the inmate will be subject if released, and provide any additional information that may assist the Governor in deciding whether to grant the medical parole request.

If the request is granted, the inmate must agree to abide by all terms and conditions, including a requirement that the inmate be medically evaluated if requested by ODRC. A supervising parole officer monitors the physical condition of the released inmate in the community. If the releasee survives for 9 months, the Governor is notified. He may choose to revoke the medical parole at this time or allow the inmate to remain on it. The Governor ultimately grants medical parole to about 40 percent of those recommended for it (see appendix B, "Site Visit Report: Ohio Department of Rehabilitation and Correction").

Oregon

An inmate's health status or medical needs can serve as the basis for early release from the Oregon prison system through either a request for executive clemency, which the inmate makes on his or her own, or through early parole release (EPR). A centralized EPR committee consists of the systemwide medical director, a medical case manager, a unit health services representative, and the inmate's assigned release counselor. Medical criteria for EPR include being elderly and incapacitated, having a serious or terminal medical condition that is incapacitating, or having a condition that prevents the inmate from participating in prison life. The EPR committee makes a recommendation regarding early release to the DOC's Executive Committee. If it agrees, the request is forwarded to the DOC director. If the director agrees, the matter is referred to the Board of Parole for a final decision. The process usually takes about 2 months. Inmates who have committed certain serious crimes are excluded from consideration for EPR (see appendix B, "Site Visit Report: Oregon Department of Corrections").

PRERELEASE PLANNING

Although the number of in-prison deaths is increasing, most inmates are released to the community at the expiration of their sentence or under some type of supervision. As a consequence, prerelease planning is particularly important for those who are elderly, who are chronically or terminally ill, or who have other special health needs. At a minimum, special needs patients should be discharged with an appointment or referral to a provider in the community to which they are returning, and they should have a supply of medication sufficient to last until the community provider is seen. Patients who are too frail or too ill to be candidates for home care will need assistance in finding placement in an appropriate community facility, such as a hospital, nursing home, or hospice.

Additional services that should be considered as part of an adequate prerelease planning program include classes on how to apply for government entitlements (e.g., Medicaid/Medicare, Social Security, welfare benefits, food stamps) and provision of a social worker or case manager to coordinate the release plan with the inmate, the family, correctional staff, parole or supervising authorities, and community health providers. With the inmate's permission, certain information about the inmate's health status should be shared with all concerned to give the inmate the best chance of succeeding on the outside.

In Minnesota, inmates who observe the rules serve two-thirds of their sentence in prison and one-third in the community under supervised release (which is similar to parole). Since most inmates in Minnesota leave prison under supervised release, all get some prerelease planning. Each facility has case managers who work with the inmates to develop acceptable release plans. In addition, a prerelease class called "Invest" is offered to any inmate who is within 20 months of release. Two 1- or 2-hour class sessions are offered each week for 6 weeks. Among the topics covered are how to apply for Medicaid/Medicare, Minnesota Care, or another medical plan when the inmates leave the prison. An information packet and applications are provided. Inmates with ongoing medical conditions are given a prescription as well as a 7-day supply of needed medications on release. Inmates with disabilities are assisted in obtaining adaptive devices as needed (see appendix

B, "Site Visit Report: Minnesota Department of Corrections").

In Oregon, all inmates receive prerelease planning and information on applying for benefits, such as Social Security, Medicaid/Medicare, disability, food stamps, etc. Each person is assigned a release counselor who assists the inmate in developing an appropriate release plan. Releases can occur from any institution, but there are also designated release centers. All inmates are supervised when released to the community.

The Oregon prison health service system also employs a half-time medical case manager who assists inmates with chronic and terminal illnesses in finding an appropriate placement in the community. The case manager makes followup appointments with community providers, may assist with finding residential housing, and works with other state agencies to obtain benefits and services for those in need. The DOC provides subsidized housing for releasees without other plans for up to 30 days. Prison physicians can provide up to 30 days of medications to an inmate upon release, although narcotics are usually restricted to a 2-week supply (see appendix B, "Site Visit Report: Oregon Department of Corrections").

CONCLUSION

Today's inmates are older, sicker, and staying longer behind bars than ever before. Managing the special needs of elderly, chronically ill, and terminally ill inmates behind bars is indeed challenging, but it is a responsibility that all prison systems must face. To meet this responsibility adequately, good communication between custody staff and health staff is paramount . Custody staff need to know what specific limitations such individuals have so they can make appropriate housing, work, school, and other program assignments. To ensure continuity of care, health staff must be informed of impending transfers. To conduct adequate prerelease planning, health staff must know the inmate's scheduled release date. Staff awareness training and good communication are especially important in programs designed to meet the needs of inmates who are dying because components of such programs often involve relaxing certain security rules, such as those regarding extra food or visitation policies. Health staff should take the lead in ensuring that their correctional colleagues are not just informed but are also active participants in the development of programs for special needs inmates.

NOTES

1. These can be obtained from NCCHC, 1300 West Belmont, Chicago, IL 60657 (phone 773–880–1460).

2. See, e.g., Puisis and Robertson (1998) and the references cited therein.

3. This discussion is based on a form developed by the Texas Department of Criminal Justice entitled "Health Summary for Classification," described in Anno, 2001.

4. N.Y. Exec. Law § 259–r (Consol. 2003).

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Ethical and Policy Considerations for the Care of Elderly and Infirm Inmates

Chapter V

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The problems posed by special needs populations raise wide-ranging concerns related to prison organization and specialized care, including ethical and moral issues, organization and administration, congregate care versus mainstreaming, staffing, bioethical issues of terminal care, compassionate release, and policymaking. Addressing policy challenges regarding elder and infirm care in a sociopolitical environment is complicated by the overlay of attitudes, behaviors, and beliefs on the part of government executives, legislators, prison managers, and staff. These encompass legitimate concerns about controlling costs; the concerns of corrections supervisors and officers, often about security risks posed by those convicted of serious crimes; and a pervasive belief that inmates are, by nature, malingerers capable of coercing and sometimes not-so-subtly intimidating health care providers.

Prison Organization and Specialized Care

The large increase of special subpopulations in prisons, such as the populations of elderly and infirm inmates, has imposed an unprecedented need for dramatic revision of current correctional policies and services. Correctional administrators confronted with this need may find the lack of information daunting. Effective response by caregivers requires significant autonomy to respond to the ever-changing needs of the patient population, which poses a direct challenge to the institutional control model. In addition, issues related to caring for special population inmates generate tensions between care and custody in a number of areas.

Special Needs Care in Prison

Prison health care systems were not originally designed to provide sophisticated and intensive care to large numbers of chronically ill and/or elderly inmates. These inmates require a standard of medical care and treatment well beyond that provided to the general inmate population. The emergence of special needs populations can upend prison system priorities by commanding greater staff attention and resources, intruding on operational imperatives of custody and control, and, ultimately, alienating the workforce—in short, becoming a radically destabilizing influence.

Ethical Medical Practice in Prison

The legal right to care in prisons is well established and not a matter of dispute. Inmates are constitutionally entitled to receive access to care for serious medical needs unimpeded by prison officials.[1] They are entitled to care that is medically ordered and to a medical judgment that is autonomous and made according to professional standards. Prison administrators beset with rudimentary health care systems, difficult-to-treat subpopulations, and the pervasive belief that inmates themselves are responsible for their own plight may find that caring for elderly and chronically ill inmates raises subtle and complex ethical issues.

Although scholarship in the field of biomedical ethics has provided a significant body of literature, little of it concerns prisons or offenders (Wishart and Dubler, 1983). The tension between care and custody in prisons has not, until very recently, been part of the biomedical ethical discussion. In the tradition of the Hippocratic oath, medical practitioners concern themselves with "doing no harm," and with comfort, reassurance, and teaching. Health care at its best is defined as respectful, considerate, and collegial among its practitioners; egalitarian, albeit within the class boundaries of one's professional credential; and, above all, *individualized*. Moreover, medical care is delivered in the context of informed choices, selectivity, and securing of patient satisfaction. On the other hand, prisons are authoritarian institutions, organized as hierarchies that tend to focus on expedient, time-honored, standardized solutions to problems. Prisons, furthermore, are defined by the imperatives of custody and control. Following the dictates of public safety and security, corrections officials concern themselves rather with "allowing no harm," with neutralizing threat, containment, and, on occasion, punishment. Prisons are alien and intimidating to the sensitivities and vulnerabilities of old age and illness. In short, providing care in prison settings poses significant challenges to ethical and effective medical practice (Anno, 2001).

The recent dramatic increase in the number of elderly inmates amplifies and aggravates conflicts that, until lately, have been largely submerged in prison culture. The physician-patient relationship in prison has become ever more formal and legal, while its essential attributes—mutual respect, patient comfort, implicit trust, and patient autonomy—cannot always be achieved. Similarly, informed choice—the ability to understand health information, to measure it against personal values and preferences, and to communicate medical decisions anonymously—is difficult to achieve in prison, where most behaviors are subject to surveillance and coercion. In prison, consent is not a transactional process. Rather, it begins and ends with procedures and paperwork—and paperwork is susceptible to being completed by staff on behalf of uncooperative inmates, often noting an "informed refusal" of care.

Although essential to an ethical physician-patient relationship, the objective of confidentiality—establishing the therapeutic alliance through trust—is not an organizational imperative in prison. Although intended for the protection of the rights and privacy of inmates, confidentiality rules can isolate the inmate and even interfere with his or her access to health care. Confidentiality and privacy in prison are often miscast as anonymity, giving inmates the opportunity to "hide out" in various niches in the prison system so as not to be stigmatized or penalized for weakness associated with old age or illness. Prison administrators frequently acquiesce to this tendency in the prison population because it contributes to the atomization of that population, an implicit objective of the control model of prison management. This also has the effects, intended or otherwise, of interfering with effective congregate health monitoring or health education and of discouraging health care providers from taking the initiative in addressing the needs of individual patients. It also tends to impede development of specialized or focused treatment centers where patients can be congregated and/or organized into cohorts for special care.

A final issue generated by the tension between care and custody has to do with moralism—the belief that those convicted of serious crimes have somehow earned their suffering, as if the pain of illness and old age in prison were a part of the inmate's just deserts. These beliefs are widespread and intense among some custody personnel and are prevalent also among health care providers. Corrections practitioners and policymakers must address the potential for inattention, indifference, even negativity among those in charge of custody and care of elderly and infirm inmates to ensure that they receive respectful and considerate care (Cohn, 1999).

Health Care Organization and Administration

Modern health care delivery systems in the free world are organized so as to clearly separate the administration of health care services from the delivery of patient care (National Commission on Correctional Health Care, 1997, p. 3). In some state prison systems, administration of health care has not been centralized. In others, it has occurred only incompletely. Even when care is centrally organized, facility health care staff frequently report that they cannot always rely on the central health services authority for assistance and encouragement in addressing and solving the health care problems and needs encountered at the facility level, even when problems arise from such broader issues as staffing or access to hospital facilities.

Health Care Dispersion

A complete and sophisticated range of services and a multidisciplinary approach to inmate patients—one that draws on the medical, nursing, dietary, psychological, social work, and pastoral disciplines—are required to deal with the increasing numbers of elderly, infirm, and ill inmates. To establish these, the same kind of centralization that governs custody needs to be adopted for health care. Most institutional health care delivery systems were not designed to meet complex care demands. Rather, they are primary care systems oriented to respond to patient demand for service. When confronted with elderly, debilitated, or chronically ill inmates, managers of decentralized systems are often driven to an ever-increasing reliance on public and community hospital-based inpatient and outpatient services at a time when community agencies show increasing resistance to providing those services to inmates.

A more serious consequence of decentralized authority is that usually no single entity exists that can determine the appropriate level of care that facilities are able to provide (i.e., determine how much complexity or severity of illness a given facility is competent to assess and manage). Moreover, such tasks as personnel recruitment and administration, purchasing, housekeeping, arranging for specialty care, fiscal management, and organization of the daily functions of an institution's medical department tend to be left to the clinicians and allied health care workers at the various facilities. Consequently, the energies of the professionals responsible at most institutions for the quality and availability of direct medical care (e.g., the medical director and registered nurse "administrator") are often diverted to tasks that would be more efficiently accomplished at a central office.

The lack of an integrated, statewide delivery system with defined levels of care and centralized administrative leadership can result in wide variation in the level of care, quality of care, and access to care. The relative quality of health care staff, more often than not, depends on the professional human resources available in the community. Similarly, the range of essential outpatient services, specialty clinics, and special programs are largely local phenomena that may bear little relationship to the needs of the target population.

Sick Call

Aside from serious accidents or other medical emergencies, access to primary care in prisons is primarily through sick call. Sick call represents a unique challenge to the delivery of primary care to the elderly or chronically ill. First, sick call operates on the assumption that the patient base is primarily healthy and that illness is the exception—an assumption that is unfounded with the elderly and chronically ill.[2] Second, inmates are often encouraged to use sick call access for trivial reasons. Inmates often seek out health care staff for assistance in obtaining patent medicines, excuses from work, extra blankets, an unscheduled shower, or even in resolving problems with shoes or a bed. Sick call becomes a way for an inmate to secure an encounter with someone equipped and motivated to give him or her individual help. This generates skepticism among

corrections health care providers and custodial personnel about whether inmates are requesting medical services for frivolous reasons. Third, sick call visits are driven by patient demand and thus tend to be episodic, discontinuous, and not under the advice and control of treatment providers. These problems and attitudes can have a profound impact on how motivated medical personnel are to explore the increasingly atypical inmate health complaints of elderly and chronically ill inmates as they age and their health fails.

Infirmaries

Many state prison infirmaries, originally designed for medical supervision of convalescing or debilitated inmates, are situated in facilities that offer only the most basic features of primary care. Day areas and visiting space are scarce. Inmates who have no medical or habilitative problems are sometimes housed there for security or protective reasons. Yet, infirmaries are often pressed into service for the elderly and the terminally and chronically ill. Thus, owing to a lack of alternatives, elderly and chronically ill inmates pass their days in these units, inappropriately sharing quarters with inmates who do not belong there.

Hospitals

Other than those few large state systems that maintain full-service correctional hospitals, correctional managers who seek to provide effective care to the elderly and chronically ill have to make do with having a significant portion of needed acute care provided outside prison at area hospitals. Daily trips for emergency department referrals or planned admissions are to be expected. Prison system executives and policymakers face the challenge of establishing satisfactory service agreements with a hospital that is staffed and equipped to provide effective care to elderly and infirm inmates. Such facilities can be difficult to find in rural locales (where state prisons are often located) because hospital resources are scarce. Also, the managers and staff at local hospitals may be unfamiliar with and/or resistant to working with inmates with special needs, so they will require special orientation and training. To ensure that appropriate medical resources are available, careful planning is needed, particularly when deciding where to admit concentrations of elderly and chronically ill inmates.

Congregate Care Versus Mainstreaming

Correctional executives face a number of policy challenges associated with the management of elderly, terminally ill, and chronically ill inmates, specifically those aspects of care that concern the conditions of daily living. Of primary concern is whether to house elderly inmates in one congregate setting or to mainstream them with the general population at various locations throughout the prison system.

Congregate housing for the elderly and infirm may be provided in dedicated, separately managed care units or in freestanding facilities. In congregate settings, care levels can be stratified according to need in subunits to which inmates are assigned according to the results of functional assessments. Many of the problems associated with fragmentation of health care services for elderly and chronically ill inmates can be avoided by locating medical staff, resources, and patients needing special services at a central location. Health care staff interested in gerontology and chronic disease care can opt for assignment to such comprehensive facilities or units and receive advanced and continuing medical education to pursue the health care career path of their choice. Arrangements for outpatient subspecialty care, hospital inpatient care, and rehabilitative and supportive services are easier to make at congregate facilities and are more cost effective owing to economies of scale. Once initial costs for capital development, equipment, and human resource development are amortized, annual operating expenditures in congregate elder care settings can be stabilized and made predictable. In a typical comprehensive care setting, such care would cost $65,000 per inmate year in

2002.[3] In contrast, attempts to replicate services for individual elderly and infirm inmates wherever they may be found in a multi-institutional system will likely introduce service duplication and gaps in care and, in addition, considerable cost instability and additional expense.

Consolidation of health services for this population succeeds in addressing the fiscal concerns of the corrections system and in meeting the daily living needs of elderly and chronically ill inmates. Economies of scale in health care staff deployment and group utilization of such services as pharmacy, dialysis, and respiratory care are achieved. Better care and more amenable and humane living conditions can be obtained at lower cost (Flynn, 1992). Moreover, long-term inmates and prison recidivists, two of the three types of elderly offenders cited by Craig-Moreland, respond well to treatment in congregate care (Neeley, Addison, and Craig-Moreland, 1997). These inmates can also be of great help in facilitating stability in the inmate population, which, in turn, will assist in managing the third type: the volatile first offender.

Congregate units also afford the policy planner an opportunity to comprehensively furnish or retrofit facilities for safe, controlled, and amenable surroundings. At a minimum, the following habilitation issues should be addressed:

- Visitation access.
- Dayroom settings.
- Alternative disciplinary procedures that take the problems of aging and terminal illness into account.
- Alternative work rules and assignments.
- Hospital access.
- Ramps and grades.
- Handrails and thresholds.
- Unobstructed sightlines.
- Physical therapy.
- Bathing facilities.
- Sound control.
- Enhanced lighting.
- Laundry services.

Some corrections executives and criminal justice practitioners nevertheless favor dispersal of elderly and infirm inmates among several institutions and their integration with other inmates. They contend that separate facilities should be established only if the number of elderly and infirm inmates warrants it. Many prison officials believe that they can successfully address habilitation concerns with wheelchair ramps, special cells, "old man" dormitories, and relaxed work rules. Those who advocate mainstreaming contend that it ensures equal access to existing prison programs. Also, the presence of older inmates in the general population is said to have a stabilizing effect. Furthermore, federal requirements for mainstreaming the elderly are easier to meet when they are housed in the general prison population, especially given that the alternative may be segregation in unsuitable settings that are not program rich.

Despite these claims, a hint of hostility is sometimes evident in the arguments of the more outspoken advocates of the geriatric mainstreaming school of thought. Prisons should not, of course, be dungeons. But, they say, adjustments to accommodate life-term, serious criminals must be justified as absolutely necessary before being implemented (Pelosi, 1997). Such attitudes are less prevalent today, as more corrections managers recognize that humane and secure care for special needs populations is more effectively and efficiently provided in congregate environments.

STAFFING FOR THE CARE OF THE ELDERLY AND INFIRM

Another argument in favor of a dedicated congregate care setting is the enriched staffing patterns

typically required for an ill and/or debilitated patient cohort. A skilled and committed nursing staff is the mainstay of a successful elderly and chronic care program. The most successful congregate care programs, some profiled in this report (e.g., "Site Visit Report: Pennsylvania Department of Corrections," appendix B), provide overall nursing staff-to-patient ratios approaching 1:6. Nursing care concentrated in skilled nursing and assisted living settings have typical professional/patient staff ratios of 1:3. When all ancillary staff are taken into account, multidisciplinary staff ratios in full-service congregate care units are often found to be close to 1:1.[4] Of course, not only the number of staff but also their quality and skills are of critical importance.

A potential barrier to appropriate special needs care for an elderly and chronically ill inmate is the lack of a carefully selected and adequately trained security staff. Not everyone who works in a correctional setting may have the aptitude, interest, or essential skills needed to manage elderly inmates. Careful recruitment of staff, followed by extensive and sustained inservice training appropriate to these issues, is essential. In matters of staff selection, a premium should be placed on attributes of sensitivity and adaptability to the unique requirements of elderly inmates. Flexibility and the capacity to work with inmates and supervisors to maintain a disciplinary system that keeps order but also accounts for the cognitive and emotional problems of the elderly and chronically ill are particularly vital. Exceptional interpersonal communication skills and the ability to be selective and adaptable in matters of enforcement are important. To that end, interdisciplinary training involving administrative personnel, line security staff, and health care staff should emphasize increased knowledge of the aging process, living with chronic illness, the social and emotional needs of the elderly, dynamics of death and dying, signs of depression, and skills for making referrals to expert care (Aday, 1994).

Terminal Care: Bioethical Issues

Although they are a direct consequence of being elderly or having a chronic or life-threatening disease, the biomedical and ethical issues associated with death and dying in prison are significantly different from the consideration of care for the elderly and chronically ill inmate and require separate discussion. The demographics of inmate aging and crime and sentencing trends inevitably will lead to dramatic increases in death from chronic and terminal illness in prison. In 2000, more than 3,200 state prison inmates died nationwide, approximately 78.3 percent of them from natural causes (Camp and Camp, 2001).

Despite the constitutional right to care, which is beyond dispute in modern correctional practice, the usual circumstances of dying in prison are very different from those in the free world. This is due, in part, to inmates' lack of freedom and to their inability to choose from among health care and other end-of-life options. For these reasons, say medical ethicists Nancy Dubler and Budd Heyman, what may be called a "good death"—one that involves reconciliation with the inevitable outcome and time with family and friends, supported by professionals in an appropriate setting—is rarely available to inmates. The dilemma is that planning and implementing a good death may run afoul of prison routines and priorities (Dubler and Heyman, 1998).

Ethical treatment of dying inmates requires making a host of policy choices, most of which depart from the usual prison norms. Important features of end-of-life options include—

- Continuing palliative care, which enables staff to assess and ameliorate patient discomfort and includes aggressive pain control.
- Enhanced opportunities for family visitation without regard to the frequency or number of visitors.

- Opportunities for reestablishing or maintaining family relationships, including telephone, mail, and family outreach, such as planned family-oriented events.
- Professional, pastoral, mental health, and social services that include assistance with finances, family problems, insurance, personal property, and other issues.
- Professional assistance with end-of-life arrangements, including advance directives; health care proxy appointments; orders not to resuscitate; and wills, trusts, and funeral arrangements.

As with care for the elderly and chronically ill in general, humane and compassionate end-of-life care is best provided in a multicare-level congregate setting that is equipped to provide terminal care along with skilled care, assisted living, and chronic care.

Compassionate Release

Compassionate release programs for state inmates came into vogue during the height of the AIDS pandemic of the late 1980s and were initiated in some jurisdictions as late as 1990. The procedures for compassionate release are often so convoluted—and involve so many levels of review and consent—that they make release of any but the most profoundly ill inmates virtually impossible. Often, compassionate release is in name only, as in cases where inmates are released only days before death and are simply transferred from prison to a community hospital so that it can be said that, at least, the patient did not die in prison. A few jurisdictions, such as California, actively employ compassionate release. In that state, as many as 35 percent of compassionate release applications are approved each year (Dubler and Heyman, 1998). Most jurisdictions, however, release proportionately far fewer inmates. Although compassionate release procedures exist in every state, many states release few prisoners or none at all. Because they are so narrowly employed, compassionate release programs are not viable end-of-life policy alternatives for the vast majority of those who might qualify.

Health Care Policymaking for Inmates

A host of questions are unanswered concerning correctional policies related to elderly and infirm inmates. Do prison systems have the capacity to medically manage and care for large numbers of elderly, chronically ill, and terminally ill inmates? Do they have the current resources to address the wide-ranging operational implications? Should elderly, chronically ill, and debilitated inmates be mainstreamed into the general population or placed in separate, specialized units? How will correctional agencies redefine their policies to better address elderly, chronically ill, and terminally ill inmates as their numbers continue to increase?

Sometimes, it is difficult to see a problem at all. As economist Aaron Wildavsky points out, "[a] *difficulty* is a problem only if something can be done about it" (Kingdon, 1997). Policy problems, by definition, must be judged to be problems appropriate for governmental action, a judgment that is heavily influenced by values and ideology. Policy analyst John Kingdon notes that, depending on one's viewpoint, the presence of *poor people* might be a problem; poverty, however, might just as easily be seen as a natural condition. It is from this framework that the challenge of geriatric prison health care policy emerges. Until now, prison health care policy has not been developed as a series of deliberate choices from among identified alternatives, or even from intentional steps in one direction but, rather, has more often been formulated on the basis of a series of defaults that stem from a lack of prospective planning.

Prison systems are "command" or "machine" bureaucracies dedicated to the safety of the public

and the prison staff. As long as the work remains predictable and the environment remains stable, they function without undue stress or serious incident. This, and the isolation of prisons from the community at large, reinforces inflexible prison management practices. Over the short term, innovation is often discouraged as too risky. For that reason, a disciplined, objective approach is needed, one that (as articulated by policy analyst Stephen Toulmin and later elaborated by William Dunn) seeks to determine what prisoner old age and infirmity actually *are*; what is *right*, both for these inmates and for the rest of the correctional system; and what *to do* about their growing presence and insistent need (Dunn, 1994). This can be a daunting task, given the limitations discussed thus far. Still, as evidenced by some of the model programs presented in this work, progress is possible. In the most successful of these programs, policy formulation was a preeminent value: A problem was recognized, a solution was at hand, the policy change was compelling, and the potential constraints were not prohibitive. Care in these custody settings improved substantially, making these systems safer, stable, and more humane.

NOTES

1. The landmark case establishing a constitutional right to prison medical care is *Estelle* v. *Gamble*, 429 U.S. 97(1976), which held that deliberate indifference to a prisoner's medical needs violated the eighth amendment's prohibition against cruel and unusual punishment.

2. This is also a basic assumption in the military, which also uses sick call, and thus is often cited by prison executives as validating its use in prison. However, chronically or otherwise seriously ill military personnel are usually discharged, whereas the prison system cannot employ that remedy.

3. Personal communication from Fredric Rosemeyer, Superintendent, SCI Laurel Highlands, Somerset, PA, to James E. Lawrence, November 8, 2001.

4. Ibid.

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Conclusion

Chapter VI

Chapter VI

Conclusion

To be consistent with basic tenets of humaneness and to comply with constitutional standards, prison systems must provide special accommodations that meet the medical and security needs of elderly inmates and inmates with chronic and terminal illnesses.

Program, Housing, and Treatment Considerations

Most individuals who are elderly, chronically ill, or terminally ill require special accommodation in their housing and program assignments because of their physical conditions.

Elderly Inmates

Many older inmates suffer from chronic illnesses, including heart disease, hypertension, diabetes, and chronic obstructive lung disease. They also are subject to conditions that accompany the normal aging process, including loss of vision, impaired hearing, sleep disturbances, incontinence, mental confusion, and gastrointestinal disorders. A number of older inmates are healthy and do not require special housing. They can be placed in any housing area that is appropriate to their custody classification. Others may require placement in a nursing home environment or an infirmary. When determining appropriate work assignments, program assignments, and recreational activities for older inmates, it is important to consider such physical limitations as hearing and vision loss, reduced physical strength, and the inability to stand for long periods of time.

Chronically Ill Inmates

By definition, chronic illnesses are either ongoing or recurring. Individuals with such chronic diseases as asthma, AIDS, heart disease, diabetes, hypertension, and hepatitis C, and those with certain permanent physical conditions (e.g., paraplegia), need to be monitored closely to maintain their health status or slow the progression of their disease or condition. It is important to identify the number of inmates in a system with specific chronic conditions. Although this may seem obvious, health care staff in many correctional agencies do not know at any given time precisely how many inmates they have with specific chronic conditions.

People with chronic conditions generally are among the sickest of the prison population and should be placed in facilities that have the highest level of health services available. Such services include around-the-clock emergency services and nursing care, infirmary care, and specialty care.

Terminally Ill Inmates

Terminally ill inmates also need to be placed in facilities with the highest level of available health services. These inmates require palliative care and frequent access to specialty services. They tend to cycle in and out of infirmaries and hospitals. As their conditions worsen, they often will require around-the-clock nursing services. Inevitably, they reach a point

where medicine can offer little more. The primary health goal then shifts from curing illness to keeping the patient comfortable and pain free and helping the inmate adjust to imminent death. Hospice services are becoming increasingly common for terminally ill people in prisons as well as in the community. Terminally ill inmates need to be kept humanely and comfortably occupied. The availability of books, music, and, above all, companionship can elevate the dying patient's mental outlook.

THE FUNCTIONAL ASSESSMENT

The correctional managers who are now being asked to meet the needs of a growing population of elderly inmates and inmates who exhibit a variety of complex medical problems must properly identify these inmates' needs immediately upon their entry into the prison system. Early identification will result in more effective and efficient care for special needs inmates and will reduce court challenges and liability risks for the prison system.

Medical staff in most prison systems perform an intake history or screening exam shortly after the inmate arrives at a reception center. The purpose of this initial screening is to identify the individuals whose medical needs must be addressed immediately, usually on the same day as the screening. Pitfalls in the intake screening process may result in the development of an inaccurate or incomplete plan for the inmate. These problems can interfere with the inmate's receiving necessary and effective treatment and create serious potential liabilities for the corrections agency. Several strategies exist for corrections systems to plan for, identify, and address inmate special needs. Two effective strategies are highlighted in this report. The medical history and physical examination are critical elements in determining and responding to functional needs both inside and outside correctional settings. In the free world, however, many hospitals and health care organizations also employ an effective functional assessment tool (the SF–36) that attempts to determine both how the patient perceives his or her own functioning and how that current perception differs from past perceptions. This tool also may be used to determine whether the patient's perception of his or her health status corresponds with the health care provider's perception. Unfortunately, many correctional agencies have not yet incorporated this type of assessment into their intake medical protocols.

POLICY CONSIDERATIONS

Prison health care systems are not designed to provide sophisticated and intensive care to large numbers of chronically ill people. Providing for elderly and chronic care inmates requires a standard of medical care and treatment well beyond that provided to the general inmate population. Many issues associated with managing special needs inmates affect policy. Issues to be considered include staffing for the care of elderly and infirm inmates, compassionate release, health organization and administration, and congregate care versus mainstreaming.

Regardless of the accommodations and services that are made available to prisoners within institutions, correctional practitioners have to be mindful that most inmates are released to the community or under some type of supervision at the expiration of their sentence. As a consequence, prerelease planning is particularly important for those who are elderly, chronically ill, or terminally ill or who have other special health needs.

Today's inmates are older, sicker, and staying in prison longer than ever before. Managing the special needs of elderly, chronically ill, and terminally ill inmates poses many challenges but is a responsibility that all prison systems must face. It requires highly effective intake assessments; appropriate housing, programming, and treatment; and creative and thoughtful policies.

Criminal Justice Institute Survey:

Managing the Needs of Aging Inmates and Inmates With Chronic and Terminal Illnesses

April 2001

Appendix A

Appendix A

Managing the Needs of Aging Inmates

Does Your Agency Have a Definition for When an Inmate Is Considered "Elderly"?

Agency	Definition of Elderly	Age Elderly	No. Inmates Age 50+ As of 12/31/00
Alabama			2,006
Alaska[1]	✓	50	456
Arizona			2,399
Arkansas[2]			860
California			12,215
Canada[3]	✓	50	1,544
Colorado[4]	✓	65	1,406
Connecticut			813
Delaware			277
District of Columbia	✓	65	425
Federal[5]			13,872
Florida	✓	50	5,873
Guam			16
Idaho	✓	50	220
Illinois			2,392
Indiana[6]			1,619
Iowa			477
Kansas[7]			727
Kentucky			1,541
Louisiana			3,091
Maryland	✓	60	1,253
Massachusetts[8]	✓	60	1,219
Michigan[9,10]	✓	60	4,380
Minnesota	✓	55	374
Mississippi[11]			1,170
Missouri			2,054
Montana	✓	55	276
Nebraska			294
New Hampshire	✓	55	281
New Jersey			1,854
New Mexico	✓	50	52
New York			5,111
New York City			674
North Carolina	✓	50	
North Dakota	✓	62	65
Ohio	✓	50	
Oklahoma			946
Oregon	✓	55	1,076
Pennsylvania			3,613
Philadelphia			249
Rhode Island			209

(continued on next page)

Does Your Agency Have a Definition for When an Inmate Is Considered "Elderly"? (continued)

Agency	Definition of Elderly	Age Elderly	No. Inmates Age 50+ As of 12/31/00
South Carolina[12]	✓	55	1,433
South Dakota[13]		60	202
Tennessee	✓	55	708
Texas	✓	55	
Utah			465
Virginia	✓	55	2,474
Washington			1,378
West Virginia	✓	50	372
Total/Average	**22**	**55**	**1,835**
% of Total	**44.9**		

1. Definition of elderly is 50 years of age and suffering from one or more chronic illnesses and/or physical/mental disabilities.
2. Depends on degree of debility; Arkansas prisons have housed 70-year-olds who were not considered elderly and 40-year-olds who were.
3. Canada does not use the term "elderly" but rather "older offenders."
4. Over 65 years of age and are unable to care for themselves.
5. 13,872 represents the number of inmates age 51 or older.
6. As of 1/2/01.
7. NCCHC uses age 55 in its definition of elderly, so Kansas DOC uses this age breakdown for accreditation. This definition is also used in medical planning discussions.
8. Varies by purpose; however, usually 60 years.
9. Definition of elderly: An inmate who has reached 60 years of age and does not have a debilitative chronic illness or disability.
10. As of 2/1/01.
11. No state statute.
12. In jurisdiction; 1,399 in institutions.
13. This is the age SD DOC would consider to be elderly, but there is no definition per se.

Does Your Agency Provide Supervised Recreational Programs Specifically Designed for Older and Elderly Inmates?

Agency	"Yes"
Alabama	
Alaska	
Arizona	✓
Arkansas	
California	
Canada	
Colorado	✓
Connecticut	
Delaware	
District of Columbia	
Federal[1]	
Florida	No answer
Guam	
Idaho	
Illinois	
Indiana	
Iowa	
Kansas	No answer
Kentucky	✓
Louisiana	✓
Maryland	
Massachusetts	
Michigan	✓
Minnesota	
Mississippi	✓
Missouri	
Montana	✓
Nebraska	
New Hampshire	✓
New Jersey	
New Mexico	
New York	
New York City	
North Carolina	✓
North Dakota	No answer
Ohio	✓
Oklahoma	
Oregon	
Pennsylvania	✓
Philadelphia	✓
Rhode Island	
South Carolina	
South Dakota	✓
Tennessee	
Texas	
Utah	
Virginia	✓
Washington	
West Virginia	✓
Total	**15**
% of Total	**30.61**

1. Games such as Bingo are available but are not specifically designed for the elderly population.

Do You Designate Special Housing Areas for Elderly Inmates Within Your Prisons?

Agency	Special Housing Areas Designated	Discrete Subpopulation?	At What Age?
Alabama			
Alaska			
Arizona[1]			
Arkansas	✓		
California[2]			
Canada			
Colorado[3]			
Connecticut			
Delaware			
District of Columbia	✓		
Federal			
Florida			
Guam			
Idaho[4]	✓		
Illinois			
Indiana			
Iowa			
Kansas			
Kentucky	No answer		
Louisiana[5]	✓	✓	
Maryland[6]			
Massachusetts			
Michigan	✓		
Minnesota[7]			
Mississippi[8]	✓	✓	50
Missouri	✓		
Montana			
Nebraska			
New Hampshire	✓		
New Jersey			
New Mexico	✓	✓	55
New York[9]	✓		
New York City			
North Carolina			
North Dakota			
Ohio[10]	✓	✓	
Oklahoma			
Oregon			
Pennsylvania[11]	✓		
Philadelphia			
Rhode Island[12]			
South Carolina			
South Dakota[13]			

Do You Designate Special Housing Areas for Elderly Inmates Within Your Prisons? (continued)

Agency	Special Housing Areas Designated	Discrete Subpopulation?	At What Age?
Tennessee		✓	55
Texas[14]	✓	✓	
Utah			
Virginia	✓		
Washington			
West Virginia	✓	✓	50
Total	**15**	**7**	
% of Total	**30.61**	**14.29**	

1. Not by operations policy.
2. Housing is based on medical needs and security, not age.
3. Only if hospice care is needed.
4. When medically necessary.
5. Based on physical condition.
6. Although special housing units are not specifically designated, elderly inmates are usually assigned to specific areas of specific institutions.
7. Only if they have chronic medical needs.
8. When medically necessary.
9. Based on disability/care needs.
10. Based on inmate's request or physical condition.
11. As needed.
12. Housing depends on function.
13. Not exclusively for elderly inmates.
14. Depends on mobility and general health.

Do You Designate Facilities for Elderly Inmates Within Your Prisons?

Agency	Special Facilities Designated?	Age Eligible for Referral	No. of Special Facilities in System
Alabama[1]	✓		1
Alaska			
Arizona[2]			
Arkansas	✓	Any	3
California			
Canada			
Colorado			
Connecticut			
Delaware			
District of Columbia			
Federal			
Florida	✓	50	1
Guam			
Idaho			
Illinois			
Indiana			
Iowa			
Kansas	No answer		
Kentucky			
Louisiana[3]	✓		1
Maryland			
Massachusetts			
Michigan	✓		1
Minnesota[4]			
Mississippi[5]	✓	50	3
Missouri			
Montana[6]	✓		1
Nebraska			
New Hampshire	✓	55	1
New Jersey			
New Mexico	✓	55	1
New York			
New York City			
North Carolina			1
North Dakota			
Ohio[7]	✓		1
Oklahoma			
Oregon			
Pennsylvania[8]	✓		3
Philadelphia			
Rhode Island			
South Carolina			
South Dakota			

Do You Designate Facilities for Elderly Inmates Within Your Prisons? (continued)

Agency	Special Facilities Designated?	Age Eligible for Referral	No. of Special Facilities in System
Tennessee	✓	55	1
Texas	✓	60	8
Utah			
Virginia	✓	Any	1
Washington			
West Virginia			
Total/Average	**14**		**2**
% of Total	**29**		

1. Age is variable.
2. Only according to medical need.
3. Based on physical condition.
4. MN DOC has one unit designated for elderly inmates with chronic medical needs.
5. When medically necessary.
6. Based on handicap.
7. Based on inmate's physical condition.
8. As medically needed. Three special facilities as of July 2001.

Are Older Inmates in Your Agency Scheduled for Annual Comprehensive Health Appraisals?

Agency	"Yes"	At What Age?
Alabama	✓	50
Alaska	✓	50
Arizona	✓	50
Arkansas[1]	✓	64
California		
Canada		
Colorado	✓	50
Connecticut		
Delaware	✓	50
District of Columbia	✓	
Federal	✓	50
Florida	✓	
Guam		
Idaho	✓	50
Illinois		
Indiana[2]	✓	
Iowa	✓	50
Kansas	No answer	
Kentucky	✓	
Louisiana	✓	45
Maryland		
Massachusetts	✓	50
Michigan[3]	✓	
Minnesota	✓	50
Mississippi	✓	50
Missouri	✓	50
Montana	✓	40
Nebraska	✓	50
New Hampshire[4]	✓	
New Jersey[5]		
New Mexico	✓	50
New York	✓	50
New York City	✓	40
North Carolina	✓	50
North Dakota	✓	
Ohio	✓	50
Oklahoma	✓	40
Oregon	✓	55
Pennsylvania	✓	50
Philadelphia[6]	✓	
Rhode Island	✓	40
South Carolina		
South Dakota[7]		

Are Older Inmates in Your Agency Scheduled for Annual Comprehensive Health Appraisals? (continued)

Agency	"Yes"	At What Age?
Tennessee	✓	65
Texas		
Utah	✓	
Virginia		
Washington	✓	40
West Virginia	✓	50
Total/Average	**37**	**49**
% of Total	**76**	

1. Unless other chronic illnesses are present.
2. All inmates receive annual health appraisals.
3. All inmates receive annual health exams.
4. In accordance with ACA Standards.
5. Every 2 years for age 50 and older.
6. All inmates have an annual physical exam.
7. All inmates age 40 and older receive a health appraisal every 2 years.

What Assistive Devices Are Provided for Geriatric Inmates?

Agency	Geriatric Chairs	Geriatric Beds	Walkers/ Canes	Hearing Aids	Dentures	Eyeglasses	Supportive Devices	Warmer Clothing	Extra Blankets
Alabama	✓	✓	✓	✓	✓	✓	✓		✓
Alaska		✓	✓	✓	✓	✓	✓	✓	✓
Arizona			✓	✓	✓	✓	✓	✓	✓
Arkansas	✓	✓	✓	✓	✓	✓	✓	✓	✓
California			✓	✓	✓	✓	✓	✓	✓
Canada	✓		✓	✓	✓	✓	✓	✓	✓
Colorado	✓	✓	✓	✓	✓	✓	✓	✓	✓
Connecticut	✓		✓	✓	✓	✓	✓	✓	✓
Delaware	✓	✓	✓	✓	✓	✓	✓	✓	✓
District of Columbia			✓	✓	✓	✓	✓	✓	✓
Federal	✓	✓	✓	✓	✓	✓	✓	✓	✓
Florida	✓	✓	✓	✓	✓	✓	✓	✓	✓
Guam			✓			✓			
Idaho	✓		✓	✓	✓	✓	✓	✓	✓
Illinois	✓	✓	✓	✓	✓	✓	✓	✓	✓
Indiana	✓	✓	✓	✓	✓	✓	✓	✓	✓
Iowa	✓		✓	✓	✓	✓	✓	✓	✓
Kentucky	✓	✓	✓			✓	✓		✓
Louisiana	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maryland			✓	✓		✓	✓		
Massachusetts	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michigan	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minnesota			✓	✓	✓	✓	✓	✓	✓
Mississippi	✓	✓	✓	✓	✓	✓		✓	✓
Missouri	✓	✓	✓	✓	✓	✓	✓	✓	✓
Montana			✓	✓	✓	✓	✓	✓	✓
Nebraska	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Hampshire			✓	✓	✓	✓	✓	✓	
New Jersey	✓		✓	✓	✓	✓	✓	✓	✓
New Mexico			✓	✓	✓	✓	✓	✓	✓
New York	✓	✓	✓	✓	✓	✓	✓	✓	✓
New York City			✓	✓	✓	✓	✓		✓
North Carolina	✓	✓	✓	✓	✓	✓	✓	✓	✓
North Dakota			✓	✓	✓	✓	✓	✓	✓
Ohio	✓	✓	✓	✓	✓	✓	✓	✓	
Oklahoma			✓	✓	✓	✓	✓		
Oregon	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pennsylvania	✓	✓	✓	✓	✓	✓	✓	✓	✓
Philadelphia		✓	✓	✓	✓	✓		✓	✓
Rhode Island			✓	✓	✓	✓	✓	✓	✓
South Carolina	✓	✓	✓	✓	✓	✓	✓	✓	✓

What Assistive Devices Are Provided for Geriatric Inmates? (continued)

Agency	Geriatric Chairs	Geriatric Beds	Walkers/ Canes	Hearing Aids	Dentures	Eyeglasses	Supportive Devices	Warmer Clothing	Extra Blankets
South Dakota			✓	✓	✓	✓	✓	✓	✓
Tennessee	✓	✓	✓	✓	✓	✓	✓	✓	✓
Texas	✓	✓	✓	✓	✓	✓	✓	✓	✓
Utah	✓	✓	✓	✓	✓	✓	✓	✓	✓
Virginia	✓	✓	✓	✓	✓	✓	✓	✓	✓
Washington	✓		✓	✓	✓	✓	✓	✓	✓
West Virginia			✓	✓	✓	✓	✓		
Total	**31**	**27**	**48**	**46**	**45**	**48**	**45**	**41**	**42**
% of Total	**65**	**56**	**100**	**96**	**94**	**100**	**94**	**85**	**87**

Appendix A

Managing the Needs of Terminally Ill Inmates

Does Your Agency Operate a Hospice Unit?

Agency	Hospice Unit?	Is It a Separate Unit?	Part of Infirmary?	Part of Housing Unit?	An Outpatient Program?	No. of Beds
Alabama						
Alaska						
Arizona						
Arkansas[1]						
California[2]	✓	✓				15
Canada[3]						
Colorado	✓		✓			1–4
Connecticut	✓		✓		✓	3–4
Delaware						
District of Columbia						
Federal[4]	✓		✓	✓	✓	
Florida						
Guam	✓		✓			1
Idaho						
Illinois	✓		✓			4
Indiana						
Iowa	✓	✓	✓	✓	✓	
Kansas[5]						
Kentucky	✓	✓	✓		✓	50
Louisiana	✓		✓			44
Maryland	✓		✓			4
Massachusetts						
Michigan						
Minnesota	✓		✓			39
Mississippi[6]	✓		✓			4–8
Missouri	✓		✓			
Montana						
Nebraska	✓		✓		✓	5
New Hampshire[7]	✓		✓			
New Jersey[8]						
New Mexico	✓		✓			34
New York[9]						
New York City	✓	✓			✓	6
North Carolina	✓		✓			
North Dakota						
Ohio	✓					6
Oklahoma[10]						
Oregon[11]	✓		✓	✓	✓	21
Pennsylvania	✓	✓	✓			3
Philadelphia	✓		✓			
Rhode Island[12]						
South Carolina[13]	✓		✓	✓	✓	
South Dakota[14]						

Does Your Agency Operate a Hospice Unit? (continued)

Agency	Hospice Unit?	Is It a Separate Unit?	Part of Infirmary?	Part of Housing Unit?	An Outpatient Program?	No. of Beds
Tennessee						
Texas[15]	✓		✓			24
Utah						
Virginia[16]						
Washington						
West Virginia	✓		✓			
Total	**25**	**5**	**22**	**4**	**8**	

1. Arkansas DOC operates a licensed hospital, but it has no specific designation as hospice.
2. 17 male, 8 female, table lists 15 beds.
3. Palliative care patients are sent to a hospital when needed.
4. The hospice unit is part of the inpatient area of the infirmary. The number of beds varies.
5. Kansas DOC has plans for a hospice unit underway.
6. Available beds as needed.
7. Available beds as needed.
8. NJ DOC is in the process of developing a hospice unit.
9. NY DOC has hospice services available to patients who need them.
10. A pilot program is underway.
11. Oregon DOC's hospice is a philosophy, not a specific designation.
12. RI DOC does not have a specific hospice unit; however, special provisions can be made with outside facilities.
13. No number designated.
14. SD DOC contracts health services. Terminally ill patients can be moved to a medical facility.
15. The number of beds can expand on an as-needed basis.
16. No separate hospice unit; however, hospice care is provided in major infirmaries.

If Your Agency Does Operate a Hospice Unit, Does the Unit Have a Dedicated Staff?

Agency	Dedicated Staff?	What Are Their Job Classifications/Titles?
California	3	Male Unit: RN, Medical Technical Assistant, Certified Nursing Assistants Female Unit: RN, Certified Nursing Assistant
Colorado	3	Nurses, Mental Health Staff, Chaplain
Connecticut		
Federal[1]		
Guam		
Illinois		
Iowa	3	Deputy Warden of Treatment, Physician, Psychologist, RN, Treatment Director, Pharmacist, Counselor, Correctional Officer, Dietician, Chaplain, Activity Director
Kentucky	3	Physician, RNs, LPNs, Caseworker
Louisiana	3	RN, Social Workers, Nurses
Maryland		
Minnesota	3	RNs, LPNs, Social Workers, and Physicians Provided Under Contract With Vendor
Mississippi		
Missouri	3	RNs, LPNs, Physicians, Psychologists, Caseworker, Chaplain
Nebraska		
New Hampshire		
New Mexico		
New York City		
North Carolina		
Ohio		
Oregon		
Pennsylvania	3	RN, LPN, Counselor
Philadelphia	3	Nurse Managers, Physicians, Psychiatrist, Social Worker, Correctional Officer
South Carolina	3	Social Workers
Texas	3	Physician, Chaplain, Nurses, Social Workers, Psychologist
West Virginia[2]		
Total	**11**	

1. Chemotherapy and medical/surgical nurses who have continuing education in this area are routinely scheduled to work with these patients.
2. Medical services are handled on a contract basis.

Are There Provisions for Compassionate Release?

Agency	Provisions?	Who Initiates the Request?	Who Makes Final Decision?	No. of Requests	No. Granted
Alabama	✓	Inmate's Family	Parole Board	5	1
Alaska	✓	Medical	Parole Board	2	2
Arizona	✓	Staff through Deputy Warden	Director	22	0
Arkansas	✓	Primary Care Physician	Parole Board or Governor	7	4
California	✓	Health Care Man./Chief Medical	Superior Court	6	1
Canada[1]	✓	Institutional Parole Office	National Parole Board	3	1
Colorado[2]	✓	Team Approach	Parole Board	N/A	
Connecticut	✓	Clinical Director	Board of Parole	5	1
Delaware	✓	DOC/Warden	Parole Board/Judge	5	3
District of Columbia	✓	Health Care Providers	Parole Board		
Federal	✓	Warden	Agency Director	38	34
Florida	✓	Facility Chief Health Officer	Parole Commission	31	17
Guam	✓	Inmate and Facility Physician	Parole Board	0	0
Idaho	✓	Case Worker/Medical	Pardons and Parole Comm.	12	2
Illinois					
Indiana	✓	Commissioner	Governor	0	0
Iowa					
Kansas					
Kentucky[3]	✓	Physician	Parole Board	33	15
Louisiana	✓	Warden	Secretary/Parole Board	12	12
Maryland[4]	✓	Physician	Parole Commission	55	16
Massachusetts					
Michigan					
Minnesota[5]	✓	Health Services Administrators	Commissioner/Designee	5	5
Mississippi					
Missouri	✓	Inmate, Staff, Physician	Board of Prob. and Parole	66	19
Montana[6]	✓	Family, Inmate, Physician	Parole Board		
Nebraska	✓	Inmate Facilitated by Medical Staff	Parole Board	2	1
New Hampshire	✓	Div. of Med. and Psychiatric Services	Commissioner	3	3
New Jersey	✓	Inmate/Rep./Admin.	Parole Board/Governor	13	1
New Mexico	✓	Inmate/Case Worker/Medical	Parole Board	10	8
New York	✓	No One Initiating Source	Parole Agency	21	12
New York City	✓	Legal and Medical	District Attorney and Judge	28	27
North Carolina[7]	✓	Physician, Family, or Custody	Governor		0
North Dakota	✓	Medical Staff	Parole Board	1	0
Ohio	✓	Warden	Governor or Parole Board	9	7
Oklahoma	✓	Physicians	Governor	59	8
Oregon[8]	✓	Health Services	Parole Board	6	3
Pennsylvania[9]	✓	Corrections Health Care Administrator	Court Order		
Philadelphia	✓	Physician and Admin. Diagnostic Manager	Judge	12	11
Rhode Island[10]	✓	Inmate's Attending Physician	Parole Board	8	4
South Carolina	✓	Attending Physician with Patient	Director		2
South Dakota[11]	✓	Inmate, Family, Staff, or Health Services	Governor	4	3

Are There Provisions for Compassionate Release? (continued)

Agency	Provisions?	Who Initiates the Request?	Who Makes Final Decision?	No. of Requests	No. Granted
Tennessee	✓	Institutional Physician	Commissioner	2	1
Texas[12]	✓	Inmate, Family, Staff	Board of Pardons and Parole	115	49
Utah	✓	Clinical Director	Board of Pardons		
Virginia[13,14]	✓	Clinical Director	Board of Pardons or Governor	25	7
Washington	✓	Physician	DOC Secretary	24	4
West Virginia	✓	Inmate	Governor	15	2
Total/Average	**43**			**18**	**8**
% of Total	**87.76**				

1. From those eligible for release.
2. Team includes medical doctor, mental health worker, case manager, clinical team leader.
3. During 2000.
4. FY 2000.
5. FY 2000.
6. MSP allows medical paroles but not compassionate releases.
7. Actual number unknown.
8. Two pending.
9. Unknown.
10. Approximately.
11. One still pending.
12. 781 referrals, 666 not processed, 115 eligible.
13. If parole eligible; if not, Governor makes the decision.
14. Clemency requests to Governor. Parole requests unknown.

In Your Agency, Do Terminally Ill Inmates Issue Advance Directives? DNR Orders?

Agency	Advance Directives?	DNR Orders?
Alabama[1]		✓
Alaska	✓	✓
Arizona	✓	✓
Arkansas	✓	✓
California[2]		✓
Canada	✓	✓
Colorado	✓	✓
Connecticut[3]		✓
Delaware	✓	✓
District of Columbia		
Federal	✓	✓
Florida	✓	✓
Guam		✓
Idaho	✓	✓
Illinois	✓	✓
Iowa	✓	✓
Indiana	✓	✓
Kansas	✓	✓
Kentucky	✓	✓
Louisiana	✓	✓
Maryland	✓	✓
Massachusetts[4]	✓	
Michigan	✓	✓
Minnesota		✓
Mississippi		✓
Missouri	✓	✓
Montana		✓
Nebraska	✓	✓
New Hampshire	✓	✓
New Jersey	✓	✓
New Mexico	✓	✓
New York	✓	✓
New York City		
North Carolina	✓	✓
North Dakota	✓	✓
Ohio	✓	✓
Oklahoma[5]		
Oregon	✓	✓
Pennsylvania[6]	✓	
Philadelphia		
Rhode Island		
South Carolina	✓	✓
South Dakota	✓	✓

In Your Agency, Do Terminally Ill Inmates Issue Advance Directives? DNR Orders? (continued)

Agency	Advance Directives?	DNR Orders?
Tennessee	✓	✓
Texas	✓	✓
Utah	✓	✓
Virginia	✓	✓
Washington		✓
West Virginia		✓
Total	**35**	**42**
% of Total	**71.43**	**85.71**

1. Doctor discusses and patient signs.
2. Policy is being finalized for final approval.
3. Staff members issue advance directives, not the inmates.
4. Not in prison but maybe in hospital.
5. Legislation is pending.
6. Per physician.

Are Special Foods and Beverages Available to Terminally Ill Inmates?

Agency	Special Foods/Drinks	Any Restrictions?
Alabama[1]	✓	✓
Alaska[2]	✓	✓
Arizona[3]	✓	
Arkansas[4]	✓	✓
California[5]	✓	✓
Canada	✓	
Colorado[6]	✓	✓
Connecticut	✓	
Delaware	✓	
District of Columbia	✓	
Federal	✓	
Florida	✓	
Guam	✓	
Idaho[7]	✓	✓
Illinois	✓	
Indiana[8]	✓	
Iowa	✓	
Kansas	✓	
Kentucky	✓	
Louisiana	✓	
Maryland	✓	
Massachusetts	✓	
Michigan	✓	
Minnesota	✓	
Mississippi	✓	
Missouri	✓	
Montana	✓	
Nebraska[9]	✓	✓
New Hampshire	✓	
New Jersey[10]	✓	
New Mexico	✓	
New York	✓	
New York City	✓	
North Carolina	✓	
North Dakota	✓	
Ohio[11]	✓	✓
Oklahoma		
Oregon	✓	
Pennsylvania[12]		
Philadelphia		
Rhode Island	✓	
South Carolina	✓	
South Dakota	✓	

Are Special Foods and Beverages Available to Terminally Ill Inmates? (continued)

Agency	Special Foods/Drinks	Any Restrictions?
Tennessee	✓	
Texas		
Utah[13]	✓	✓
Virginia	✓	
Washington	✓	
West Virginia	✓	
Total	**45**	**9**

1. For weight loss as ordered by site physician.
2. Restrictions are limited to the individual and his/her medical diagnosis and assessment.
3. Diets are developed on medical advisement of needs prior to determination of terminally ill status.
4. Diet trays only available at meal times, or as ordered by medical staff.
5. For inpatients in licensed health care facility, meals are available at standard meal times; if some items are held in unit refrigerator, nursing staff may provide at a later time. Nourishment and supplements are provided for inmates to consume when they choose.
6. Special dietary needs are accommodated by the facility, and the facility may also order canteen items not available to offenders in the infirmary. Nursing staff monitor the food from the canteen to prevent theft and overeating.
7. Food or healthy choice, extra portions, etc.
8. As part of a special diet for specific illnesses only.
9. By medical order only.
10. As medically indicated.
11. Food must be prepared by inmate dining room staff.
12. Very occasional, with exception of Jello or puddings.
13. Usually at pill line.

Appendix A

Managing the Needs of Chronically Ill Inmates

How Are Chronic Illnesses Discovered in Your Agency?

Agency	Reception Health Screening	Reception Health Appraisal	Sick Call	Annual Health Appraisal	Self-Referral
Alabama	✓	✓	✓	✓	✓
Alaska	✓	✓	✓	✓	✓
Arizona	✓	✓	✓	✓	✓
Arkansas	✓	✓	✓	✓	✓
California	✓	✓	✓	✓	✓
Canada	✓				✓
Colorado	✓	✓	✓	✓	✓
Connecticut	✓	✓	✓	✓	✓
Delaware	✓	✓	✓	✓	✓
District of Columbia	✓	✓	✓	✓	✓
Federal	✓	✓	✓	✓	✓
Florida	✓	✓	✓	✓	✓
Guam	✓	✓	✓	✓	✓
Idaho	✓	✓	✓	✓	✓
Illinois	✓	✓	✓	✓	✓
Indiana	✓	✓	✓	✓	✓
Iowa	✓	✓	✓	✓	✓
Kansas	✓	✓	✓	✓	✓
Kentucky	✓	✓	✓	✓	✓
Louisiana	✓	✓	✓	✓	✓
Maryland	✓	✓	✓	✓	✓
Massachusetts	✓	✓	✓	✓	✓
Michigan	✓	✓	✓	✓	✓
Minnesota	✓	✓	✓	✓	✓
Mississippi	✓	✓	✓	✓	✓
Missouri	✓	✓	✓	✓	✓
Montana	✓	✓	✓	✓	✓
Nebraska	✓	✓	✓	✓	✓
New Hampshire		✓	✓	✓	✓
New Jersey	✓	✓	✓	✓	✓
New Mexico	✓	✓	✓	✓	✓
New York	✓	✓	✓	✓	✓
New York City	✓	✓	✓		✓
North Carolina	✓	✓	✓	✓	✓
North Dakota	✓	✓	✓	✓	✓
Ohio	✓	✓	✓	✓	✓
Oklahoma	✓	✓	✓	✓	✓
Oregon	✓	✓	✓	✓	✓
Pennsylvania	✓	✓	✓	✓	✓
Philadelphia	✓	✓	✓	✓	✓
Rhode Island	✓	✓	✓	✓	✓
South Carolina	✓	✓	✓	✓	✓
South Dakota	✓	✓	✓		✓

(continued on next page)

How Are Chronic Illnesses Discovered in Your Agency? (continued)

Agency	Reception Health Screening	Reception Health Appraisal	Sick Call	Annual Health Appraisal	Self-Referral
Tennessee	✓	✓	✓	✓	✓
Texas	✓	✓	✓	✓	✓
Utah	✓	✓	✓	✓	✓
Virginia	✓	✓	✓	✓	✓
Washington	✓	✓	✓	✓	✓
West Virginia	✓	✓	✓	✓	✓
Total	**48**	**48**	**48**	**46**	**49**
% of Total	**98.0**	**98.0**	**98.0**	**93.9**	**100.0**

Do Chronically Ill Inmates Have Access to a Congregate Activity Place Separate From the General Population of Inmates?

Agency	"Yes"
Alabama	
Alaska	
Arizona	
Arkansas[1]	✓
California	
Canada	
Colorado	
Connecticut	
Delaware	
District of Columbia	✓
Federal[2]	
Florida	
Guam	
Idaho[3]	✓
Illinois	
Indiana	
Iowa	✓
Kansas	
Kentucky[4]	✓
Louisiana	
Maryland	
Massachusetts	
Michigan	✓
Minnesota	✓
Mississippi[5]	✓
Missouri	✓
Montana[6]	
Nebraska	
New Hampshire	
New Jersey	
New Mexico	
New York	
New York City	✓
North Carolina	
North Dakota	
Ohio[7]	✓
Oklahoma	
Oregon	✓
Pennsylvania	
Philadelphia	
Rhode Island	
South Carolina	
South Dakota	✓
Tennessee	
Texas	
Utah	
Virginia	✓
Washington	
West Virginia	
Total	**15**
% of Total	**30.6**

1. Not segregated based on illness, but those in sheltered living do.
2. Yes, in the sense that sick inmates are housed in a specific area and they congregate in the television room/recreation area where other inmates would be out of bounds.
3. Some chronically ill inmates.
4. Some chronically ill inmates.
5. HIV-positive inmates have a separate living area.
6. Montana DOC has one unit where many chronically ill inmates reside; however, it is not designated specifically for chronically ill inmates.
7. Only at OCI Frasier Unit.

Are Inmate Volunteers Used To Assist Chronically Ill Inmates?

Agency	"Yes"	Duties
Alabama	✓	Feed, bathe, change clothes
Alaska	✓	
Arizona		
Arkansas	✓	Push wheelchairs, assist with transfer, advise staff of crises
California	✓	
Canada[1]	✓	
Colorado		
Connecticut		
Delaware		
District of Columbia		
Federal	✓	Provide transportation within prison, carry food trays, etc.
Florida	✓	
Guam		
Idaho		
Illinois	✓	Assist with activities of daily living
Indiana[2]	✓	
Iowa		
Kansas		
Kentucky	✓	Provide transport, read mail, provide other assistance
Louisiana	✓	Assist in ambulation, provide moral support to HIV/AIDS patients
Maryland		
Massachusetts		
Michigan		
Minnesota	✓	Assist with wheelchair and transport
Mississippi[3]	✓	
Missouri[4]	✓	
Montana[5]	✓	
Nebraska		
New Hampshire		
New Jersey	✓	Perform duties of infirmary orderlies
New Mexico	✓	Assist with activities of daily living
New York[6]		
New York City		
North Carolina		
North Dakota		
Ohio[7]	✓	Provide companionship
Oklahoma	✓	
Oregon		
Pennsylvania	✓	
Philadelphia		
Rhode Island	✓	

Are Inmate Volunteers Used To Assist Chronically Ill Inmates? (continued)

Agency	"Yes"	Duties
South Carolina	✓	Assist with activities of daily living and ambulation
South Dakota		
Tennessee		
Texas[8]	✓	
Utah		
Virginia	✓	Push wheelchairs
Washington	✓	Push wheelchairs, act as peer counselors
West Virginia	✓	
Total	**26**	
% of Total	**53.1**	

1. In some cases, only where a program to train caregivers exists.
2. Minimally—outpatient settings only.
3. Inmate volunteers work under the direct supervision of prison staff.
4. Only trained offenders who participate in the hospice program.
5. Inmate volunteers assist when the chronically ill inmate becomes terminally ill.
6. NY DOC is considering implementing an inmate volunteer program.
7. Only in hospice unit.
8. Only in hospice.

Are Community Volunteers Used To Assist Chronically Ill Inmates? How?

Agency	"Yes"	Duties
Alabama		
Alaska		
Arizona		
Arkansas	✓	Recreational activities, visit in hospital
California		
Canada		
Colorado		
Connecticut		
Delaware		
District of Columbia		
Federal		
Florida		
Guam		
Idaho		
Illinois		
Indiana		
Iowa		
Kansas		
Kentucky	✓	
Louisiana	✓	To provide religious/spiritual services
Maryland		
Massachusetts		
Michigan[1]	✓	
Minnesota		
Mississippi		
Missouri	✓	
Montana		
Nebraska		
New Hampshire		
New Jersey		
New Mexico		
New York	✓	Bereavement counseling and religious services
New York City		
North Carolina	✓	
North Dakota		
Ohio	✓	Religious services and support
Oklahoma		
Oregon		
Pennsylvania		
Philadelphia		
Rhode Island		
South Carolina		
South Dakota		

Are Community Volunteers Used To Assist Chronically Ill Inmates? How? (continued)

Agency	"Yes"	Duties
Tennessee	✓	Spiritual services and support
Texas		
Utah		
Virginia		
Washington		
West Virginia		
Total	**9**	
% of Total	**18.4**	

1. Very limited use of community volunteers; however, one individual who works with a local hospice volunteers at the prison hospital.

Appendix A

Staff Training

Is Training Provided for Correctional Officers in Working With the Following Populations?

Agency	Elderly Inmates	Terminally Ill Inmates	Chronically Ill Inmates
Alabama			
Alaska	✓	✓	✓
Arizona			
Arkansas[1]		✓	✓
California		✓	✓
Canada			
Colorado	✓	✓	✓
Connecticut[2]		✓	
Delaware		✓	
District of Columbia			✓
Federal[3]			✓
Florida			
Guam			
Idaho			
Illinois			
Indiana	✓	✓	✓
Iowa	✓		✓
Kansas			
Kentucky	✓	✓	✓
Louisiana			
Maryland			
Massachusetts			
Michigan			
Minnesota			
Mississippi			
Missouri			
Montana			
Nebraska			
New Hampshire			
New Jersey			
New Mexico			
New York[4]	✓	✓	✓
New York City			
North Carolina[5]			
North Dakota			
Ohio	✓	✓	✓
Oklahoma			
Oregon		✓	✓
Pennsylvania[6]			
Philadelphia		✓	✓
Rhode Island			
South Carolina[7]			
South Dakota[8]			

(continued on next page)

Is Training Provided for Correctional Officers in Working With the Following Populations? (continued)

Agency	Elderly Inmates	Terminally Ill Inmates	Chronically Ill Inmates
Tennessee			
Texas			
Utah			
Virginia	✓	✓	✓
Washington			
West Virginia			
Total	**8**	**13**	**14**
% of Total	**16.33**	**26.53**	**28.57**

1. Not for all officers. Medical services and mental health services have specially trained officers.
2. In the process of developing a lesson plan for working with terminally ill inmates.
3. For mental health issues only.
4. Training provided for staff in Regional Medical Units only.
5. All custody training is standard; specialized training is provided as needed.
6. Not at present; however, PA DOC is working on programming and education for staff and inmates working with these populations.
7. AIDS only.
8. No general training; however, medical staff for correctional officers working in area of infirmary receive some training.

Appendix A

Classification and Treatment

Does Your Agency Use the Following Classification and Assessment Instruments?

Agency	Objective-Based Classification Instrument	Treatment Needs Assessment Feature	Perform Treatment Needs Assessments at Intake?
Alabama	✓	✓	✓
Alaska	✓	✓	✓
Arizona	✓	✓	✓
Arkansas	✓	✓	✓
California	✓	✓	✓
Canada	✓		✓
Colorado	✓		✓
Connecticut	✓	✓	✓
District of Columbia	✓	✓	✓
Delaware	✓	✓	✓
Federal	✓		✓
Florida[1]	✓		✓
Guam	✓		✓
Idaho	✓	✓	✓
Illinois	✓		✓
Indiana	✓	✓	✓
Iowa	✓	✓	✓
Kansas	✓		✓
Kentucky	✓		✓
Louisiana	✓	✓	✓
Maryland	✓		
Massachusetts	✓		✓
Michigan	✓		✓
Minnesota	✓		✓
Mississippi			
Missouri	✓	✓	✓
Montana	✓	✓	✓
Nebraska	✓		✓
New Hampshire[2]		✓	✓
New Jersey	✓		
New Mexico[3]		✓	✓
New York	✓	✓	✓
New York City	✓	✓	✓
North Carolina	✓	✓	✓
North Dakota	✓	✓	✓
Ohio	✓	✓	✓
Oklahoma	✓	✓	✓
Oregon	✓		✓
Pennsylvania[4]		✓	✓
Philadelphia[5]	✓	✓	
Rhode Island	✓	✓	✓
South Carolina	✓	✓	✓
South Dakota	✓	✓	✓

(continued on next page)

Does Your Agency Use the Following Classification and Assessment Instruments? (continued)

Agency	Objective-Based Classification Instrument	Treatment Needs Assessment Feature	Perform Treatment Needs Assessments at Intake?
Tennessee[6]		✓	✓
Texas[7]			✓
Utah			
Virginia	✓	✓	✓
Washington	✓	✓	✓
West Virginia	✓	✓	✓
Total	**42**	**31**	**44**
% of Total	**86**	**63**	**90**

1. Classification instrument does not include a treatment needs feature because health-related treatment is confidential.
2. The provider decision is based on a 1–5 scale indicative of ability to work. A "5" may indicate the need for infirmary placement assessed individually.
3. Assessment is by a physician or midlevel provider.
4. Clinical review conducted by central office coordinator of receiving facility.
5. Assessment is performed by Social Services.
6. Decision of medical director.
7. Offenders are referred by medical staff.

Does Your Agency Employ or Engage the Services of Any of the Following Health Care Specialists?

Agency	Rehabilitation Specialists			Occupational Specialists			Physical Specialists			Speech Specialists		
	C	E	T*	C	E	T	C	E	T	C	E	T
Alabama	✓	✓					✓	✓				
Alaska[1]	✓	✓					✓	✓				
Arizona[2]	✓			✓			✓			✓		
Arkansas							✓					
California	✓	✓	✓				✓	✓	✓	✓	✓	✓
Canada[3]												
Colorado	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Connecticut												
District of Columbia	✓	✓		✓	✓		✓	✓				
Delaware												
Federal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Florida[4]				✓	✓	✓	✓	✓	✓	✓	✓	✓
Guam												
Idaho												
Illinois	✓	✓		✓			✓	✓	✓	✓	✓	
Indiana[5]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Iowa												
Kansas							✓	✓	✓			
Kentucky	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Louisiana	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maryland[6]				✓	✓	✓	✓	✓	✓	✓	✓	✓
Massachusetts	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michigan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minnesota[7]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mississippi							✓	✓	✓			
Missouri	✓	✓		✓	✓		✓	✓		✓	✓	
Montana												
Nebraska							✓	✓	✓		✓	
New Hampshire							✓	✓	✓			
New Jersey	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
New Mexico	✓	✓	✓	✓	✓	✓	✓	✓	✓			
New York	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
New York City							✓	✓	✓			
North Carolina[8]		✓								✓		
North Dakota												
Ohio												
Oklahoma							✓	✓				
Oregon												
Pennsylvania[9]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Philadelphia[10]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rhode Island[11]				✓	✓	✓	✓	✓	✓	✓	✓	✓

(continued on next page)

Does Your Agency Employ or Engage the Services of Any of the Following Health Care Specialists? (continued)

Agency	Rehabilitation Specialists			Occupational Specialists			Physical Specialists			Speech Specialists		
	C	E	T*	C	E	T	C	E	T	C	E	T
South Carolina	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
South Dakota	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Tennessee	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Texas	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Utah												
Virginia												
Washington	✓			✓			✓			✓		
West Virginia							✓	✓				
Total	**25**	**24**	**18**	**25**	**22**	**20**	**36**	**33**	**27**	**24**	**22**	**19**
% of Total	**51**	**49**	**37**	**51**	**45**	**41**	**73**	**67**	**55**	**49**	**45**	**39**

1. Alaska DOC also employs eye specialists.
2. Geriatric/elderly inmates may be afforded all of the services identified (e.g., chronically or acutely ill patients can be geriatric).
3. Occupational therapists are employed in regional mental health treatment facilities. When required, the other three specialists are hired on contract. They will provide these services at the institution or on an outpatient basis.
4. Contract services based on medical need.
5. As ordered by attending physician.
6. Services provided on an as-needed basis to all inmates.
7. Services provided on an as-needed basis to all inmates.
8. Therapists are provided on a case-by-case basis as needed.
9. The facility may engage any medical service through a physician's order.
10. Services are provided through specialty clinics whenever deemed medically necessary by a physician.
11. Contracted professionals come to the site to provide rehabilitation and physical therapy services.

*C = Chronically Ill; E = Elderly; T = Terminally Ill.

Managing Long-Term Inmates and Inmates With Chronic and Terminal Illnesses:

Site Visit Reports

Appendix B

Appendix B

Managing Long-Term Inmates and Inmates With Chronic and Terminal Illnesses: Site Visit Reports

To impart currency and relevancy to the findings of this report, three of the project's expert consultants visited six representative departments of corrections (DOCs) that are considered to have considerable experience with elderly, chronically ill, and terminally ill inmates. Each of these DOCs also has in place a comprehensive approach for planning and delivery of services for these inmate populations. A consistent checklist of questions was developed for these site visits (see appendix C). Information and examples from the site visits are mentioned throughout this report. This appendix provides more detailed information about the programs and policies in place at the six sites, including responses to the checklist of questions.

SITE VISIT REPORT: MICHIGAN DEPARTMENT OF CORRECTIONS

SITE EVALUATOR: RONALD SHANSKY, M.D.

EVALUATION DATE: NOVEMBER 7–8, 2001

The Functional Assessment

1. What is the screening tool used for inmates with special needs on entry to systems?

The Michigan Department of Corrections has an intake history screening form that is completed by a nurse at the time of the inmate's arrival. This is a history of any types of problems, including medical and mental health problems, that the inmate may provide. If the inmate has a special need, such as impaired mobility, the inmate is immediately referred to a physician who identifies the need and arranges for the inmate to be placed in appropriate housing during the reception process. Within 10 days of entry into the system, the inmate receives a complete history and physical examination. During that examination any specific accommodations needed for medical problems are identified. After identifying the special needs, the physician fills out the bottom half of the Special Needs Identification Screening Form, which lists particular treatments, procedures, specialty medical care, and any restrictions (e.g., low bunk) that the inmate may require. In addition, the physician fills out the Special Accommodation Notice. This form allows for four copies: one to be kept in the medical record, one to be kept in the inmate's master file, one to go to the inmate's counselor, and one to be kept by the inmate. This accommodation form is considered to be documentation of permanent accommodation needs. If the inmate's needs change, the physician fills out a new form and replaces the old form with the new form. This Special Accommodation Notice is designed to ensure that the special accommodations are maintained even when inmates are transferred between institutions. Data on this form are maintained in an electronic system.

2. What other kinds of screening mechanisms are used at intake to determine functionality?

Additional screening tests used for inmates include psychological tests consisting of the draw-a-person test, the finish-sentence test, and the Minnesota Multiphasic Inventory (MMPI). These are used to screen for mental health problems and developmental disabilities. No other special screening mechanisms are used at intake.

3. Is a functional assessment routinely conducted on all inmates at intake? If yes, what does the functional assessment entail?

The functional assessment performed at intake is the history and physical performed by the physician. At the time inmates with specific disabilities, such as mobility or sensory neural impairments, are identified, they are enrolled in a disability chronic clinic and seen for their first chronic care visit within 5 days of entering the permanent facility. In addition, the inmates are seen for their first visit, during which time the comprehensive database on the disability is completed.

4. How does your classification program work to separate inmates based on need?

The Special Accommodation Notice is sent to the counselor responsible for the inmate; the counselor then makes housing and programmatic decisions based on needs identified on the form. Some jobs are designed for individuals with certain types of impairments. There is no structural method to the medical classification, such as classifying people as class 1, 2, 3, or 4. Rather, the specific accommodations identified are used for each inmate.

5. How do you ensure that the special needs which have been identified are recognized?

Michigan ensures that identified needs are recognized by use of the Special Accommodation Notice. These accommodations are, by policy, required to be recognized and provided for at all facilities. At the G. Robert Cotton facility, one of the facilities that houses a large number of special needs inmates, the accommodation needs are listed on a computer count sheet so that each day the count for the facility includes the inmates' location, beds, and housing needs. It is planned that other institutions within the department will use this system.

6. What is your mechanism to ensure that the special needs of the inmate are always maintained? (Including upon transfer from one facility to another.)

The mechanism to ensure that the special needs of inmates are always maintained, even upon transfer, is use of the Special Accommodation Notice. The health care staff receives a printout once each month with a list of the special accommodation needs, including any about to expire (those that are of less than 6 months' duration), and they also receive a list of all inmates with permanent accommodations.

Balancing Custody Concerns and Appropriate Care

1. Does your departmental offender tracking system count inmates considered to be elderly separately?

The Michigan Department of Corrections has a statewide Committee on Geriatrics that plans for the needs of these inmates. The committee is appointed by the regional prison administrators. This committee is developing recommendations regarding programming, facility housing, and medical needs. The Michigan Department of Corrections does not have an offender tracking system that separately identifies the elderly. It can, however, print out a list of inmates by age, gender, race, county of commitment, prior commitments, felony, most serious commitment offense, and initial security classification assignment. In the State of Michigan, an inmate is defined as elderly if he or she is 60 years or older and has no significant disability. This is in contrast to the Michigan Department of Corrections definition of a geriatric inmate: a special needs inmate who is 60 years or older and has a chronic illness or disability related to the aging process that has caused permanent impairment in the individual's ability to pursue activities of daily living, such that special housing or special programs are required.

2. Does your departmental offender tracking system distinguish between:

> *Inmates who entered the system younger than age 50 and who attained that age while incarcerated?*
>
> *Inmates who were age 50 or older at entry but were never incarcerated before?*
>
> *Inmates who were age 50 or older at entry who were previously incarcerated?*

Michigan does not differentiate between inmates who entered the system younger than 50 and attained that age while incarcerated, inmates who were age 50 or older at entry but were never incarcerated before, or inmates who were age 50 or older at entry who were previously incarcerated.

3. Are elderly inmates in your department housed congregately in special housing as a discrete subpopulation?

Elderly inmates are housed in congregate housing, but by functional need, and they may be housed with younger inmates.

4. Are elderly inmates housed in one or more separate facilities in your departmental system?

Most elderly inmates are housed at the Lakeland facility, the Cotton facility, or at one of two of the southern Michigan prisons, Parnall Correctional Facility and Southern Michigan Correctional Facility. In addition, younger inmates with special needs are frequently housed in the same units. Women with special needs are mainstreamed at each of the two women's facilities.

5. Does your department provide educational or other personal development programs specifically designed for elderly inmates that include issues and problems?

The Michigan Department of Corrections does provide some special recreation programs, particularly at the Lakeland facility, and some educational programs, but these are individually based. Lakeland has a tutor to work with the inmates.

6. If yes, does the program include:

Education on the aging process?

Education on physical, psychological, and social issues associated with aging while incarcerated?

Education on self-care and activities of daily living basic adult education and literacy?

The state Department of Aging provides education on the aging process. There is some individual education on physical, psychological, and social issues associated with aging, and there is some group counseling. There is no formal structure to provide education on activities of daily living or basic adult education and literacy, although individuals may enroll for tutorials.

7. Does your department provide supervised recreational programs specifically designed and appropriate for elderly inmates? Please describe the programs available.

The Lakeland facility provides some supervised recreational programs specifically designed and appropriate for elderly inmates, such as horseshoes and playing cards.

8. Does your department survey/sample your population of inmates age 50 or older to assess their perceptions of their needs?

A survey of older women was conducted recently, but the data have not been compiled yet. Males have not yet been surveyed.

9. Does prerelease planning for elderly inmates include information on

Social Security?

Medicare?

Estates and wills?

Advance directives (such as "do not resuscitate")?

Funeral preplanning?

Other community-based services for the elderly (e.g., "meals on wheels")?

Some individual counseling is provided for inmates with concerns about Social Security, Medicare, and estates and wills. There is discussion regarding advance directives that is done each year at the inmates' annual exam, but compliance with this policy is not very good.

10. Does your departmental health services division provide organized health education services to inmates considered elderly?

The departmental health services division does not provide organized health education services to inmates considered elderly. Most of the education they provide is disease specific, such as education about diabetes or hypertension.

11. Is there a peer-visiting program for elderly inmates?

There is no peer-visiting program for elderly inmates.

12. In your department, do inmates who are debilitated, frail, or medically fragile have access to a congregate therapeutic living community where they can be medically supervised, specially programmed, and assisted with the activities of daily living? If yes, is that program available to both men and women?

There is no congregate therapeutic living community where inmates can be medically supervised, specially programmed, or assisted with the activities of daily living. There is a chronic care unit that is more like skilled nursing at the Dwayne Waters Hospital, and the Lakeland facility has a geriatric unit where inmate aides are available to assist inmates in some activities of daily living. The vast majority of inmates at Lakeland are independent with regard to activities of daily living.

13. Does your department's health services division promulgate and implement chronic protocols or guidelines for all of the major chronic conditions?

The department does promulgate and implement chronic disease protocols for all the major chronic

diseases, such as diabetes, hypertension, asthma, seizure disorder, HIV, and TB prophylaxis; and they have a special disability clinic that is unique. The disability clinic results in a thorough disability evaluation for each inmate who is enrolled in the clinic, and these inmates are seen on a regular basis no less frequently than every 3 months, regardless of their condition. If an inmate has a disability, such as mobility impairment, and has other chronic diseases, his or her major clinic is the disability clinic and the other diseases are addressed during that clinic session.

14. Does your department operate prerelease centers or halfway houses with programs designed for elderly inmates?

The Michigan Department of Corrections does not operate prerelease centers or halfway houses with programs designed for elderly inmates.

15. Are inmates who are considered elderly in your department provided:

Universal access to the entire physical plant housing them?

Single or lower bunks?

Additional heat in cold weather?

Air conditioning in warm weather?

Inmates who are considered elderly are provided universal access to the entire physical plant and single or lower bunks. They may get extra blankets or clothing in cold weather. There is no air conditioning. A list of high-risk inmates, including those on psychotropic medications, is maintained, and these inmates' concerns regarding heat and cold are specifically addressed.

16. Are medical social services professionals available to your department's population of inmates directly or to your health services division as case management consultants?

No medical social services professionals are available to this population except for those housed at Dwayne Waters Hospital.

17. Does your department operate or have access to levels of care ordinarily identified with nursing homes?

A level of nursing home care is available at the Dwayne Waters Hospital, at Huron Valley Correctional Center, and at the Marquette State Prison.

18. Does all or part of your department's physical plant comply with the Americans with Disabilities Act?

Of the approximately 43 state prisons, 18 are barrier free and comply with the Americans with Disabilities Act.

Medical, Program, and Housing Considerations: Requirements for Elderly, Chronically Ill, and Terminally Ill Inmates

A. Compassionate release

1. Is there a compassionate release/medical parole program for terminally ill inmates in your system?

2. Who initiates the request for compassionate release?

3. How long does the process generally take?

4. Which agency can grant the release request?

Although there is a compassionate release/medical parole process, it like most others is subject to political decisions and thus relatively few inmates are able to benefit from it. The institution would initiate the request. The process may take a very long time. The release is granted by the Governor's office.

B. Hospice care

1. Do you have a hospice unit for inmates who are terminally ill?

Plans are being made for a hospice to be housed at the Dwayne Waters Hospital. This will not be in a specific room. Rather, a group of services will be available to inmates deemed eligible for hospice services. The services that would be made available would include increased property availability,

increased visitation, increased dietary options, and the use of standing orders by the nurses for symptom management. There are plans to utilize volunteers from the hospice of the town of Jackson. There are currently case management care teams at the Dwayne Waters Hospital, and it would be up to these teams to refer inmates who may be eligible for hospice care.

2. What are the eligibility criteria in terms of:

a. The definition of "terminal illness"?

b. The level of functioning?

c. The type of crime the inmate committed?

d. The diagnosis?

e. Other?

3. Is this a discrete unit? Part of the infirmary? Part of a housing unit? An outpatient program?

4. How many beds are in the hospice unit?

5. How many patients do you usually serve at one time?

6. How many patients in all did you serve last year?

7. Are there dedicated staff for the hospice unit? If yes, what types?

8. Do you use other inmates as volunteers in your program?

9. If yes, describe the screening selection process, the training program, the types of activities they perform, and any rules/restrictions they operate under.

10. Do you use any volunteers from the community? If yes, describe this program.

N/A (Questions 2–10)

11. Do terminally ill inmates in your system issue advance directives? DNR orders? If yes to either, what safeguards are in place to ensure that they have given non-coerced informed consent?

In general, advance directives and "do not resuscitate" (DNR) orders are used only by inmates at Dwayne Waters Hospital. It is state policy to resuscitate all other inmates. The state is interested in putting together a committee to reevaluate this process and possibly to create greater flexibility with regard to the DNR policy.

12. What is the visitation policy for the terminally ill patient's family? Other inmates?

Now on a case-by-case basis, a warden may make exception to structured rules with regard to family. No other inmates are allowed to visit.

13. Are special foods and drinks available to terminally ill patients at all times?

Currently, no special foods and drinks are available to terminally ill inmates, although the plans for the hospice, which may start within the next few months, would allow for such.

14. Are there or were there institutional barriers (e.g., security rules, administrative concerns) that affect your ability to provide support for the terminally ill in your system? If yes, what are they and how are you addressing them?

There are the usual medical needs versus security-level barriers that preclude some options. Terminal inmates who are mainstreamed are currently not allowed to have a DNR order, although this issue may be revisited.

15. Do you have hospice programs in all of your facilities? If not, how many do you have?

There are currently no hospice programs in any of the facilities.

16. Are terminally ill inmates in all facilities able to be transferred to a unit with a hospice program?

No. The planned program will be voluntary. Currently, if a terminally ill inmate is bedridden, he or she may go to the Marquette or Huron Valley infirmary or Dwayne Waters Hospital. In those units, they may have a DNR order.

C. Palliative care

1. Is there a palliative care program in your facilities?

There is currently a pain management program at the Joint Commission on Accreditation of

Healthcare Organizations (JCAHO)-accredited Dwayne Waters Hospital. This program is designed to meet JCAHO accreditation requirements. The structured pain evaluation is currently utilized both pre- and postmedication. What is extremely exciting is that there are plans to allow nurses to use standing orders that offer a significant degree of flexibility on the dosages of controlled substances to be provided to the inmates based on the inmates' self-assessment of the level of pain. There are plans to start this on a pilot basis at Dwayne Waters on December 1, 2001. I strongly recommended that the institution develop data on the number of inmates utilizing controlled substances for pain management at Dwayne Waters between September 1 and December 1, and on the total number of doses provided. I also encouraged them to maintain the same data for a 6-month period after December 1. There is a goal, if the Dwayne Waters Hospital pilot program works, to look to expanding the pain management program statewide where possible.

2. If yes, is palliative care available to those with advanced disease but who have not yet been defined as terminal?

No.

3. What types of palliative care do you offer?

See answer to no. 1, above.

4. What are the eligibility criteria for receiving it?

A booklet on the pain management program, which I've included with this report, includes the criteria for inmates receiving such care. The current program requires a pain assessment and a flowsheet to record the status of the pain, including a form for cognitively impaired patients and a flowsheet for them. There is also a patient's rights statement. Three institutional needs assessments have been conducted looking at implementation of the pain management program. Implementing this program at the Dwayne Waters Hospital has resulted in some attitude changes among nurses.

5. Does your pain management program include the use of narcotics? If yes, did you encounter any resistance from custody staff? If yes, how did you overcome it? Describe what is available.

The pain management program does include the use of narcotics. Custody staff have accepted it as part of a medical program.

6. (No question no. 6 was listed on the form.)

7. Do you use an interdisciplinary team in your palliative care program? If yes, what types of personnel are on it? Who leads the team? What is the team's role?

An interdisciplinary team works on the palliative care program. It includes physicians, nurses, social workers, physical therapists, custody staff, and dietitian.

8. Do you develop individualized care plans for your palliative care patients?

Individualized care plans are part of the palliative care program.

9. Can patients in the palliative care program continue to receive curative care?

Inmates who receive the palliative care program can also receive curative care.

D. General

1. Are your end-of-life programs available to women inmates as well as men? Are there any differences in terms of what is available to women?

The end-of-life programs that are available at Dwayne Waters Hospital will be available to both genders.

2. Are you satisfied with the end-of-life care you are able to offer currently? If not, what more is needed?

The plan is to pilot the use of this end-of-life pain management program and possibly move it statewide. In addition, there are plans to develop hospice services more on an outpatient basis but to make special services previously listed available to groups of inmates who meet the criteria.

3. How are your end-of-life programs funded?

There is no discrete funding for the planned hospice programs. There are plans to use existing staff and volunteers.

11/19/01

SITE VISIT REPORT: MINNESOTA DEPARTMENT OF CORRECTIONS

SITE EVALUATOR: B. JAYE ANNO, PH.D.

EVALUATION DATE: NOVEMBER 2001

Preface

In November 2001, I visited two correctional facilities in Minnesota to see how they manage their elderly, chronically ill, and terminally ill inmates. I toured the Minnesota Correctional Facility (MCF)-Faribault on November 1 and the Minnesota Correctional Facility (MCF)-Oak Park Heights on November 2. My observations and findings are noted below.

Background

The Minnesota Department of Corrections (MDC) operates nine facilities, including seven for adult males, one for adult females (MCF-Shakopee), and one for juveniles (MCF-Red Wing). The total population averages 6,400 adults and 100 juveniles on any given day. The majority (51 percent) of inmates are people of color, and the balance are Caucasian.

Minnesota has a centralized health system with all health services (i.e., medical, dental, and mental health) organized under a single health authority. At the MDC central office, there is a director of health services who reports to the deputy commissioner. Additional staff include a director of nursing, a director of mental health services, a half-time medical director, and a budget manager. The latter oversees health expenditures of $31 million annually. MDC contracts with a for-profit group, Correctional Medical Services (CMS), for its providers (i.e., MDs, DOs, and midlevels), specialty care, and hospitalization at the rate of $12.8 million per year. All other health staff at the units, including nurses, lab and x-ray technicians, dental staff, and mental health staff (excluding psychiatrists), are state employees.

Management of the Chronically Ill and Inmates With Special Health Needs

Assessment of chronic and special health needs occurs at intake (MCF-Saint Cloud for males and MCF-Shakopee for females). The form used is a traditional one that gathers information on the inmate's health history on arrival and is followed by a physical exam consisting of a review of systems within 14 days of confinement. A brief mental health assessment is also completed within the first 24 hours of an inmate's arrival. More extensive followup assessments are completed if any mental illness or disability is noted. At the unit level, chronic care patients are followed individually. There are no chronic care clinics per se, and no clinical protocols for the management of specific diseases, although I was told that the CMS medical director was working on developing the latter. MDC plans to implement chronic care clinics at each of its facilities when the protocols are in place. All of the adult male institutions will have the same schedule for clinics to ensure that inmates who are transferred do not miss their appointments.

MDC does not do any functional assessment on intake. I was told that the classification committee does not consider health needs when making unit assignments for adult males. Rather, inmates are assigned to a facility based on their security rating only. If it turns out that the facility cannot meet their medical needs, the inmate is transferred (see policies on "Transfers for Needed Care" and "Special Needs Transfer Process").

Three adult male facilities provide special health services. MCF-Faribault is a medium security facility that has a dedicated housing unit, called Linden, for inmates who are 55 or older with chronic health problems or younger inmates with disabilities (e.g., blind, deaf, wheelchair-bound inmates). MCF-Oak Park Heights is the only maximum-security facility in the system. It also has the only Transitional Care Unit (TCU or infirmary). The TCU has 38 beds, and

a separate Mental Health Unit (MHU) has 46 beds (see attached policies for admission criteria to these two units). The MCF-Lino Lakes facility has 10 beds for mentally ill or developmentally disabled inmates and a 30-bed unit for dually diagnosed (mentally ill/chemically dependent) inmates.

Management of Elderly Offenders

MDC defines anyone 55 or older as elderly. An offender tracking system, referred to as "COMS," has the capacity to track the elderly separately, but this is not done. The system includes fields for gender, race, county of commitment, number of prior commitments, level of felony, most serious commitment, and initial classification assignment as well as fields for certain health information. Elderly inmates are not separated into those who were 55 or older when incarcerated and those who attained the age of 55 while incarcerated.

Elderly inmates in MDC may remain in the general population. As noted previously, MCF-Faribault has the Linden unit available for older inmates who need extra monitoring or want to live in a more protected environment. Inmates who are 55 or older can submit a request to live at Linden. If they do so, they cannot work because they are considered to be "retired." The Linden unit has 100 beds. At the time of my visit, 80 beds were filled with special needs inmates (both elderly and disabled). General population inmates used the other beds. I was told the general population inmates would be moved out if beds were needed for special needs inmates, but they are required to keep the beds filled.

The Linden unit has 16-hour-per-day coverage by licensed practical nurses. Nursing coverage is available 24 hours per day in the main clinic area. Inmates housed at Linden must be able to perform their own activities of daily living (ADLs). If they require assistance with their ADLs or 24-hour nursing care, they are transferred to the TCU at MCF-Oak Park Heights. There is no "keep on the person" medication program here. The nurses pass all medications individually to ensure better compliance.

The Linden unit is handicapped accessible, including the recreation equipment, dining area, and telephone booths. There are TTY machines for the deaf, and interpreters are provided for all hearings. Special needs inmates stay in two-person rooms (not cells). Hospital beds with railings are available as needed. General population inmates assigned to this unit stay in dorms.

Inmates who are wheelchair bound or severely disabled may be assigned a "personal care attendant" (i.e., an inmate helper), who helps clean the room, push the wheelchair, etc. They may not assist with ADLs because, as noted above, inmates at Linden must be able to perform their own ADLs.

All inmates at the Faribault facility use a common dining room, with two units eating at the same time. Inmates assigned to the Linden unit share the dining room with a treatment unit. The Linden unit has its own weight room, recreation area with a pool table, patio, and courtyard. Job assignments include janitor, kitchen worker, personal care attendant, and industry jobs in woodshop or ballroom assembly. Linden inmates can become involved in crafts, attend school, or serve as tutors to inmates in the general population.

Release and Discharge Planning

In Minnesota, inmates who observe the rules serve two-thirds of their sentence in prison and one-third in the community under supervised release (which is similar to parole). If someone is gravely ill or cannot be medically managed within the MDC system, the state also has a provision for conditional medical release. In this case, the offender is placed in an appropriate community health facility to receive needed care. The basic criteria for an inmate to be considered for conditional medical release are that he or she has a grave health condition that is not likely to improve, is incapable of self-care, does not pose a risk to public safety, and has health needs that can be better met by a community facility. With conditional medical release, an offender can be placed in the community during his or her incarceration term but can be brought back into the prison

system if the health condition improves to the point that it can be managed within MDC facilities.

A request for conditional medical release of a specific inmate is initiated by facility health services personnel, sent through the facility chain of command, then sent to the central office hearings and release unit (HRU). HRU makes a recommendation to the director of health services, assistant commissioner for facilities, and commissioner. Usually about a month is required to complete the process, but it can be expedited as necessary.

Since most inmates in Minnesota leave prison under supervised release, they all get some prerelease planning. Each facility has case managers who are responsible for working with the inmates to develop acceptable release plans. In addition, prerelease classes are offered to any inmate who is within 4 to 6 months of release. The topics covered include how to apply for Medicaid/Medicare, MinnesotaCare, or another medical plan when inmates leave the prison. An information packet with applications is provided. Furthermore, inmates with ongoing medical conditions are given a prescription and a 7-day supply of needed medications on release. Also, inmates with disabilities are assisted in obtaining adaptive devices as needed.

Management of the Terminally Ill

Owing to its small size, the Minnesota Department of Corrections does not have a hospice unit per se. Instead, terminally ill inmates (males only) are managed in the TCU or MHU at MCF-Oak Park Heights or in community facilities under the conditional release process described above (both males and females). Hospice care is included as part of MDC's contract with Correctional Medical Services. CMS contracts with HealthEast Hospice, which is a part of Saint Joseph's Hospital in Saint Paul. When a terminally ill inmate chooses hospice care and will remain at MCF-Oak Park Heights, a nurse and a social worker from HealthEast Hospice come into the facility and discuss their services with the patient and his family. The hospice staff explain the options available to the patient, and based on the patient's wishes, help him execute advance directives, which can include "do not resuscitate" orders, "do not intubate" orders, maximum pain relief, etc. Hospice staff also visit with the facility's nursing staff and the patient and develop a plan of care. Thereafter, they visit the patient at least once per week.

The department does not define "terminal illness" in its policy but uses HealthEast's definition. By virtue of obtaining hospice care, the offender has no more than 6 months to live, generally. The patient's specific diagnosis is not a factor, and the type of crime the individual committed is not considered. A physician must recommend that a patient have a consultation with hospice staff.

The basic visitation policy at MCF-Oak Park Heights is 16 hours per month. Special arrangements are made for the hospice patient's family over and above the regular visits, however, including bedside visits when the individual is no longer ambulatory. Decisions regarding visits by other inmates are made on a case-by-case basis. Hospice patients also receive nutritional supplements as needed. Religious counseling is available if the hospice patient requests it. Memorial services led by religious leaders are held when the patient dies.

Palliative care is available to terminally ill inmates and to those with other painful conditions. Patient-controlled and intravenous narcotics are not used—only patches, pills, and injectable liquids are permitted. All narcotics are administered under directly observed therapy. If a patient is in the general population rather than the TCU, only oral narcotics are permitted.

I was told that there was never any concern or resistance to the hospice or palliative care programs by administrative or custody staff at MCF-Oak Park Heights. According to the warden, "Medical staff make the medical decisions and we figure out how to implement them."

SITE VISIT REPORT: NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES

SITE EVALUATOR: B. JAYE ANNO, PH.D.

EVALUATION DATE: DECEMBER 2001

Preface

On December 7, 2001, I visited the Coxsackie Correctional Facility in Coxsackie, New York, to see how they manage their elderly, chronically ill, and terminally ill inmates. My observations and findings are noted below.

Background

The New York State Department of Correctional Services (NYSDOCS) operates 57 major institutions housing more than 70,000 inmates. Five of these facilities have regional medical units (RMU), including one at the Coxsackie prison and one for females at Bedford Hills. The Coxsackie Correctional Facility (CCF) is a maximum-security prison housing approximately 1,100 male inmates. In terms of health services, it has an ambulatory clinic for the CCF residents, specialty clinics for male inmates in the region it serves (more than 100 inmates come for specialty care each weekday), a 20-bed infirmary for the CCF general population, and a 60-bed inpatient unit known as the RMU. The RMU is operated by Correctional Medical Services (CMS), a national for-profit health provider.

Management of the Chronically Ill and Inmates With Special Health Needs

Assessment of chronic and special health needs occurs at intake at a reception facility. Inmates are assigned a medical classification level of I through IV during the initial health appraisal, which is performed within the first week of admission. Each institution has a corresponding number that indicates the level of medical acuity it can accept. Unfortunately, I did not have time to visit a reception center, so I do not know the extent of the health appraisal that is performed upon admission. Once at their unit of assignment, chronic care patients are followed regularly. The New York correctional system has a series of primary care practice guidelines for several of the most common diseases and conditions, including HIV, diabetes, asthma, hepatitis C, and high blood pressure.

Management of Elderly Offenders

NYSDOCS does have a computerized inmate tracking system. I was told, however, that elderly inmates are not tracked separately and that there are no special programs for elderly offenders at the Coxsackie facility.

Release and Discharge Planning

An inmate's health status or medical needs can serve as the basis for early release from NYSDOCS through either a request for executive clemency or medical parole (see attached policies). The former is run by a separate Bureau of Executive Clemency, and the medical parole program is managed by the deputy commissioner for health services. Requests for medical parole for terminally ill inmates may be initiated by the nurse administrator or by anyone on behalf of the inmate, such as family or staff. Requests are forwarded to the deputy commissioner for

approval and processing. The legislature and the NYSDOCS commissioner have developed specific criteria for medical parole, including the following.

The inmate must:

1. Be serving an indeterminate sentence;
2. Have a terminal condition;
3. Be "so debilitated or incapacitated as to be severely restricted in his or her ability to self-ambulate and to care for himself or herself"; and
4. Not be serving a sentence for "murder in the first or second degree, manslaughter in the first degree, any sex offense. . . or any attempt to commit any of these offenses."

Individuals who qualify for medical parole are usually released to a subacute setting or sometimes to home with hospice care. The process generally takes about 2 months.

Management of the Terminally Ill

The Coxsackie facility currently operates the only hospice program in the NYSDOCS system, although others are planned for other RMUs. The hospice program is physically located within the Coxsackie RMU and is managed as part of the RMU contract by Correctional Medical Services. It is not a discrete unit with a specific number of beds but, rather, a series of services provided to individuals who have been identified as terminally ill and have chosen hospice for their end-of-life care. At the time of my visit, 6 hospice patients were at the RMU, but there have been as many as 12 at one time. Last year, the program served 28 male inmates. Hospice services have been available at Coxsackie since 1997 through a contract with a community hospice program, but it has only been since October of last year that the CMS staff began providing these services themselves.

The Coxsackie hospice program uses the National Hospice and Palliative Care Organization definition of "6 months or less to live" as its definition of terminal illness. Staff have developed worksheets for several diseases and conditions to assist physicians in determining who may be terminally ill. Unlike medical parole, the type of crime the inmate committed is not a factor in determining eligibility for hospice services.

All staff at the RMU have had training in hospice philosophy and programs. In addition, the director of nursing for the RMU is a certified case manager and hospice and palliative care nurse, and a certified hospice volunteer from the community assists as well. The program also benefits from the services of four hospice aides, who are inmates paid to work in these positions. The aides receive 40 hours of preservice training. Their primary role is to provide companionship for the dying patient (e.g., reading, talking, writing letters, listening). They do not assist in any way with patient care activities but are permitted to touch the patient (e.g., hold his hand, rub his back) if staff have approved such contact. I found this to be a compelling and compassionate feature of this hospice program, particularly because correctional health staff are repeatedly warned not to become emotionally involved with their patients or to touch them in anything other than a professional manner. Allowing the aides to have such contact provides the necessary "human touch" that is so important at the end of life. When death is imminent, the aides hold a 24-hour vigil to ensure that the inmate does not die alone.

All inmates are encouraged to issue advance directives when they are admitted to the RMU. Therefore, these are on file if the inmate becomes terminally ill and elects to receive hospice services. Inmates are not required to issue "do not resuscitate" orders to receive hospice care, but if they do not, the staff questions whether they really understand the hospice philosophy.

Visits are available to all RMU patients on Saturdays and Sundays. Arrangements can be made for midweek visits when necessary, and bedside visits are permitted when the patient is critical. Terminally ill patients receive extra snacks and nutritional

supplements, and staff try to fulfill special requests if possible.

Palliative care is available to terminally ill inmates as well as to those with other painful conditions. Both intravenous and peroral medications (including narcotics) are available for symptom control. Patient-controlled analgesia (PCA) pumps are seldom used, and I was told that the physicians are getting away from prescribing patches because of their abuse potential.

According to the health staff I spoke with, the primary barrier to implementing the hospice program was the resentment from line correctional officers who were "morally opposed" to criminals receiving such services. The key to eliminating this barrier has been to educate staff that the basic rule of treating inmates professionally but not compassionately shifts at the end of life.

SITE VISIT REPORT: OHIO DEPARTMENT OF REHABILITATION AND CORRECTION

SITE EVALUATOR: RONALD SHANSKY, M.D.

EVALUATION DATE: NOVEMBER 5–6, 2001

The Functional Assessment

1. What is the screening tool used for inmates with special needs on entry to systems?

The Ohio Department of Rehabilitation and Correction (ODRC) uses a screening by a nurse or nurse practitioner immediately upon intake and performs a complete medical, mental health, and dental evaluation within 14 days. This includes a history, a physical exam, and a variety of diagnostic tests, including tuberculosis (TB) screening. Hearing and vision are tested during the comprehensive evaluation; a history is taken with regard to substance use and abuse; a detailed mental health screening is given, including suicide screening; and a comprehensive health history is taken. At the completion of the physical exam, the physician classifies the inmate according to medical need. Classifications include the following:

- **Class 1.** Basically healthy inmates who may be sent to any institution.
- **Class 2.** Individuals who are medically stable but require routine followup care and examinations, such as those with chronic illnesses. These individuals can also be housed in almost all institutions.
- **Class 3.** Inmates who require frequent intensive skilled medical care, but who can maintain their own activities of daily living. These would include patients on dialysis; those with severe lung disease, HIV or AIDS, or advanced cardiovascular disease; paraplegics; hemiplegics; unstable patients with seizure disorder; or those undergoing aggressive cancer treatment. Individuals in Class 3 may be housed at only one of two facilities.
- **Class 4.** This classification includes inmates who require constant skilled medical care and those who need assistance with activities of daily living. This includes those who require convalescent pre- and posthospitalization. In this category would be unstable diabetics, those who require oxygen therapy on a continued basis, advanced cases of HIV disease, advanced cardiovascular disease, quadriplegics, severely unstable patients with seizure disorder, and patients with advanced cancer and terminal cancer. All inmates in class 4 are housed at the Corrections Medical Center.

2. What other kinds of screening mechanisms are used at intake to determine functionality?

In addition to each inmate being classified in classes 1 through 4, functional need is identified and checked off on the physical exam form. Functional needs include wheelchair user, speech impaired, hard-of-hearing/deaf, mobility impaired, vision impaired, or other. The classification number is followed by a letter or a number of letters that indicate the function needs. Inmates who may have been identified as having a vision or hearing impairment through a routine exam are referred to the correctional medical center for more thorough evaluation.

3. Is a functional assessment routinely conducted on all inmates at intake? If yes, what does the functional assessment entail?

A functional assessment, per se, is not conducted on all inmates at intake. There is, however, a history and physical. No other specific tool is used for all inmates.

4. How does your classification program work to separate inmates based on need?

As indicated previously, there is a medical classification with a functional need attached where indicated, and there is a medical classification grid that identifies which medical needs and classifications can be housed in different facilities. Once the physician has completed the classification and functional needs assessment, this information is provided to the classification staff. Ultimately, the classification staff considers the inmate's medical needs and security status and the number of available beds to determine where the inmate will be housed.

5. How do you ensure that the special needs which have been identified are recognized?

Ohio uses an intrasystem transfer and receiving health screening form. This form is used to ensure that medical classification and functional needs are identified and continued on transfers between institutions. When an inmate is received at a new facility, a physician must see that inmate face-to-face within 72 hours and determine whether all of his or her current needs have been identified.

6. What is your mechanism to ensure that the special needs of the inmate are always maintained? (Including upon transfer from one facility to another.)

As indicated in question 5, the intrasystem transfer and receiving health screening form are used to ensure that the special needs are always maintained. Beyond these things, a physician may order specific restrictions on a separate form that is then sent to Custody (for things like a cane or a slow-walking pass, etc.).

Balancing Custody Concerns and Appropriate Care

1. Does your departmental offender tracking system count inmates considered to be elderly separately?

ODRC does not track inmates considered to be elderly separately. However, their computerized offender tracking system could generate a list of inmates above a given age and by gender, race, county of commitment, number of prior commitments, level of felony, most serious commitment offense, and initial security classification assignment.

2. Does your departmental offender tracking system distinguish between:

Inmates who entered the system younger than age 50 and who attained that age while incarcerated?

Inmates who were age 50 or older at entry but were never incarcerated before?

Inmates who were age 50 or older at entry who were previously incarcerated?

ODRC's offender tracking system does not distinguish between inmates who entered the system younger than age 50 and who attained that age while incarcerated. Such a list could, however, be generated. The same is true for inmates who are age 50 or older at entry but were never incarcerated before, and the same is also true for inmates who were age 50 or older at entry who were previously incarcerated.

3. Are elderly inmates in your department housed congregately in special housing as a discrete subpopulation?

Elderly inmates as a group are housed in part at the Hocking Correctional Institution; a census on the day I visited indicated approximately 403 inmates. The average age of inmates at Hocking is currently 61 years. Additionally, four other institutions have distinct housing units in which groups of older inmates are housed together.

4. Are elderly inmates housed in one or more separate facilities in your departmental system?

Inmates older than 50 years old are mainstreamed.

5. Does your department provide educational or other personal development programs specifically designed for elderly inmates that include issues and problems?

Yes.

6. If yes, does the program include:

Education on the aging process?

Education on physical, psychological, and social issues associated with aging while incarcerated?

Education on self-care and activities of daily living basic adult education and literacy?

All wardens received training on the aging process and its impact on inmates. In addition, at Hocking a program called "50+ and Aging" addresses the physical, psychological, and social needs of older inmates. Programs such as chair aerobics, adult basic education, and GED are all provided. All inmates at Hocking have a job assignment that meets their needs, including jobs such as elevator operator and other sitdown jobs. A case manager is responsible for working with the inmates and helping them handle issues such as Social Security, Medicare, wills, outside meals, placement, etc. Placement postrelease for some of these inmates who have no family is difficult. One of the things that the staff would like to see is a postrelease assisted living unit that would accept convicted felons.

7. Does your department provide supervised recreational programs specifically designed and appropriate for elderly inmates? Please describe the programs available.

The Ohio Reformatory for Women has approximately 12 different educational or recreational programs that deal with problems and issues relevant to elderly or special needs female inmates. This includes a program entitled "The Aging Process"; a program entitled "Topic Talk," which encourages inmates to take more control of their lives; a program entitled "Helping Others Together"; a program entitled "Heart to Heart," which is an educational support program for women who are chronically ill; and a program entitled "Topics of Powerful Significance," which includes health issues, codependency issues, substance abuse, etc. A special recreation program is suited to the needs of special needs inmates, and a garden club encourages inmates to get involved in outdoor horticultural activities. The programs at Hocking and at the Ohio Reformatory for Women provide supervised recreational programs specifically designed and appropriate for elderly inmates.

8. Does your department survey/sample your population of inmates age 50 or older to assess their perceptions of their needs?

Hocking Correctional Institution conducts an annual survey to determine the inmates' perception of their needs, and there is a plan to have each department at Hocking create a separate survey to determine whether the specific department is meeting or can better meet the inmates' needs.

9. Does prerelease planning for elderly inmates include information on

Social Security?

Medicare?

Estates and wills?

Advance directives (such as "do not resuscitate")?

Funeral preplanning?

Other community-based services for the elderly (e.g., "meals on wheels")?

There is prerelease planning for inmates with regard to Social Security, Medicare, estates and wills, advance directives, funeral preplanning including cremation or donation of a body to science, and other community-based services.

10. Does your departmental health services division provide organized health education services to inmates considered elderly?

The departmental health services division does not have specific organized health care programs aimed at the elderly. There are, however, chronic disease health education programs. These are all one-on-one health education.

11. Is there a peer-visiting program for elderly inmates?

There is no peer-visiting program for elderly inmates in Ohio. There are only volunteer religious-based programs that visit the elderly.

12. In your department, do inmates who are debilitated, frail, or medically fragile have access to a congregate

therapeutic living community where they can be medically supervised, specially programmed, and assisted with the activities of daily living? If yes, is that program available to both men and women?

Inmates who are debilitated or medically fragile can live in congregate living only at the Corrections Medical Center or at the Ohio Reformatory for Women. Inmates at the Hocking facility must be independent. Programs at the Corrections Medical Center are available both to men and to women; a few co-ed programs are also there.

13. Does your department's health services division promulgate and implement chronic protocols or guidelines for all of the major chronic conditions?

The Department of Health Services does have a chronic care program. The chronic clinic program includes a cardiovascular/hypertension clinic, a diabetes clinic, a seizure clinic, a pulmonary clinic, and a TB infection clinic. An HIV clinic protocol also exists.

14. Does your department operate prerelease centers or halfway houses with programs designed for elderly inmates?

Ohio does not operate prerelease centers or halfway houses with programs designed for elderly inmates.

15. Are inmates who are considered elderly in your department provided:

Universal access to the entire physical plant housing them?

Single or lower bunks?

Additional heat in cold weather?

Air conditioning in warm weather?

Elderly inmates are provided universal access to the entire physical plant housing them. They are provided lower bunks if that is indicated. They are provided extra blankets in cold weather when needed. Those inmates who are considered high-risk based on diseases or based on being on certain medications, including psychotropics, are monitored more carefully for heat-related problems.

16. Are medical social services professionals available to your department's population of inmates directly or to your health services division as case management consultants?

Counselors perform some social service-type activities.

17. Does your department operate or have access to levels of care ordinarily identified with nursing homes?

Levels of care at the Corrections Medical Center are similar to those that would be found in a nursing home. There is no ability, however, to release inmates who pose no threat into a nursing home rather than maintain them in a prison.

18. Does all or part of your department's physical plant comply with the Americans with Disabilities Act?

At least 15 institutions contain an environment that complies with the Americans with Disabilities Act.

Medical, Program, and Housing Considerations: Requirements for Elderly, Chronically Ill, and Terminally Ill Inmates

A. Compassionate release

1. Is there a compassionate release/medical parole program for terminally ill inmates in your system?

2. Who initiates the request for compassionate release?

3. How long does the process generally take?

4. Which agency can grant the release request?

A policy is designed to establish procedure guidelines for the medical assessment of inmates in imminent danger of death and to establish criteria for consideration of their release as if on parole. Imminent death in Ohio would be a predicted life expectancy of less than 6 months. A physician initiates the request for medical parole at the facility. The physician forwards a statement to the warden's office, and the warden then directs his heads of social services and mental health each to generate a

summary of the inmate's condition. Based on the accumulated data, the warden makes a recommendation to the regional director. The regional director approves or disapproves and forwards the recommendation with the accompanying medical director's statement, a placement investigation request, and a background report to the director. The director will then require the Adult Parole Authority to conduct an investigation into an appropriate community placement, identify the terms and conditions to which the inmate will be subject if released, and provide any additional information that will assist the Governor in deciding whether to grant the release as if on parole. The Adult Parole Authority will issue a report of the investigation to the director with 10 days. The director will then forward the investigation report and other information from the Adult Parole Authority to the Governor, together with a statement indicating whether or not the director concurs with the warden's recommendation. If the Governor authorizes release as if on parole, the inmate may be released as if on parole upon written acceptance of the terms and conditions of such release, including the condition that the inmate agrees to be evaluated at a facility designated by the department at any time requested following his or her release. Following the inmate's release, the supervising parole officer monitors the physical condition of the released inmate. If the releasee survives for a period of 9 months, the department's medical director will confer with the releasee's personal physician and with the ODRC director, and the director will notify the Governor that the releasee has survived for 9 months. The Governor may choose to revoke the parole or to allow the inmate to remain on parole.

I was informed that recently, approximately 40 percent of those recommendations from the Corrections Medical Center this year have been granted. That would be about 8 requests granted out of 20 total requests.

B. Hospice care

1. Do you have a hospice unit for inmates who are terminally ill?

Ohio has a six-bed hospice at the Corrections Medical Center.

2. What are the eligibility criteria in terms of:

a. The definition of "terminal illness"?

b. The level of functioning?

c. The type of crime the inmate committed?

d. The diagnosis?

e. Other?

Eligibility to be housed in the hospice includes a prognosis of less than 6 months and a discontinuation of any curative efforts. There are no criteria related to level of functioning, type of crime, diagnosis, or any other factors, although residing in the hospice is a voluntary decision by the inmate.

3. Is this a discrete unit? Part of the infirmary? Part of a housing unit? An outpatient program?

The hospice is on a ward. Two separate three-bed rooms are considered to be the hospice rooms. There is no outpatient program.

4. How many beds are in the hospice unit?

Six.

5. How many patients do you usually serve at one time?

On average about four patients are in hospice beds at any one time.

6. How many patients in all did you serve last year?

Last year, six inmates resided in the hospice.

7. Are there dedicated staff for the hospice unit? If yes, what types?

No staff are dedicated for the hospice. Nursing staff are available nearby, as are other staff from the Corrections Medical Center.

8. Do you use other inmates as volunteers in your program?

Yes, other inmates volunteer as part of this program and receive training.

9. If yes, describe the screening selection process, the training program, the types of activities they perform, and any rules/restrictions they operate under.

Stephen Ministries provides a training program geared to listening for all inmate volunteers. After completing the training process provided by Stephen Ministries, inmate volunteers are screened by medical services for appropriateness, including their behavior within the prison system. Those selected are matched with the patients according to personality type. These inmate volunteers function as companions. They provide no care. They may interact with the families of patients and on occasion have even attended the funeral of the terminal patient who died. They do participate in a predeath vigil.

10. Do you use any volunteers from the community? If yes, describe this program.

Some volunteers, mostly from religious-based groups in the community, participate.

11. Do terminally ill inmates in your system issue advance directives? DNR orders? If yes to either, what safeguards are in place to ensure that they have given noncoerced informed consent?

Terminally ill inmates in Ohio do use advance directives, and there are "do not resuscitate" (DNR) orders. DNR orders are not required in order for a person to be in the hospice, and, in general, family input is always sought prior to any DNR decision. ODRC has found that occasionally the family itself may try to coerce the patient.

12. What is the visitation policy for the terminally ill patient's family? Other inmates?

Once an inmate is in the hospice, visitation is three times per week *per visitor* on the inmate's list for each inmate in the hospital. When death is imminent, there is no limitation to visitation. Nonhospice patients are allowed up to four total visits per week at the Corrections Medical Center. If someone is terminal and mainstreamed, the number of visits allowed is based on his or her security level, either once or twice a month. Other inmates may visit hospice inmates only if they are volunteers as part of the program or if they live in the same unit. Exception will be made for a blood-relative inmate.

13. Are special foods and drinks available to terminally ill patients at all times?

A special refrigerator is in the hospice, and additional food and drink are available to inmate patients at all times.

14. Are there or were there institutional barriers (e.g., security rules, administrative concerns) that affect your ability to provide support for the terminally ill in your system? If yes, what are they and how are you addressing them?

With regard to institutional barriers, the biggest problem to the hospice was the mindset of the prison regarding rules on visits, but for the hospice patients, this really has changed. The hospice has also allowed much greater family involvement.

15. Do you have hospice programs in all of your facilities? If not, how many do you have?

The only hospice program is at the Corrections Medical Center. There is no hospice for females, but they could come to an area in the Corrections Medical Center that could be designated as a hospice. That has not occurred yet.

16. Are terminally ill inmates in all facilities able to be transferred to a unit with a hospice program?

Terminally ill inmates from all facilities may take part in the hospice program.

C. Palliative care

1. Is there a palliative care program in your facilities?

2. If yes, is palliative care available to those with advanced disease but who have not yet been defined as terminal?

No regular organized palliative care program is available at the Corrections Medical Center. Pain treatment is provided on a case-by-case basis.

3. What types of palliative care do you offer?

Inmates may be referred from the Corrections Medical Center to the Ohio State University Pain Management Clinic.

4. What are the eligibility criteria for receiving it?

No specific criteria would exclude an inmate from being referred to this pain management clinic.

5. Does your pain management program include the use of narcotics? If yes, did you encounter any resistance from custody staff? If yes, how did you overcome it? Describe what is available.

Pain management at the Corrections Medical Center includes the use of Roxanol and morphine. However, at all other institutions, only Darvon or codeine are used. Custody staff at the Corrections Medical Center have exhibited no resistance to the use of narcotics.

6. (No question number 6 was listed on the form.)

7. Do you use an interdisciplinary team in your palliative care program? If yes, what types of personnel are on it? Who leads the team? What is the team's role?

At the Corrections Medical Center, an interdisciplinary team, including physician, nurse, clinical social worker, clergy, dietician, and custody staff, may develop a treatment plan for each inmate and suggest strategies to better meet the inmate's needs.

8. Do you develop individualized care plans for your palliative care patients?

Yes, there are individualized care plans for patients at the Corrections Medical Center.

9. Can patients in the palliative care program continue to receive curative care?

Patients at the Corrections Medical Center can continue to receive curative care.

D. General

1. Are your end-of-life programs available to women inmates as well as men? Are there any differences in terms of what is available to women?

End-of-life programs may be available to women at the Corrections Medical Center, but they would be housed in a separate area.

2. Are you satisfied with the end-of-life care you are able to offer currently? If not, what more is needed?

The staff at Corrections Medical Center would like to be able to use the services of a music therapist. They would also like to be able to use a massage therapist; however, they anticipate there would be some resistance to this.

3. How are your end-of-life programs funded?

The end-of-life program is funded out of regular revenues plus the efforts of volunteers. Staffing is minimal, and the program is conducted on a shoestring. Donations are received for special foods and appliances.

Additional Special Programs

The Ohio system maintains a facility called the Robert Frazier facility, which provides a type of congregate housing for partially disabled inmates who may need the assistance of other inmates to perform some duties. A 24-bed infirmary is provided; a registered nurse's note is required in the infirmary on each shift, and a medical doctor's note is required each week. There are 76 residential housing unit inmates; in those units, the medical doctor writes a note monthly, and the nurses write a note once a day.

The Robert Frazier facility also contains the department's dialysis unit. It has 14 chairs, 1 of which is used for inmates infected with hepatitis B. The current census was 52; it appears to go up in winter and down in summer. The staffing for the dialysis program includes two licensed practical nurses and six registered nurses. Each inmate is seen monthly by an Ohio State nephrology fellow through the telemedicine program.

11/19/01

SITE VISIT REPORT: OREGON DEPARTMENT OF CORRECTIONS

SITE EVALUATOR: B. JAYE ANNO, PH.D

EVALUATION DATE: DECEMBER 2001

Preface

In December 2002, I visited three correctional facilities in Oregon to see how they manage their elderly, chronically ill, and terminally ill inmates. I toured the Oregon Women's Correctional Center (OWCC) and the Oregon State Correctional Institution (OSCI) on December 11, 2001, and the Oregon State Penitentiary (OSP) on December 12, 2001. My observations and findings are noted below.

Background

The Oregon Department of Corrections operates 13 facilities, including 10 for adult males, 1 for females, and 2 that are coed. It houses 10,600 inmates on any given day.

Oregon has a centralized health care system. Medical and dental services are under one division and mental health services under another. The directors of both of these divisions report to the same correctional administrator, who heads up correctional programs. Both the health services director and the mental health services director have line authority over the institutional health staff in their divisions.

Management of the Chronically Ill and Inmates With Special Health Needs

Assessment of chronic and special health needs occurs at intake. Inmates receive screening for health problems on admission, and followup occurs within 7 days with a more detailed health appraisal. Traditional forms designed to comply with the standards of the National Commission on Correctional Health Care are used. Inmates identified on admission as being at risk for mental illness are referred for a more indepth mental assessment, which is completed within 14 days.

The Oregon Department of Corrections has a computerized inmate tracking system that also includes information regarding each individual's medical needs, mental health needs, educational level, etc. The "health status" portion does not indicate diagnoses but, rather, any restrictions the person has in terms of housing (e.g., handicapped accessible, lower bunk), work, or other programming. Health staff enter any such restrictions into the database at the time of the initial health appraisal. Classification and programming staff use this information to make unit and job assignments. If someone tries to place a person in a unit where their needs cannot be met or in a job they cannot do, the computer flags it. Designation of available services has been made for each of the Oregon facilities, so it is easy to see at a glance what special needs can be accommodated at any given facility.

At the unit level, chronic care patients are followed regularly—at least every 3 months for HIV patients and at least every 4 months for other diagnoses and conditions. Providers refer to "Practitioner Guidelines for Special Needs Clinics" to guide their management of specific diseases and conditions. There

also are flowsheets for specific diagnoses to record what was done at each visit. In the Oregon system, inmates with the same diagnoses are not all scheduled to be seen in the chronic clinic on the same day. Staff felt this was stigmatizing. In addition, many inmates have multiple problems that do not fit neatly into one diagnosis. A computerized information system allows health staff to track inmates with special needs. Lists can be compiled by diagnoses, age, disability, etc.

The Oregon system makes several other accommodations for inmates with specific disabilities. Several units have a "wheelchair taxi service" available. This is a paid job for inmates providing the service. Blind inmates may be assigned a "seeing eye" cellmate. Closed caption TV and specially equipped phones are available for the hearing impaired. Although only the newer units comply with the Americans with Disabilities Act, most prisons have at least some cells that are handicapped accessible.

Nursing home care is available at the male prison in Snake River. At OSCI, a 61-bed dorm (called Unit 13) is available for elderly, disabled, and mobility-impaired male inmates. Eighteen inmate orderlies work in this dorm (12 as janitors and 6 who assist inmates assigned there with activities of daily living and provide "wheelchair taxi service" as needed). Hospital-style beds (with extra padding, bedding, trapeze, etc.) are provided when needed. Toilets, sinks, and showers are all handicapped accessible. Unit 13 inmates can use a therapeutic gym at special times, and a pool table is available at a lower height to accommodate those in wheelchairs. An elevator ramp is available adjacent to the stairway leading to the gym. Unit 13 has its own barbershop and sewing program to reduce the amount of movement these inmates must make. It is important to note that Unit 13 is not an inpatient unit. Although nursing care is available at OSCI 22 hours per day, the inmates assigned to Unit 13 do not require ongoing nursing services. If they do, they are transferred to the nursing home at the prison in Snake River.

At present, the Oregon system has more difficulty accommodating women with special needs owing to the age and space limitations of the primary female facility. At OWCC, women with special needs are tracked on a computerized system by their condition. There is no infirmary, though, and there is no space to house individuals with special needs together. Instead, the facility staff try to address special needs creatively. For example, a doublewide bed and oversize wheelchair were purchased for a woman weighing 600 pounds who had difficulty ambulating. A special toilet railing was erected in the cell of a woman without legs. A handicapped shower was installed. Whenever possible, health staff try to take services to inmates with special needs to reduce the amount of movement those who have difficulty ambulating have to make. In addition, inmate "caregivers" are paid to assist certain women with activities of daily living. The women are expected to be moved to a new prison at Coffee Creek in April that will have a 16-bed infirmary, a larger clinic area, and more housing options for females with special needs.

Management of Elderly Offenders

The Oregon Department of Corrections defines anyone "over 50" as elderly. However, it does not have any special programs or housing specifically for elderly inmates. Unit, program, and work assignments are based on the functional abilities of those over 50.

Release and Discharge Planning

In Oregon, all inmates receive prerelease planning and information on applying for benefits such as Social Security, Medicaid/Medicare, disability, food stamps, etc. Each person is assigned a release counselor who assists the inmate in developing an appropriate release plan. Releases can occur from any institution, but there are also designated release centers. All inmates are supervised when released to the community.

An inmate's health status or medical needs can serve as the basis for early release from the prison system through either a request for executive clemency (which the inmate makes on his or her own) or through "early parole release" (EPR). A centralized EPR committee includes the systemwide medical director, a medical case manager, a unit health services representative, and the inmate's assigned release counselor. Medical criteria for early release include being elderly and incapacitated, having a serious or terminal medical condition that is incapacitating, or having a condition that prevents the inmate from participating in prison life. The EPR committee makes a recommendation regarding early release to the Oregon Department of Corrections' Executive Committee. If they agree, the request is forwarded to the director. If he agrees, it goes to the Board of Parole for a final decision. The process usually takes about 2 months. Inmates who have committed certain serious crimes are excluded from consideration for EPR.

The Oregon prison health service system employs a half-time medical case manager, who helps inmates with chronic and terminal illnesses find an appropriate placement in the community. She also makes followup appointments with community providers, may assist with finding residential housing, and works with other state agencies to obtain benefits and services for those in need. The DOC provides subsidized housing for releasees without other plans for up to 30 days. Prison physicians can provide up to 30 days of medications to an inmate upon release, although narcotics are usually restricted to a 2-week supply. Fourteen case managers are provided for those with mental illness who need assistance with release planning.

Management of the Terminally Ill

The hospice program for males is located at OSP. Currently, there are no terminally ill females, but a room has been readied at OWCC and the health staff there have received hospice training.

At OSP, hospice patients are kept in the general population as long as possible, since that is their "home." When they become too ill, they are moved to the infirmary, which has a 21-bed ward, 2 single rooms, and 2 hard cells. The hospice patient can elect to be housed in one of the separate rooms or in the ward, depending on whether he wants privacy or company.

The only criteria for receiving hospice care are that two practitioners have determined that an inmate has less than 1 year to live, and that the inmate elects to receive hospice services. The inmate's diagnosis, level of functioning, and the type of crime he committed are not considered. No staff are dedicated for hospice care (in part, because few inmates require these services), but health staff at OSP have received training from a community hospice expert. The program also utilizes pastoral counseling and 22 inmate volunteers, who have received 44 hours of training in hospice philosophy and services. Criteria for their selection include an absence of disciplinary reports over the last year, but no restrictions are in place in terms of the seriousness of the crime committed. The volunteers are supervised by a nurse coordinator, who also gives them their assignments. When death is imminent, a 24-hour per day vigil is held by the hospice volunteers.

Individuals electing hospice care are not required to sign advance directives, including "do not resuscitate" orders, but most do. Inmate law clerks in the law library have copies of these forms if a terminally ill inmate wishes to use them.

Hospice inmates in the general prison population follow the regular visitation rules. Those in the infirmary can have bedside visits, including those from other inmates whom the patient has identified as "family." If the patient is dying, children under 18 may visit. One dying patient's dog was even permitted to visit. Other amenities while in the infirmary include special food and drinks, a TV with a VCR so the patient can watch movies, a CD player for music, and access to the health services telephone so the patient does not have to call collect.

Palliative care is available to terminally ill inmates as well as those with other painful conditions. Patches and pills are available to individuals in the general population, and patient-controlled analgesia (PCA) pumps are available for those in the infirmary. Most of the narcotics in pill form are crushed and floated in water, and all are directly observed when taken. Staff admitted that the patches could cause some problems with contraband but said they check on those with patches daily.

Staff indicated they were satisfied with their current end-of-life care but would like to do more in the way of bereavement services after a patient dies, especially for institutional staff and the inmate's prison family. They do hold a memorial service in the chapel when someone dies, but the infirmary staff would like to start a bereavement group.

Staff stated that the costs of hospice care are paid for out of the regular health services budget. They feel that hospice may even save money because inmates are not dying in the hospital.

The health staff I spoke with said there were no real barriers to implementing the hospice program. Once they received an okay from the director of the Oregon Department of Corrections, the rest of the correctional staff fell in line. They felt that it was a real advantage that health services in the Oregon Department of Corrections is a separate division and that they report to the systemwide medical director rather than to a warden.

SITE VISIT REPORT: PENNSYLVANIA DEPARTMENT OF CORRECTIONS

SITE EVALUATOR: JAMES E. LAWRENCE

EVALUATION DATE: NOVEMBER 8–9, 2001

Preface

Opened in July 1996 and located in Somerset County in rural western Pennsylvania, State Correctional Institution (SCI) Laurel Highlands is a former state mental hospital that was converted into a medium-security state correctional facility, presently housing 582 inmates, including 111 long-term care inmates and 73 personal care or assisted-living inmates. The staff complement totals 407. This congregate-care facility was developed to provide for the special needs of the long-term care and physically challenged inmates housed throughout the Pennsylvania Department of Corrections' 23 other male state correctional institutions. Although Pennsylvania's average inmate age is 24, the average age of inmates living at SCI Laurel Highlands is almost twice that at 47 years. SCI Laurel Highlands and SCI Waymart are the state's only institutions specifically developed and designated for the care, custody, and control of long-term assisted living, wheelchair-bound, and chronically ill prisoners. A host of special needs programs are provided. These are focused on advanced medical, nursing, and mental health care supplemented by substance abuse treatment, adult education, life skills training, and leisure and recreational activities, all managed through individualized, age-appropriate treatment plans.

Developmental History

SCI Laurel Highlands was established in 1996 with the conversion of the Somerset State Hospital after it was closed as part of the deinstitutionalization of the state mental heath system. During the late 1980s and first half of the 1990s, Pennsylvania Department of Corrections policy analysts and executives began noting that one ominous effect of longer sentences due to truth-in-sentencing was a growth in the inmate population older than age 55 of approximately 10 percent per year. This burgeoning elderly and infirm population was hitherto managed at multiple sites throughout the system, requiring duplicative services, which increased costs and impaired quality. Then-Secretary of Corrections Martin Horn recognized the need to consolidate and centralize services and was able to get this issue recognized as a policy problem worthy of the attention of the state's executive and legislative leadership.

The first and present superintendent of SCI Laurel Highlands, Fredric Rosemeyer, Ph.D., was recruited from SCI Waynesburg to design and implement the program. In an atypical and innovative development, it was decided not only to convert Somerset State Hospital to a corrections/geriatric/assisted living program but also to convert the existing staff to that purpose. State Department of Welfare employees at Somerset, consisting mostly of registered professional nurses, licensed practical nurses, and certified nurse assistants, were screened and then offered correctional health positions with the understanding that a new program for elderly inmates would be developed. This saved 251 jobs slated for abolition and created a positive work ethic and high morale that continue to contribute to the program's success.

Program Overview

The physical plant is a multibuilding complex sited on 53 acres in southwestern Pennsylvania. The environment is fully renovated. "A" Unit consists of three mirror-image floors with semiprivate rooms, large dayrooms with full outside views, an integrated

officer/nurses' station, chart room, pharmacy, visiting room with children's play area, and bath and showers with full handicap accessibility for toilet use and bathing. A fully equipped physical therapy unit is attached to the ambulatory services unit first floor. A fully equipped dialysis unit has eight complete stations. The Laurel Highlands medical director is a board-certified nephrologist.

The overall client census includes 582 inmates consisting of Long-Term Care Program inmates (capacity 111) managed at the skilled nursing/high-acuity level; the Personal Care Program (capacity 73), which is a self-care/assisted living program; and a general or "cadre" population that maintains the facility and provides workers for essential services. Of 407 total staff members, 77 are nursing and allied nursing positions. Expenditures average approximately $65,000 per inmate year versus $27,000 for the rest of the Pennsylvania system. The Deputy Superintendent responsible for operations is a registered professional nurse, the former nurse-administrator of the Somerset State Hospital.

The health services management, administration, physical therapy, occupational therapy, dialysis, and support services programs, as well as the medical director and other physician services, are provided through a contract vendor. The Pennsylvania Department of Corrections exclusively provides overall program administration and all nursing services. The uniformed security staff is organized for unit management. All inmate security classifications are eligible for the SCI Laurel Highlands Long-Term Care Program if otherwise qualified. SCI Laurel Highlands' administration is empowered to reject inappropriate or maladjusted patients or to require their transfer once admitted.

Medical and Nursing Staff

A full-time medical director is employed who, as a board-certified nephrologist, also heads the renal dialysis program. A full complement of clinical physicians and certified physician's assistants provide medical care, which includes the staff of an ambulatory services clinic for outpatient care of the inmate service cadre. The nursing staff is enriched for high-acuity care and for effective organization and administration. On weekdays, the nursing staff consists of five registered professional nurses, six licensed practical nurses, and four certified nurse's assistants. On evenings, the staff includes four registered nurses, six licensed practical nurses, and three nurse's aides. At night, the facility staffs three registered nurses, three licensed practical nurses, and four nurse's aides. Weekend coverage is similar to that on weekday evenings.

Functional Assessment

The institution offers multiple, coordinated levels of care. The Long-Term Care Program provides high-acuity skilled nursing for inmates who are bedridden, depend on a respirator, or are terminal total care patients. Moderate acuity patients needing nursing supervision are also managed, as are those requiring nursing assistance with activities of daily living and those with altered mental status, including dementia. The Personal Care Program, sited in a separate building, provides assisted living at the health-related facility level of care.

An eight-page referral/application is completed at the originating institution; Laurel Highlands occasionally sends a senior registered nurse to originating facilities to assist with the functional assessment, which begins with the medical director's or health services administrator's referral with application. Medical autonomy is an important element in each admissions process. Final approval for all placements rests with the Bureau of Health Care Services in the Pennsylvania Department of Corrections' Central Office. An intensive second functional and medical assessment is completed upon reception at Laurel Highlands.

Admission/Reception and Continuity of Care

Patient admissions are planned and begin with a comprehensive screening by a registered nurse immediately upon arrival. A complete history, physical examination, and mental health evaluation follow

within 1 day. This includes a complete review of systems and a supplemental functional assessment.

A registered nurse is dedicated for chronic care coordination in each of the two main programs, i.e., Long-Term Care (Unit "A" skilled) and Personal Care (assisted living). Chronic care clinics are held weekly; these include clinics for asthma, renal, surgery, neurology, hypertension, cardiology, and infectious disease. A weekly superintendent's meeting is held with all service chiefs. The medical audit committee (MAC), the primary interdisciplinary organizational and therapeutic workgroup, meets monthly. A medical and administrative meeting provides a quarterly review of vendor performance. A full-time registered nurse is assigned to Quality Improvement; activities are scheduled monthly and reported to the MAC. A policy and procedure review meeting is held bimonthly. The Pharmacy and Therapeutics Committee meets quarterly. A full-time registered nurse is assigned to manage the infection control program; results are reported to the MAC. Apart from organizational and administrative controls, the continuity-of-care model is one of case management with multidisciplinary treatment team meetings on problem cases.

Support Services

Laboratory. A contract laboratory provides next-day courier service; a staff phlebotomist is available twice each week; results are sent via fax. STAT laboratory services are available at nearby Somerset Hospital.

Pharmacy. A local contractor is employed. At Laurel Highlands, a main pharmacy and five satellite substocks are provided.

Radiology. A full installation is on site.

Laundry. Nearby SCI Somerset handles all institutional laundry at temperatures sufficient to eliminate biohazard.

Medical Records. The problem-oriented (SOAP) medical record is exclusively employed.

Chronic Care. A flowsheet system is used for all chronic care.

Nutrition. Commissary access is limited for therapeutic reasons; 137 therapeutic diets are available on same-day notice.

Dental Care. Three fully equipped modern operatories, a panoramic x-ray, a full-time dentist, and a hygienist/assistant are provided. An oral surgeon is contracted. Dentures are fabricated and repaired by a contract laboratory with 3-day service.

Hospital Services

Somerset Hospital, a community general hospital located in the facility's host community, provides a full range of inpatient and emergency department services to SCI Laurel Highlands. At present, Superintendent Rosemeyer serves as a member of the Hospital Board.

Mental Health Services

SCI Laurel Highlands provides a full range of psychiatric and adjunct mental health services. The facility staffs a clinical psychologist, two psychiatric social workers (Ph.D. or master's prepared), together with 12 hours of psychiatry (medical doctor) weekly.

Habilitation Services and Programs

Substance Abuse Services. Group therapy, multimedia teaching aids, and drug and alcohol treatment from Department of Corrections-certified counselors are offered.

Life Skills Program. A comprehensive program is offered in four modules: Positive Change, Informed Decisions and Choices, Anger Management, and Interpersonal Communication.

Employment. Opportunities are offered in carpentry, groundskeeping (including horticulture), library, maintenance/small engine repair, stock clerking, and custodial jobs. The Barber Manager's Program

combines vocational education with an essential inmate service.

Leisure Activities. Passive games, particularly puzzles for cerebral stimulation, are emphasized. Large-format games, puzzles, books, and playing cards are available for the visually impaired. The Arts and Crafts Program is designed around bench-style crafts, such as ceramics and painting, to accommodate physical limitations.

Religious Activities. SCI Laurel Highlands staffs a full chaplaincy department offering congregate and individualized worship. Religious education and spiritual group activities are available to residents.

Education. Full Adult Basic Education and GED programs are offered to all inmates; classrooms are equipped to accommodate wheelchairs, and all learning equipment is adjustable to meet physical limitations. Programming, instruction, and tutoring are delivered to inmates who cannot attend classes owing to debilitation or other limitations.

Discipline. The standard Pennsylvania Department of Corrections disciplinary system is modified at SCI Laurel Highlands to include an informal resolution component overlying the due process system. Senior correctional supervisors are able to resolve even serious infractions on the spot with mild sanctions, provided that agreement exists between security staff charging the offense, any involved victim, and the medical staff.

Visitation. Rules and schedules are relaxed so that families may visit virtually at will; frequency is generally unlimited, and amenities and services are excellent, including full accommodations for children.

Hospice. Complete hospice care is provided as medically indicated. At SCI Laurel Highlands, patients who become terminal are not ordinarily transferred elsewhere and are managed palliatively as their conditions progress. Hospice St. John's at SCI Waymart operates a second hospice program.

Despite its unique history and innovative programs, SCI Laurel Highlands remains a state correctional facility. It is tasked first and foremost to provide safe, humane, and secure confinement for inmates committed to its care and custody. However, SCI Laurel Highlands represents one of the first and best accommodations to the fact that, throughout the United States, inmates committed for serious crimes will be staying in prison longer and growing old there. This facility, its staff, and its programs can serve as an object example to corrections departments nationwide as they all eventually, but inevitably, confront the problem of safe and humane management of elderly and infirm inmate populations.

Site Visit Checklist:

The Functional Assessment—Issues Considered and Questions Covered During the Site Visits

Appendix C

Site Visit Checklist: The Functional Assessment—Issues Considered and Questions Covered During the Site Visits

The Functional Assessment

Issues To Be Considered

What are current and ideal practices on conducting functional assessments of inmates upon commitment?

> While there is a high level of agreement among medical professionals that conducting an initial comprehensive functional assessment is the critical initial step in determining the kind and level of care for these inmates, few adult institutions have such a protocol in place, or even persons qualified to carry one out.
>
> What can free-world medicine teach corrections about the conduct of such assessments? Are there efficient and effective assessment protocols available that would work well in corrections settings?
>
> How might the results of such assessments be employed to prescribe the right kind and level of care for individual inmates?
>
> How might the results of such assessments be employed to determine the amount and kind of specialty care resources that are required to efficiently and effectively respond to the needs and requirements of aging, chronically ill, and terminally ill inmates?

Based on such assessments, what kinds of approaches, strategies, and programs are indicated?

> How might the results of such assessments be employed to prescribe the right kind and level of care for individual inmates?
>
> What kinds of programs and strategies might be considered? [Hospice care, compassionate leave, special medical technologies, etc.]
>
> What programmatic issues are likely to be encountered?

What is the system doing to ensure that the special needs of inmates are recognized?

What is the mechanism used to ensure that the special needs of the inmate are always maintained?

Specific Questions To Be Covered

1. What is the screening tool used for inmates with special needs on entry to systems?
2. What other kinds of screening mechanisms are used at intake to determine functionality? (Gather available forms.)
3. Is a functional assessment routinely conducted on all inmates at intake? If "yes," what does the functional assessment entail?
4. How does your classification program work to separate inmates based on need?

5. How do you ensure that the special needs which have been identified are recognized?

6. What is your mechanism to ensure that the special needs of the inmate are always maintained? (Including upon transfer from one facility to another.)

BALANCING CUSTODY CONCERNS AND APPROPRIATE CARE: HOW DO WE COME TO TERMS WITH THE SPECIAL NEEDS AND REQUIREMENTS OF ELDERLY, CHRONICALLY ILL, AND TERMINALLY ILL INMATES?

Issues To Be Considered

What kinds of approaches, strategies, and programs are indicated? What kinds of programs and strategies might be considered? [Hospice care, compassionate leave, special medical technologies (such as telemedicine), etc.]

What are the enablers and barriers to establishing provision of appropriate care for these populations?

What programmatic issues are likely to be encountered? [For instance, under what circumstances should chronically ill and terminally ill inmates, as distinguished from aging and elderly inmates, be housed in separate facilities and/or segregated from other inmates, and under what circumstances might they be "mainstreamed" with the general inmate population?]

What are the current and proposed correctional policies relating to these populations?

What are the political and financial costs involved?

Specific Questions To Be Covered

1. Does your departmental offender tracking system count inmates considered to be elderly separately? _____ Yes _____ No

   _____ By gender?

   _____ By race?

   _____ By county of commitment?

   _____ By number of prior commitments?

   _____ By level of felony?

   _____ By most serious commitment offense?

   _____ By initial security classification assignment?

2. Does your departmental offender tracking system distinguish between

   Inmates who entered the system younger than age 50 and who attained that age while incarcerated? _____ Yes _____ No

   Inmates who were age 50 or older at entry but were never incarcerated before?
   _____ Yes _____ No

   Inmates who were age 50 or older at entry who were previously incarcerated?
   _____ Yes _____ No

3. Are elderly inmates in your department housed congregately in special housing as a discrete subpopulation? _____ Yes _____ No

4. Are elderly inmates housed in one or more separate facilities in your departmental system?
   _____ Yes _____ No

5. Does your department provide educational or other personal development programs specifically designed for elderly inmates that include issues and problems? _____ Yes _____ No

6. If "yes," does the program include

   _____ Education on the aging process?

   _____ Education on physical, psychological, and social issues associated with aging while incarcerated?

   _____ Education on self-care and activities of daily living, basic adult education, and literacy?

7. Does your department provide supervised recreational programs specifically designed and appropriate for elderly inmates?
   _____ Yes _____ No

Please describe the programs available:

8. Does your department survey/sample your population of inmates age 50 or older to assess their perceptions of their needs?
_____Yes _____No

9. Does prerelease planning for elderly inmates include information on

_____Social Security?

_____Medicare?

_____Estates and wills?

_____Advance directives (such as "do not resuscitate" (DNR) orders)?

_____Funeral planning?

_____Other community-based services for the elderly (e.g., "meals on wheels")?

10. Does your departmental health services division provide organized health education services for inmates considered elderly?
_____Yes _____No

11. Is there a peer-visiting program for elderly inmates? _____Yes _____No

12. In your department, do inmates who are debilitated, frail, or medically fragile have access to a congregate therapeutic living community where they can be medically supervised, specially programmed, and assisted with the activities of daily living? _____Yes _____No

If "yes," is that program available to both men and women?

_____Men only

_____Women only

_____Men and women

13. Does your department's health services division promulgate and implement chronic protocols or guidelines for all of the major chronic conditions? _____Yes _____No

14. Does your department operate prerelease centers or halfway houses with programs designed for elderly inmates? _____Yes _____No

15. Are inmates who are considered elderly in your department provided

_____Universal access to the entire physical plant housing them?

_____Single or lower bunks?

_____Additional heat in cold weather?

_____Air conditioning in warm weather?

16. Are medical social services professionals available to your department's population of inmates directly or to your health services division as case management consultants?
_____Yes _____No

17. Does your department operate or have access to levels of care ordinarily identified with nursing homes? _____Yes _____No

18. Does all or part of your department's physical plant comply with the Americans with Disabilities Act?

_____All institutions

_____Number of institutions

_____None

MEDICAL, PROGRAM, AND HOUSING CONSIDERATIONS: REQUIREMENTS FOR ELDERLY, CHRONICALLY ILL, AND TERMINALLY ILL INMATES

Issues To Be Considered

What kinds of approaches, strategies, and programs are indicated? What kinds of programs and strategies might be considered?

Specific Questions To Be Covered

A. Compassionate release

1. Is there a compassionate release/medical parole program for terminally ill inmates in your system?
2. Who initiates the request for compassionate release?
3. How long does the process generally take?
4. Which agency can grant the release request?

B. Hospice care

1. Do you have a hospice unit for inmates who are terminally ill? _____ Yes _____No
2. What are the eligibility criteria in terms of:

   a. The definition of "terminal illness"?

   b. The level of functioning?

   c. The type of crime the inmate committed?

   d. The diagnosis?

   e. Other?

3. Is this a discrete unit?_____
   Part of the infirmary?____
   Part of a housing unit?_____
   An outpatient program?_____
4. How many beds are in the hospice unit? _____
5. How many patients do you usually serve at one time?_____
6. How many patients in all did you serve last year?_____
7. Are there dedicated staff for the hospice unit? If "yes," what types?
8. Do you use other inmates as volunteers in your program? _____
9. If "yes," describe the screening selection process, the training program, the types of activities they perform, and any rules/restrictions under which they operate.
10. Do you use any volunteers from the community? If "yes," describe this program.
11. Do terminally ill inmates in your system issue advance directives? _____ DNR orders?_____
    If "yes" to either, what safeguards are in place to ensure that they have given noncoerced informed consent?
12. What is the visitation policy for the terminally ill patient's family? Other inmates?
13. Are special foods and drinks available to terminally ill patients at all times?
    _____ Yes _____No
14. Are there or were there institutional barriers (e.g., security rules, administrative concerns) that affect your ability to provide support for the terminally ill in your system? If "yes," what are they and how are you addressing them?
15. Do you have hospice programs in all of your facilities? _____ Yes _____No

    If not, how many do you have? _____
16. Are terminally ill inmates in all facilities able to be transferred to a unit with a hospice program?
    _____ Yes _____No

C. Palliative care

1. Is there a palliative care program in your facilities? _____ Yes _____No
2. If "yes," is palliative care available to those with advanced disease but who have not yet been defined as terminal? _____ Yes _____No
3. What types of palliative care do you offer?
4. What are the eligibility criteria for receiving it?
5. Does your pain management program include the use of narcotics? _____ Yes _____No

   If "yes," did you encounter any resistance from custody staff? If "yes," how did you overcome it? Describe what is available.
7. Do you use an interdisciplinary team in your palliative care program?

   _____ Yes _____No

   If "yes," what types of personnel are on it? Who leads the team? What is the team's role?
8. Do you develop individualized care plans for your palliative care patients?
   _____ Yes _____No
9. Can patients in the palliative care program continue to receive curative care?
   _____ Yes _____No

D. General

1. Are your end-of-life programs available to women inmates as well as men?

   Are there any differences in terms of what is available to women?
2. Are you satisfied with the end-of-life care you are able to offer currently? If not, what more is needed?
3. How are your end-of life programs funded?