The Aging Inmate Population

Prepared by
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Southern Legislative Conference
of The Council of State Governments
The Aging Inmate Population

A Special Series Report of the Southern Legislative Conference
ACKNOWLEDGMENTS

The Human Services and Public Safety Committee of the Southern Legislative Conference, chaired by Senator Diana E. Bajoie, Louisiana, has recently focused on several issues affecting southern states' correctional systems. This Special Series Report continues that trend, examining the aging of our region's prison population and the challenges posed to corrections departments in meeting the special needs of these inmates.

A special thanks is due to all corrections officials across the South who participated in gathering and presenting the information needed for this report. In addition to the authors of the texts cited in the references, the Committee especially thanks Professor Ronald H. Aday, Gerontology Program Director, Middle Tennessee State University, for his assistance. His prior research in this area provided a foundation on which to expand the information for this report.

This report was prepared by Todd Edwards, Regional Representative for the Southern Legislative Conference of The Council of State Governments, under the Chairmanship of Speaker David H. Wilkins, South Carolina.
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INTRODUCTION

Today, many states’ correctional systems are finding it difficult to deal with the burden of overcrowded and outdated prison facilities. Recent laws aimed at getting tough on crime — including longer, minimum, mandatory, two- and three-strikes sentencing; parole abolition; and truth-in-sentencing — will most likely continue to place a tremendous strain on correctional budgets and states’ abilities to house increasing prison populations.

Though sentences and parole used to be influenced by such issues as the inmate’s record in prison, crowding, remorse and sometimes an inmate’s religious conversion, there has been increasing public pressure to get tougher on criminals. In addition, demographic shifts such as longer life expectancy and the graying of the inmate population soon will pose unique challenges to states in this area.

While the proportion of older prisoners in state prisons has risen only slightly in recent years, their numbers have jumped substantially over the past decade, both in absolute terms and as a proportion of states’ entire prison populations. If current trends continue, the increased costs of housing and caring for elderly offenders will represent a substantial portion of most corrections departments’ budgets in the near future. Unfortunately, the body of knowledge regarding elderly inmates and the challenges posed to correctional systems in meeting their special needs is not extensive.

This SLC Special Series Report examines the growth of this prison population in the South, illustrates several relevant issues and challenges confronting southern states and reviews the facilities, programs and policies which states have implemented to address the needs of older and/or geriatric inmates. The report also reflects what corrections officials in the South feel are their most pressing concerns facing their correctional systems in responding to the growth of this aging population. Information was compiled both through existing research and polling the 16 Southern Legislative Conference (SLC) member states: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

Although the focus is on older inmates, the challenges surrounding their care are similar to those faced by caring for the physically disabled, infirm, those living with HIV-AIDS or terminal illnesses, and those having debilitating mental or physical impairments. Though all of these
populations differ on the care they require, they do have many special needs in common which can be met simultaneously, and which are addressed in this report.

With a predicted rise of offenders who are older, sicker and serving longer sentences, coupled with institutions' stretched resources, many believe our corrections departments are facing an inevitable crisis. Such a predicament can be avoided if policymakers and corrections officials are alerted to the increase in the geriatric prison population and the unique challenges facing correctional systems in meeting their projected needs. Correctional policy can then be shaped to account for those needs more effectively and efficiently.

AGING INMATES

Elderly Inmates on the Increase

Historically, due to the small and stable size of the aged inmate population, little thought was given by policymakers to this issue. However, trends are showing a dramatic increase in the number of elderly prisoners over the past decade. Corrections practitioners have been warned since the early 1980s that as the number of elderly people in America's general population increased, so too would the number of elderly inmates. The "graying" of America, due to the maturing of baby-boomers, affects many aspects of our government and social system.

Experts argue that the growth in the older prison population is not due to an elderly crime wave. According to the United States Department of Justice, the trend is more a result of recent "three strikes" and truth-in-sentencing laws. At the same time that more prisoners are being introduced into our states' correctional systems, both older and younger, they are spending more time there.

Though many states have taken precautionary measures to address this trend, some have found that the increase in the geriatric inmate population has been far greater than anticipated. For example, in June 1987, Florida had 1,350 inmates who were 50 years of age or older in the state's prison system. That same year, corrections officials estimated that number would increase to 3,094 by the year 2000.¹ By 1997, Florida already had 3,985 such inmates, a 195 percent increase in a decade and already exceeding the 2000 projection.

According to various statistics, in the 16 SLC member states, the number of inmates 50 years of age and older has increased from 4,490 to 26,404, or 480 percent, between 1985 and 1997. North Carolina experienced the greatest increase with 1,140 percent, and Arkansas experienced the least with 48 percent. During this same time, total inmate population increased only 147 percent among SLC states.² In the 1990s, this increase has been less pronounced, but still significant. Between 1991 and 1997, inmates aged 50 and over have increased 115.12 percent in SLC member states while total inmate populations increased 83.69 percent.³ Joann Morton, professor of criminal justice at the University of South Carolina, has stated that "we are setting ourselves up for a tremendous glut of elderly prisoners. It is not yet a crisis, but it will be."⁴

The total inmate populations in southern state institutions, as well as inmates 50 years of age and older between 1991 and 1997, are listed in Table I.
### Table I

**How Southern States Compare**

<table>
<thead>
<tr>
<th>State</th>
<th>Total in institutions(^b)</th>
<th>Inmates age 50 and over</th>
<th>Percent age 50 and over</th>
<th>Total in institutions</th>
<th>Inmates age 50 and over</th>
<th>Percent age 50 and over</th>
<th>% increase of inmates in institutions 1991-97</th>
<th>% increase of inmates age 50 and over 1991-97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>13,142</td>
<td>736</td>
<td>5.60%</td>
<td>21,761</td>
<td>1,223</td>
<td>5.62%</td>
<td>65.58%</td>
<td>66.17%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>6,533</td>
<td>71</td>
<td>1.09%</td>
<td>10,221</td>
<td>563</td>
<td>5.51%</td>
<td>55.45%</td>
<td>692.96%</td>
</tr>
<tr>
<td>Florida</td>
<td>43,920</td>
<td>2,098</td>
<td>4.78%</td>
<td>63,763</td>
<td>3,985</td>
<td>6.25%</td>
<td>45.18%</td>
<td>89.94%</td>
</tr>
<tr>
<td>Georgia</td>
<td>22,302</td>
<td>1,107</td>
<td>4.96%</td>
<td>36,972</td>
<td>2,082</td>
<td>5.63%</td>
<td>65.78%</td>
<td>88.08%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>7,705</td>
<td>532</td>
<td>6.90%</td>
<td>12,910</td>
<td>936</td>
<td>7.25%</td>
<td>67.55%</td>
<td>75.94%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>13,849</td>
<td>NA</td>
<td>0.00%</td>
<td>26,779</td>
<td>1,356</td>
<td>5.06%</td>
<td>93.36%</td>
<td>NA</td>
</tr>
<tr>
<td>Maryland</td>
<td>16,899</td>
<td>663</td>
<td>3.92%</td>
<td>22,109</td>
<td>869</td>
<td>3.93%</td>
<td>30.83%</td>
<td>31.07%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>6,724</td>
<td>201</td>
<td>2.99%</td>
<td>14,032</td>
<td>730</td>
<td>5.20%</td>
<td>108.69%</td>
<td>263.18%</td>
</tr>
<tr>
<td>Missouri</td>
<td>14,946</td>
<td>618</td>
<td>4.13%</td>
<td>22,025</td>
<td>1,189</td>
<td>5.40%</td>
<td>47.36%</td>
<td>92.39%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>18,605</td>
<td>853</td>
<td>4.58%</td>
<td>31,764</td>
<td>1,451</td>
<td>4.57%</td>
<td>70.73%</td>
<td>70.11%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>10,502</td>
<td>707</td>
<td>6.73%</td>
<td>20,316</td>
<td>1,430</td>
<td>7.04%</td>
<td>93.45%</td>
<td>102.26%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>15,529</td>
<td>741</td>
<td>4.77%</td>
<td>20,604</td>
<td>901</td>
<td>4.37%</td>
<td>32.68%</td>
<td>21.59%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>8,380</td>
<td>619</td>
<td>7.39%</td>
<td>18,795</td>
<td>1,116</td>
<td>5.94%</td>
<td>124.82%</td>
<td>80.29%</td>
</tr>
<tr>
<td>Texas</td>
<td>49,316</td>
<td>2,153</td>
<td>4.37%</td>
<td>132,394</td>
<td>7,923</td>
<td>5.98%</td>
<td>168.46%</td>
<td>258.00%</td>
</tr>
<tr>
<td>Virginia</td>
<td>14,507</td>
<td>851</td>
<td>5.87%</td>
<td>28,408</td>
<td>1,411</td>
<td>4.97%</td>
<td>95.82%</td>
<td>65.80%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>1,504</td>
<td>157</td>
<td>10.44%</td>
<td>2,755</td>
<td>235</td>
<td>8.53%</td>
<td>83.18%</td>
<td>49.68%</td>
</tr>
</tbody>
</table>

**Total / Total %**

| Total / Total % | 264,363 | 12,107 | 4.83%\(^c\) | 485,508 | 27,400 | 5.64% \(^c\) | 83.69% | 115.12% \(^c\) |

**Notes:**

\(^a\) It is important to note that some discrepancies occur when cross referencing data from any two sources' prison statistics, especially over an extended period of time. Thus, the *Corrections Yearbook* was utilized for obtaining data. However, the SLC could not obtain this publication for years preceding 1991. Other sources, at time of print, were either not available, out of print, or utilized different categorizations for listing the age of inmates. Therefore, *Table I* should be used only as indicative of overall, recent trends in the growth of this population.

\(^b\) Total in Institutions includes state and federal inmates, age 50 and over, confined in prisons, out in other programs/facilities/agencies, and waiting in jails for prison admission.

\(^c\) Percentage was calculated excluding the prison population for inmates, age 50 and over, from Louisiana which had no data for 1991.

**Source:**

To provide a national perspective, according to the Criminal Justice Institute, from 1990 to 1997, the percent of the nation's prison population age 50 and over increased from 4.9 percent to 6.8 percent. That organization also reported that in 1997:

- there were more than 73,543 inmates age 50 and older in U.S. correctional facilities as of January 1, 1997;
- Texas incarcerated the greatest number of inmates age 50 and over (7,923), followed by California (7,420);
- the Federal Bureau of Prisons incarcerated 11,271 inmates (10.7 percent) who were age 50 or older;
- the percentage of the total inmate population age 50 or older was largest in Maine (20.1 percent of total inmates); and
- the smallest percentage of the total inmate population age 50 or older was in Connecticut (3.2 percent).

_The New York Times_ reported that in 1989, the nation's prisons held 30,500 inmates age 50 or older and by 1993, that number had risen to almost 50,500. The American Correctional Association predicts that this elderly inmate population will reach 125,000 by the year 2000, with 50,000 of those prisoners older than 65. While these numbers may or may not seem alarming, their rise should certainly draw attention.
The Challenges Involved

It is important to understand the implications associated with the increase in this older prison population. Primarily because federal law mandates that states provide adequate health care to all inmates, many corrections departments are concerned about providing this care effectively and efficiently. Of interest is a study completed by California’s Center on Juvenile and Criminal Justice which found that the total cost of incarcerating younger inmates averages $21,000 yearly, while the cost of incarcerating inmates over 50 averages $60,000, mainly due to their health care needs. Studies completed by the Project for Older Prisoners and Newsweek magazine have reported similar findings. Regrettably, due to the difficulty obtaining age breakdown data across the states for health care, other services or overall incarceration costs, this report does not include such figures.

Health Care
According to Harold Hodgkinson, director of the Center for Demographic Policy, in a 1997 publication of the National Commission on Correctional Health Care, “age is one of the biggest issues which will continue to impact corrections and correctional health care.” Hodgkinson stated that, as more prisoners with non-commutable sentences are housed in the nation’s prisons, “correctional health care is going to have to move toward a geriatric specialization.” He sees issues such as cancer scans, life support and chronic care for those affected by heart disease, cancer, emphysema and stroke becoming increasingly important.

In a paper presented to the Virginia Department of Corrections, Jonathan Turley, director of the Project for Older Prisoners, noted that “the greatest single contributor to the high costs of older inmates is medical expenditures. On average, inmates over 55 will suffer three chronic illnesses while incarcerated.” Echoing this, the American Medical Association in its “White Paper on Elderly Health,” noted that “the health care problems of the elderly include a higher incidence of disease, increased prevalence of chronic illness and significant functional disability.”

“While states may be facing inevitable costs for treating elderly inmates,” according to Michael Dallaire, executive director for Correctional Health Care Consultants, “there are ways to mitigate those costs.” Dallaire said states are devising managed care systems for all inmates, which in effect puts them in a statewide HMO or PPO. Proponents of managed care argue that it promotes fixed budgets, which in the face of strong demand for services encourages decisions designed to allocate health care resources efficiently.

In addition, as the elderly inmate population grows, state policymakers may continue to look at privatization as a way to reduce costs and provide health care. In the South, almost all state corrections departments contract out some portion of their health services. Alabama, Georgia, North Carolina and Virginia have privatized all prison health care.

Though the privatization of correctional health services appears to offer potential savings, states’ experiences with privatization have not been universally positive. Because of this, many argue that states may wish to experiment with privatization on a regional rather than state-wide level to see if efficiency is gained.

One difficulty for policymakers and corrections officials is adequately classifying what consti-
tutes an elderly inmate. Even noted gerontologists do not agree on a specific chronological age as a benchmark for studying the elderly. Some researchers define "elderly" as 65 years of age and older, while others suggest using 60 years, while others have reported 55 years or 50 years of age or older as an appropriate definition. For the purpose of this report, the lower consensus age of 50 years and older has been used. Though this may seem younger than what many people would classify as an elderly individual, an inmate's chronological age of 50 may be deceiving at times.

Inmates as a population traditionally have medical and social histories that put them more at risk for illness and disease than their non-inmate peers. For example, many inmates have substantial health needs and engage in a number of risky health behaviors. Statistically, they have higher rates of HIV-AIDS, sexually transmitted diseases, tuberculosis and other infectious diseases than the population at-large. Lifestyle choices such as widespread tobacco use, extensive drug and alcohol use, and high-risk sexual behavior contribute to their greater need for health services. In a keynote speech at the 20th National Conference on Correctional Health Care, B. Jaye Anno, Ph.D., cited one researcher, using health hazard appraisals, who found that "an inmate's appraised age averaged 11.5 years more than their chronological age due to these and other factors."

Although the rising cost of providing adequate health care is seen by most of southern states' correctional departments surveyed for this report as the biggest challenge in meeting the needs of an aging inmate population, it is by no means the only concern of administrators. Depression, work assignments, co-payments, nutritional requirements, vulnerability to victimization, the provision of adequately trained staff to care for these inmates, housing, social and recreational activities, facility accessibility, and the diversity of this population can, and often do, pose serious challenges as well.

Depression
Studies have shown that elderly inmates are proportionately far more likely to experience serious depression than the general inmate population. According to author M.W. Gillespie, "the physical, intellectual and emotional deterioration brought on by long confinement can create bitterness and resentment among older inmates, and they may become pessimistic about their present and future status as time passes." Also, because they are more likely to experience the death of friends and family, some argue that they are in greater need of loss counseling.

Author Judy C. Anderson states that "aging and the resulting medical difficulties serve as constant reminders of the frailty of life making many elderly inmates appear to have greater psychological and emotional characteristics which means they may experience adjustment problems." Some suggest that depression should be treated with drugs and support of friends, however, author Larry W. Thompson believes the success of drug treatment is limited by the physiological processes of aging. Thompson states that behavior therapy and cognitive therapy have been shown to work better than support.

One other factor which should be taken into consideration is that release planning — helping elderly inmates find jobs outside of prison once they are released — can be extremely difficult for elderly inmates because many of them may be unable to hold full-time jobs, which often is a stipulation of parole or probation. That point, however, may be moot. Often, when individuals
live to be elderly or infirm behind bars, many of them find it difficult to survive in the outside population due to their inability to work, or to sustain themselves outside of prison. Nonetheless, states may wish to offer release planning which includes referrals to long-term care, assisted-living and eligibility counseling for Medicaid and Social Security.

Work Assignments
Suitable assignment of jobs or tasks to older prisoners also can pose challenges to corrections officials. Almost all corrections departments require inmates to perform some sort of work activity during their incarceration. Additionally, an issue which has recently surfaced, and which many state legislatures are considering, is requiring inmates to pay for their room and board. This is commonly referred to as per-diem (in county/city facilities) or subsistence charges. Legislators in Kentucky, Tennessee, and Texas, among other SLC states, are currently considering requiring these charges, and there are a number of states already employing such reimbursement practices.

Offender retribution is not a new idea in corrections. As systems struggle with dramatic increases in inmate populations — coupled with shrinking resources — some states have implemented programs requiring inmates to work to help pay for their room and board, education and health care.

Co-payments
Another example of inmate retribution is co-payment for health care services. This method, utilized by many states’ corrections departments, attempts to reduce health care costs and is similar to subsistence charges in that institutions require inmates to pay a certain percentage of the cost of utilizing health care services. The rationale behind implementing a charge for health services is the concern that many inmates abuse the system and visit sick call when they really do not need to be seen.

Studies have found that health service utilization rates in corrections facilities average 5 to 6 times higher than community utilization rates, with male inmates averaging about 20 visits per year and female inmates averaging about 24 visits per year. Some argue that the correctional environment, system-mandated visits, inefficiencies in the health delivery system, many inmates’ high-risk behavior, and other factors all contribute to this higher rate. Nonetheless, many proponents of co-payments believe these charges not only help reduce the rising cost of correctional health care, but also act as a deterrent, keeping inmates from over-utilizing health care services and saving staff time.11

Gary Crutchfield, assistant superintendent of programs with the North Carolina Department of Corrections, agrees, stating that due to the state’s new inmate co-pay policy, “requests from our medical department have been dramatically reduced, saving both big dollars and staff time.” If policies such as these are adopted, thought must then be given to what sort of work assignments elderly inmates can adequately perform given both their physical and mental condition. In many cases, subsistence or co-payment charges may have to be waived for indigent and geriatric inmates due to their physical inability to work and their need for more frequent, and potentially more costly, medical services. At one point, it was possible to bill these inmates through their Social Security benefits; however, the Social Security Amendments of 1983 changed the Social Security Act, suspending benefits to convicted felons while they are incarcerated.
Nutrition
The nutritional requirements of the elderly inmate differ from those of the general prison population. As people age, their nutrition requirements change. For example, their bodies contain less muscle tissue, need less protein and require fewer calories due to a more sedentary lifestyle. Vitamins and minerals continue to play an important role in maintaining health status, and their intake must be monitored closely, especially since many medications used by the elderly often decrease vitamin and mineral absorption and stores.¹²

In addition, older persons may need special diets and may require a longer time for eating. This being the case, corrections officials may wish to provide separate diets and eating plans in order to best maintain their health, thus helping to avoid illnesses which may prove more detrimental to their well-being and far more costly in the long-run.

Victimization
It is argued that the risk of being victimized by other inmates increases as the age of the inmate increases. As stated by author Gennaro F. Vito, “while elderly inmates do not typically represent a security risk, providing for their physical security is important to them and protecting them from younger, stronger predators presents a vexing problem for correction administrators.”¹³ States may wish to segregate older inmates in a correctional nursing home or on a different wing, unit or floor from the general prison population to protect them from victimization. Avoiding these risks also reduces a state’s liability, since federal lawsuits dating back to the 1960s have forced many states to separate their weaker inmate populations.

Staff
Another challenge facing correctional institutions is the lack of professionally trained prison staff to handle elderly inmates’ special needs. As one prison official confessed, “I know how to run prisons, not old-age homes.”¹⁴ Moreover, not everyone who works in a correctional environment may have the aptitude or essential skills needed to manage elderly people.

As Ronald Aday, gerontology program director at Middle Tennessee State University, has suggested, “careful selection for sensitivity to the unique requirements of geriatric inmates should be an important consideration. Training, involving administrative personnel, line security staff and health providers should include an increased knowledge of growing old and how this knowledge specifically affects the elderly in a prison environment.” Aday also believes prison staff need to be specifically trained to understand the social and emotional needs of the elderly, dynamics of death and dying, procedures for identifying depression, and a system for referring older inmates to experts in the community.¹⁵

Others have stressed the need for enhancing staff packages for those working with elderly inmates, including recognition that workload standards need to be adjusted for the increased time and attention these inmates require.

Housing and Centralized Facilities
Almost all state correctional institutions existing today were created to meet the needs of the young, healthy and potentially aggressive inmate population. In many instances, the facilities do not meet the mobility or accessibility needs basic to elderly or disabled inmates. Some argue that accommodating inmates’ disabilities unduly complicates prison administration and that the Americans With Disabilities Act (ADA) of 1990
does not mean to protect state prison inmates, and impinges on a state’s historic sovereign function of state prison management. In partially rejecting that argument, the United States Supreme Court, in Pennsylvania v. Yeskey, No. 97-634, June 15, 1998, ruled that “the statute’s [ADA] language unmistakably includes state prisons and prisoners within its coverage.” In writing the Court’s opinion, Justice Antonin Scalia — in noting that Congress referred in general terms to barring discrimination in the services, programs or activities run by public agencies — ruled that the law’s text “provides no basis for distinguishing the programs, services and activities from those provided by public entities that are not prisons.”

Though this decision left no doubt about the Court’s interpretation of the Act, it may not end the debate over the statute’s application to the states. California has been litigating a separate, constitutionally-based challenge to the law’s application to state prisons, arguing that Congress lacked the authority to extend the law to the states. At the time of print, the Supreme Court was expected to announce whether they would hear Wilson v. Armstrong, No. 97-686, which California lost in lower federal courts. Both of these decisions are likely to have tremendous cost implications for states if their corrections departments must now be in full compliance with the ADA. Of note, the Rehabilitation Act of 1973 has barred discrimination on the basis of disability against inmates in federal prisons for 25 years.

Currently, if special housing does exist, physical and/or mental ability, not age, is generally used by correctional departments in determining where older inmates are housed. Specialists in this area have advocated modifying existing institutions to assure the equitable treatment of the old along with the young, such as upgrading facilities to include universal access as may be required by the ADA. Many also have suggested establishing special geriatric units for older inmates requiring special care. “These units should include non-medical geriatric housing for elderly inmates assigned on a voluntary basis or earned privilege, as well as full-fledged geriatric medical units providing 24-hour nursing and medical care, pharmacy services, special diets, and supportive environments for inmates with severe medical, mental or special needs problems.”

Many southern states maintain special facilities or medical units for inmates requiring extensive care. This is primarily done to centralize otherwise duplicative health care and other services these inmates may require, to minimize transportation costs during this process, and to protect the elderly from victimization. Also, because staff salaries and benefits make up the greatest portion of health services expenditures, consolidation, thus reducing or containing personnel costs needed, may be a key means of reducing increases in the health care budget. Consolidating the delivery of health services is an issue many corrections departments may consider in the near future.

Edward Harrison, president of the National Commission on Correctional Health Care, has noted that such a facility will help keep costs down in the long-run. “Without this special attention, patients are more likely to continue to be sick, get sicker or require intensive care,” he said. “And this outweighs the costs of these facilities.”

When asked during the compilation of this report, one corrections administrator noted that “the present modality of ‘warehousing’ these individuals with minimal program or activity support(s) simply intensifies day-to-day manage-
ment concerns.” He believed this “significantly contributes to the general decline in the individual which, in turn, escalates the daily cost-of-care, institutional and health care.”

According to Larry Linton, Alabama state administrator for Correctional Medical Services, the Aged and Infirm (A&I) Unit at Hamilton saves the State money. A health care provider screens all entering prisoners for infectious conditions and provides annual tuberculosis tests for all inmates. “Because Hamilton A&I is very aggressive with disease control and providing treatment for chronic care . . . it prevents these diseases from becoming even more costly,” Linton stated. As an example, he noted, “if a cardiac problem is neglected, it can cause a heart attack. The prisoner then has to go out to “free world” hospitals for treatment because Alabama does not have the cardiac equipment and surgical facility necessary. When this happens, the taxpayer has to pick up the tab for the hospitalization.”

In Alabama and most other states, corrections departments first determine which inmates require special treatment through screening, then assign them to facilities or programs appropriately. The policies of the State of South Carolina provide an example of the process of determining whether or not an individual should be referred to a special needs, centralized facility:

First, the South Carolina Department of Corrections established the definition of handicapped status to include inmates with physical or intellectual impairment which substantially limits their abilities to function independently in the general prison population. Inmates classified as handicapped must suffer limitations from at least two of the following areas: self care; self direction; vision, hearing or speech impairment; capacity for learning; social and emotional adjustment; mobility; chronic medical problems; acute medical problems; and, a need for close medical supervision.

Second, handicapped inmates are mainstreamed as long as they can function in the general population. They are transferred to the special unit only at the point that they can no longer cope with the normal prison environment;

Third, all inmates work within their medical limitations. Inmates 65 or older can retire; however, earned work credits, which offer a way to reduce time from an inmate’s sentence, are available only to those who have jobs; and

Finally, a handicapped unit has been established to house disabled inmates with greater security needs.18

As noted, many argue that such policies and facilities not only serve to meet the special needs of elderly or infirm inmates; they also reduce costs in the long-run and allow other facilities to concentrate on housing more hard-core or predatory inmates. For example, during a 1995 interview with The New York Times, and in responding to this report, officials with the Louisiana Department of Public Safety and Corrections noted that by providing separate facilities for older inmates, their state can free up beds at the Angola State Penitentiary needed for younger criminals who are more of a threat.
THE SURVEY

The primary purposes of this report are to present many of the challenges facing correctional systems due to the increase of older inmate populations and illustrate southern states' policies, programs and facilities designed to address them. To gather the following information, surveys were sent to the corrections departments in all 16 SLC member states. Respondents were asked the following:

1. What specific policies does your correctional system have in relation to the aged/infirm inmate? (i.e., early parole, work assignment, health needs, medical care, centralization of such services for costs efficiency, etc.)

2. Does your department currently provide special geriatric facilities to accommodate elderly inmates? If so, please describe the unit, wing, floor, or facility and the number of inmates or beds involved. If not, have such facilities been proposed and failed to win legislative, gubernatorial, departmental or public approval?

3. What do you consider to be the most pressing concerns or problems, if any, your department faces in responding to the special needs of the elderly prisoner? (i.e., rising medical costs, readily accessible medical care, depression and/or other mental problems, staffing and their preparedness to deal with the elderly, victimization from younger inmates, parole problems, prison space, facilities accessible for the mobility-impaired, etc.)

4. Does your department or state have immediate or future plans to implement new policies or programs or to build new or remodel present facilities as a result of the increasing number of long-termers, late-offenders or life-without-parole prisoners? and to

5. Please identify any needed research that might prove useful for elected or correctional officials to better respond to the needs of the aging inmate.

In addition, select data have been compiled on southern states' inmate populations — overall, and those age 50 and over — from 1991 and 1997. Figures reflecting the number of lifers, natural lifers and those serving sentences of 20 or more years have been provided as well to give an indication of future increases in the elderly prison population.

The following represents the responses from the corrections departments of SLC member states to the survey and provides a synopsis on how these states confront the challenges faced in addressing the special needs of the growing elderly inmate population. Prior research conducted by Cynthia H. Douglas, Louisiana Legislative Fiscal Office, and Dr. Ronald H. Aday, Middle Tennessee State University, was utilized to supplement this material.
Southern States and Aging Inmates

Please note that for all following state statistics:
- "inmates" include state and federal inmates confined in prisons, out in other programs/facilities/agencies, and waiting in jails for prison admission
- "lifers" are inmates serving a life sentence with the possibility of parole
- "natural lifers" are inmates serving a life sentence with no possibility of parole
- inmates serving sentences of 20 years or longer excludes lifers and natural lifers


### Alabama

<table>
<thead>
<tr>
<th></th>
<th>total inmates</th>
<th>total age 50 and over</th>
<th>percent age 50 and over</th>
<th>lifers</th>
<th>natural lifers</th>
<th>sentences 20 years or more</th>
<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>13,142</td>
<td>736</td>
<td>5.6%</td>
<td>1,743</td>
<td>640</td>
<td>3,369</td>
<td>5,752</td>
<td>43.77%</td>
</tr>
<tr>
<td>1997</td>
<td>21,761</td>
<td>1,223</td>
<td>5.62%</td>
<td>2,520</td>
<td>1,016</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>percent change: 1991-97</td>
<td>65.58%</td>
<td>66.17%</td>
<td>44.58%</td>
<td>58.75%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

**Policies:** Alabama contracts for all of its prison health care needs. The contractor for medical services runs medical tests and makes the determination if an aged or infirm inmate can be detained with the general prison population or if the special unit at Hamilton is the only facility suitable for the inmate.

**Facilities:** The State maintains a 200-bed Aged and Infirm Unit in Hamilton, Alabama. This unit was opened to prevent victimization of older inmates and to respond to special needs inmates. Currently, the Hamilton facility is one of only a few in the nation specializing in aged and disabled inmates. Counseling, recreational, and educational programs have been designed for the aged. In addition, around-the-clock nursing care is provided for terminal inmates or those with acute health problems. Advanced health care services are contracted with a nearby hospital. Correctional officers in the program receive training in the health and social problems of the elderly.

This facility has gained attention both nationally and internationally for its focus on elderly prisoners. According to Larry Linton, Alabama state administrator for Correctional Medical Services, "officials from other states have looked at the facility as have officials from France, Canada and Britain." State corrections officials believe Hamilton has been a cost-effective way to deliver health care to the elderly inmate population.

**Challenges:** Department of Corrections officials listed the complications involved with aging and life without parole as the most challenging issues facing their Department.
Arkansas

<table>
<thead>
<tr>
<th></th>
<th>total inmates</th>
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<th>lifers</th>
<th>natural lifers</th>
<th>sentences 20 years or more</th>
<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>6,533</td>
<td>71</td>
<td>1.09%</td>
<td>NA</td>
<td>623</td>
<td>1,205</td>
<td>1,828</td>
<td>27.98%</td>
</tr>
<tr>
<td>1997</td>
<td>10,221</td>
<td>563</td>
<td>5.51%</td>
<td>NA</td>
<td>947</td>
<td>3,147</td>
<td>4,094</td>
<td>40.05%</td>
</tr>
<tr>
<td>percent change: 1991-97</td>
<td>56.45%</td>
<td>692.95%</td>
<td>NA</td>
<td>52.01%</td>
<td>161.16%</td>
<td>123.96%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Policies:** The Arkansas Department of Correction does not, at present, have any policy strictly addressing “aged” inmates. However, numerous policies relate to the infirm. Arkansas has early parole, but only for inmates determined to be terminal (defined as death within 12 months or less) or who suffer a permanent mental or physical incapacitation preventing them from engaging in criminal activity. Health care officials assess and classify each inmate’s general physical condition and what, if any, specific physical restrictions need to be applied when considering any work or housing assignment. These classifications are updated on a periodic basis.

**Facilities:** Arkansas has established two special housing areas (in separate, but geographically adjacent facilities) for the most chronically infirm, within close proximity of the institutional hospital in Pine Bluff. The Jefferson County Correctional Facility has 80 beds and the Diagnostic Unit has 40. These living areas are open-barrack style and incorporate the use of special beds. A member of the health care staff is assigned to make rounds in these living areas and monitor the activities of occupants. Specific endeavors such as specialty care clinics, acute care hospitalizations and special health management care are centralized nearby.

Facilities have various levels of on-site health care support. Inmates with more chronic health conditions are housed at institutions with a health support mechanism commensurate with their underlying health disorder. The Department has proposed the construction of a singular, multi-discipline, health care institution for several years. A new initiative is currently under development which will be proposed in the upcoming biennial legislative session (January - March 1999). They also are exploring an initiative with the private sector which may bring about the establishment of a single-site, dedicated, geriatric facility.

**Challenges:** Officials in Arkansas mentioned that establishing a living and work environment which is "conducive to constructive and meaningful activity for a cohort of individuals subject to frequent and fluctuating levels of depression and victimization/predation (even within their own group)" as one of the most pressing issues facing their Department in this area.

The Department’s immediate plans are to review, initiate, or revise existing policy to ensure all available resources are aimed at meeting the special housing needs of the most needy inmate population. The Department also is looking at legislative initiatives which would allow for more varied community-based supervision options, such as special housing agreements with community residential or nursing homes.
### Florida

<table>
<thead>
<tr>
<th></th>
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<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>43,920</td>
<td>2,098</td>
<td>4.78%</td>
<td>2,464</td>
<td>1,874</td>
<td>5,825</td>
<td>10,163</td>
<td>23.14%</td>
</tr>
<tr>
<td>1997</td>
<td>63,763</td>
<td>3,985</td>
<td>6.25%</td>
<td>4,618</td>
<td>1,783</td>
<td>10,215</td>
<td>16,616</td>
<td>26.06%</td>
</tr>
<tr>
<td>percent change: 1991-97</td>
<td>45.18%</td>
<td>89.94%</td>
<td>87.42%</td>
<td>-1.27%</td>
<td>75.36%</td>
<td>63.5%</td>
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<td></td>
</tr>
</tbody>
</table>

**Policies:** The Florida Department of Corrections assigns inmates to institutions contingent upon their overall inmate classification, of which their medical classification is the major component.

Florida also uses impaired-inmate assistants from among trained inmates; assigns a minimum of two inmates who are proficient in American Sign Language at any institution for the hearing impaired; provides ready access to specific clinical services such as hypertension and dialysis; and has facilities such as the Department’s North Florida Reception Center-Hospital for providing cancer treatment. These facilities also are used in preparation for inmates requiring more complex procedures which are beyond the scope of the Department’s capabilities, and are scheduled in contracted community care facilities.

Although there is no special release for elderly inmates for medical reasons, there is a conditional medical release program for all terminally ill inmates whose death is imminent (three to six months) and with reasonable medical certainty the inmate cannot harm themselves or others.

**Facilities:** The medical care of elderly inmates is incorporated into the provisions of care for all inmates dependent on their individual needs. Selected institutions have specific services to meet identified health needs. Although there is no one institution designed to house only elderly or infirm inmates, the medical facility at Lawtey has evolved into an institution serving an almost exclusively elderly population. Around-the-clock medical care is provided and special activities geared toward the geriatric inmate have been implemented.

Other aging inmates are placed at institutions that provide accessibility for the disabled. Inmates who have limited mobility and moderate to severe physical problems are usually assigned to a dorm that is accessible and accommodating. Work assignments are given to inmates based on their physical ability to perform the job.

**Challenges:** Department of Corrections officials listed providing programs specifically structured to facilitate elderly inmate participation, rather than placing them in competition with younger inmates, as one of the biggest challenges facing them in this area.

The Department is presently writing a comprehensive program for these inmates which will encompass a holistic approach, requiring greater emphasis on issues specific to the elderly. They have identified reducing the health care costs associated with providing services to this older age group as additional research needed for corrections officials.
Georgia

<table>
<thead>
<tr>
<th></th>
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<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
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<tbody>
<tr>
<td>1991</td>
<td>22,302</td>
<td>1,107</td>
<td>4.96%</td>
<td>2,977</td>
<td>NA</td>
<td>2,812</td>
<td>5,789</td>
<td>25.96%</td>
</tr>
<tr>
<td>1997</td>
<td>36,972</td>
<td>2,082</td>
<td>5.63%</td>
<td>4,971</td>
<td>66</td>
<td>4,544</td>
<td>9,581</td>
<td>25.91%</td>
</tr>
<tr>
<td>percent change: 1991-97</td>
<td>65.78%</td>
<td>88.98%</td>
<td>66.98%</td>
<td>61.59%</td>
<td>65.5%</td>
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</tbody>
</table>

Policies: Upon admission, the Georgia Department of Corrections screens inmates for special medical needs. These needs may include, but are not limited to, inmates with chronic illness, communicable disease, physical disability, terminal illness, mental health or those having difficulty with activities of daily living.

Once the medical diagnostic process is completed, a plan which includes special instructions about diet, exercise, medication, type and frequency of diagnostic testing and follow-up medical care is drawn up for the inmate. Each plan addresses issues related to adaptation to the correctional environment, including considerations for facility assignment, special housing unit or cell, and considerations for work detail. In most cases, these inmates will be managed at the resident facility as long as their medical needs can be adequately addressed.

When medical care demands exceed the capability of the facility, inmates are transferred to facilities capable of providing the appropriate care. Patients who are having difficulty, or are no longer able to independently carry out activities of daily living, will be placed in a protective environment including infirmaries, supportive living units or other facilities. Medical reprieves are considered for inmates with terminal illnesses or for those with health care requirements not available through the Department. If the health status of the inmate improves or deteriorates, the Department then develops a revised written treatment plan profiling the inmate’s health status.

Facilities: The Men’s Correctional Institution at Hardwick houses 615 inmates with various chronic diseases and disabilities, as well as the aged and infirm. The complex is divided into dormitories. Inmates in wheelchairs are assigned to dorms closest to the medical facility. The special medium-security unit provides 24-hour nursing and medical care and maintains 60 fully equipped hospital beds. Although some special programming has been developed in counseling, education and recreation, the primary purpose of the unit is to expand medical capabilities to include physical therapy, prosthetic devices, special diets, frequent medical service, and kidney dialysis treatment. There is a 384-bed assisted living unit being constructed at the Augusta State Medical Prison.

Challenges: Corrections officials list escalating medical costs and the rising demand for assisted-living and chronic care bed-space as their most pressing concerns in responding to the needs of aging inmates.
**Policies:** The Kentucky Department of Corrections has designated the Medical Treatment/Mental Health Special Management Unit at the Kentucky State Reformatory as a facility to address the special needs for both the aging population and those requiring medical or mental health treatment. This enables the Department to centralize medical services and to provide these services in close proximity to the Louisville metropolitan area.

Officials have stated that by both centralizing these services and by establishing the position of medical director, who has the responsibility for the negotiation of contracts and employing consulting doctors, they have been successful in lessening overall medical costs. This has resulted in less than an eight percent increase in medical costs, per inmate, per day, from FY 92 through FY 97.

**Facilities:** In 1995, the Department opened the 58-bed, skilled care Nursing Care Facility at the Kentucky State Reformatory to house geriatric and infirm inmates. The facility is supervised by a licensed nursing home administrator certified by the Kentucky Board of Licensure. Officials believe this to be the only licensed nursing care facility inside a medium-security correctional facility in the United States. The Reformatory has the responsibility for on-site physical therapy and dialysis for the inmate population, and contracts with specialists who visit the institution on a weekly basis to conduct clinics. This greatly reduces the necessity to transport the inmates from the facility to medical providers in the community. Kentucky plans the conversion of a 30-bed unit to house and treat short-term care inmates at the Reformatory in June 1998.

The Department has contracted and established a 10-bed medium-security medical unit to provide on-site security housing for inmates requiring medical treatment at the Tri-County Baptist Hospital in LaGrange. Additionally, a 150-bed mental health unit has been constructed on the grounds of the Kentucky State Reformatory. It is scheduled to be available for occupancy by July 1998.

**Challenges:** Officials have stated that, because the Nursing Care Facility is reaching capacity and because of the increase in inmates requiring medical and mental health services, they are pursuing innovative approaches to contain medical costs, provide suitable housing, and provide more specialized training to correctional staff. Additionally, the provisions of the Americans With Disabilities Act have required numerous modifications to physical plants and operating procedures within the correctional environment.

The Department continues to monitor the mental health and medical condition of the inmate population and will continue to modify its policies and procedures to meet the special needs of those inmates.
<table>
<thead>
<tr>
<th></th>
<th>total inmates</th>
<th>total age 50 and over</th>
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<th>lifers</th>
<th>natural lifers</th>
<th>sentences 20 years or more</th>
<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>13,849</td>
<td>NA</td>
<td>NA</td>
<td>2,089</td>
<td>NA</td>
<td>2,852</td>
<td>4,941</td>
<td>NA</td>
</tr>
<tr>
<td>1997</td>
<td>26,779</td>
<td>1,356</td>
<td>5.06%</td>
<td>NA</td>
<td>2,839</td>
<td>3,720</td>
<td>6,559</td>
<td>24.49%</td>
</tr>
<tr>
<td>percent change: 1991-97</td>
<td>93.36%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>30.43%</td>
<td>32.75%</td>
<td></td>
</tr>
</tbody>
</table>

**Policies:** The Louisiana Department of Public Safety and Corrections determines the health of all inmates and those physically and mentally able are assigned jobs. Age is not necessarily a factor in this determination. Regular age-appropriate screenings are part of routine medical care. Emergency medical furlough is available to terminally ill and permanently incapacitated inmates.

All inmates over 50 years of age are given annual physical examinations and, if necessary, are referred to a treatment center. The largest concentration of geriatric inmates is on the grounds of the Louisiana State Penitentiary (LSP) at Angola. The facility maintains ambulances on site for emergency hospital visits.

**Facilities:** When an inmate is too sick or weak to remain in a regular housing area, they are reassigned to the treatment center wards. These wards are staffed with 24-hour nursing care. Beds designated for the frail elderly and infirm have been identified at four prisons: 120 at LSP, 70 at the Elayn Hunt Correctional Center, 30 at the Dixon Correctional Institute and 20 at the Louisiana Correctional Institute for Women.

In the State, special needs inmates have gained considerable attention as a result of deficiencies cited by the courts. To alleviate LSP from having to house too many inmates with special needs, two new units have been planned to serve that population. The Dr. Martin L. Forcht, Jr. Clinical Treatment Unit, a satellite of the David Wade Correctional Center, is being built on the renovated site of the former Caddo Detention Center. Known as Forcht-Wade, it will offer 330 beds for male inmates whose age and/or physical impairments can best be handled in a special needs facility, as well as address the system's need for a centralized nursing facility for the chronically ill. This also frees up bed space at LSP for more violent offenders. Formal working relations are being developed with the Louisiana State University Medical Center and its School of Allied Health Care in Shreveport, and with faculty of the Department of Gerontology of Northeast Louisiana University in Monroe. The facility is scheduled to be in operation by September 1999.

Additionally, a new 600-bed facility is proposed as a unit of the Elayn Hunt Correctional Center. It will serve as a skilled nursing/mental health/HIV-AIDS facility and will deliver acute and chronic medical and mental health care. This facility also will house a number of support inmates who will assist in the maintenance of the facility.

**Challenges:** Officials with the Department listed rising medical costs, accessible medical care and available prison space as the most pressing concerns facing them in responding to the special needs of the elderly prisoner.
### Maryland

<table>
<thead>
<tr>
<th>1991</th>
<th>16,899</th>
<th>663</th>
<th>3.92%</th>
<th>1,174</th>
<th>52</th>
<th>303</th>
<th>1,529</th>
<th>9.05%</th>
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</thead>
<tbody>
<tr>
<td>1997</td>
<td>22,109</td>
<td>869</td>
<td>3.93%</td>
<td>1,748</td>
<td>100</td>
<td>5,165</td>
<td>7,013</td>
<td>31.72%</td>
</tr>
</tbody>
</table>

| percent change: 1991-97 | 30.83% | 31.67% | 48.89% | 92.31% | 1,604.62% | 358.67% |

**Policies:** The Maryland Department of Public Safety and Correctional Services, Division of Correction, provides an annual physical examination for all inmates over the age of 50. All inmates are eligible for work, training and treatment dependent upon health status and medical needs, as is the availability of space. The Division also offers parole for terminally ill inmates or those in need of extensive or chronic medical care which is accessible in the community, if such arrangements are approved by the Maryland Parole Commission.

**Facilities:** In general, there is no designated facility to house geriatric inmates; however, a majority of older inmates is provided special housing. This may include such options as a hospital unit, a special dormitory for the aged and infirm or, in some cases, a single cell on the first floor of a housing block. Health status and the need for medical care generally determine housing assignments. Special services include extra medical or nursing care as needed in each of the prison settings. Procedures have been established with the Department of Health and Mental Hygiene for the transfer of senile or incapacitated inmates to state hospitals or nursing homes.

**Challenges:** Division officials noted the availability of space and adequate staffing as their most pressing concerns or problems in dealing with the elderly or infirm. The Division has established a committee charged with drafting proposals to address these concerns.
**Mississippi**

<table>
<thead>
<tr>
<th></th>
<th>total inmates</th>
<th>total age 50 and over</th>
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<th>lifers</th>
<th>natural lifers</th>
<th>sentences 20 years or more</th>
<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>6,724</td>
<td>201</td>
<td>2.99%</td>
<td>1,019</td>
<td>127</td>
<td>1,510</td>
<td>2,656</td>
<td>39.5%</td>
</tr>
<tr>
<td>1997</td>
<td>14,032</td>
<td>730</td>
<td>5.2%</td>
<td>1,315</td>
<td>179</td>
<td>NA</td>
<td>NA</td>
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</tr>
<tr>
<td>percent change, 1991-97</td>
<td>108.69%</td>
<td>263.18%</td>
<td></td>
<td>29.05%</td>
<td>40.94%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
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</table>

**Facilities:** Two special units are available for older offenders. One specified geriatric unit at Parchman houses 85 offenders. This unit was designed as a nursing home in a correctional setting. A nursing staff is provided from 7:00 a.m. until 8:00 p.m., each day, to assist in dispensing medication and other ancillary activities. A physician checks with the unit daily to provide additional medical care if needed. Another unit at Parchman also houses 192 geriatric and/or disabled offenders. Various therapeutic, social and recreational programs are provided.
Missouri

<table>
<thead>
<tr>
<th></th>
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<th>total age 50 and over</th>
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<th>sentences 20 years or more</th>
<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>14,946</td>
<td>618</td>
<td>4.13%</td>
<td>772</td>
<td>278</td>
<td>1,463</td>
<td>2,513</td>
<td>16.81%</td>
</tr>
<tr>
<td>1997</td>
<td>22,025</td>
<td>1,189</td>
<td>5.40%</td>
<td>1,323</td>
<td>567</td>
<td>2,224</td>
<td>4,114</td>
<td>18.68%</td>
</tr>
<tr>
<td>percent change: 1991-97</td>
<td>47.36%</td>
<td>92.39%</td>
<td>71.37%</td>
<td>103.96%</td>
<td>52.02%</td>
<td>63.71%</td>
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</table>

Policies: Missouri Department of Corrections officials generally avoid age-specific policies or procedures, relying instead on the inmate’s medical condition. The special medical needs of inmates, regardless of age, are addressed accordingly. Missouri statute allows a medical parole for an inmate with a terminal disease; one who can no longer be safely confined because their physical condition requires extensive medical care that the Department is unable to provide; or if they require nursing home services. Facilities in each custody level are in compliance with the Americans with Disabilities Act.

A variety of specialized programs have been developed for the aged/infirm including recreational therapy, educational activities and discussion groups, exercise programs and other activities. Special efforts have been made to provide appropriate medical services and access to them including physical therapy, special diets, frequent medical exams, and continuous nursing care.

Facilities: There is a unit at the Moberly Correctional Center that can house 22 older inmates in a facility near the institutional infirmary. A second unit is available for inmates of all ages who require frequent medical care. A nurse visits each unit daily. The program provides several levels of security and bases its programming on the needs of its inmate population with chronic medical problems. In addition, there is a unit for elderly inmates with medical problems at the Jefferson City Correctional Center. These inmates are referred by a physician and remain in the unit until their condition improves. Other geriatric inmates requiring nursing home type care are assigned to one of several regional infirmaries.

Challenges: Department officials have noted that rising medical costs are one of their biggest concerns in dealing with the elderly or infirm; however, they believe themselves to be successfully managing these costs. Contracting for inmate health care allows the Department to budget health care costs for all inmates over the life of the contract, greatly assisting the Department in maintaining inmate health care costs and addressing catastrophic and routine medical cases for inmates.
**North Carolina**

<table>
<thead>
<tr>
<th></th>
<th>total inmates</th>
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<th>lifters</th>
<th>natural lifers</th>
<th>sentences 20 years or more</th>
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<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>18,605</td>
<td>853</td>
<td>4.58%</td>
<td>2,075</td>
<td>NA</td>
<td>3,826</td>
<td>5,901</td>
<td>31.72%</td>
</tr>
<tr>
<td>1997</td>
<td>31,764</td>
<td>1,451</td>
<td>4.57%</td>
<td>3,036</td>
<td>44</td>
<td>7,164</td>
<td>10,244</td>
<td>32.25%</td>
</tr>
<tr>
<td>percent change:</td>
<td>70.73%</td>
<td>70.11%</td>
<td>46.32%</td>
<td>NA</td>
<td>87.25%</td>
<td>73.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Policies:** North Carolina’s corrections program serves both geriatric and infirm minimum-custody inmates. The program provides a variety of ancillary medical services including respiratory therapy, physical therapy, special diets, a pharmacy and laboratory, and an x-ray department. This program provides special recreation, exercise, arts and crafts, and therapy programs. Specially trained social workers provide individual and group counseling. Reminiscing therapy groups are provided, especially for the geriatric inmates. A full range of nursing care is provided on a 24-hour basis.

**Facilities:** The State provides special care to more than 120 geriatric and 25 paraplegic inmates on one floor of the McCain Correctional Hospital. This facility is accessible for the mobility-impaired due to specialized housing for paraplegic inmates. The geriatric inmates are provided hospital beds for additional comfort and live, eat, and often recreate separately from the regular population. McCain Hospital has been operating for 13 years and officials state their staff is accustomed to meeting the daily needs of the elderly.

**Challenges:** Rising medical costs are cited by officials as their biggest concern in dealing with elderly or infirm inmates. They did note, however, that due to the new inmate co-pay policy, requests for medical services have been reduced substantially. Corrections officials report they rarely have a problem with elderly inmates being victimized by younger ones.
Oklahoma

<table>
<thead>
<tr>
<th></th>
<th>total inmates</th>
<th>total age 50 and over</th>
<th>percent age 50 and over</th>
<th>lifers</th>
<th>natural lifers</th>
<th>sentences 20 years or more</th>
<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>10,502</td>
<td>707</td>
<td>6.73%</td>
<td>783</td>
<td>43</td>
<td>2,837</td>
<td>3,663</td>
<td>34.88%</td>
</tr>
<tr>
<td>1997</td>
<td>20,316</td>
<td>1,430</td>
<td>7.04%</td>
<td>1,131</td>
<td>236</td>
<td>4,766</td>
<td>6,133</td>
<td>30.19%</td>
</tr>
<tr>
<td>percent change: 1991-97</td>
<td>93.45%</td>
<td>102.26%</td>
<td>44.44%</td>
<td>448.84%</td>
<td>68.0%</td>
<td>67.43%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Policies: Officials from the Oklahoma Department of Corrections cited that no specific policies are currently in place in relation to the aged/infirm inmate. They do, however, offer medical paroles to terminally ill inmates within six months of their anticipated death, provided they do not deem the inmate a threat to the general population. Additionally, work assignments and housing placement may be influenced by an inmate’s medical condition or needs, although this applies to any inmate, regardless of age.

Facilities: On May 24, 1996, the Oklahoma Board of Corrections directed a feasibility study be conducted to evaluate converting an existing state facility, building a new one or converting a minimum-security level institution to provide a facility for elderly/handicapped inmates. The Department is seeking a hospital-like setting in a maximum-security prison, housing 250 older and disabled inmates and approximately 50 more under medical care. In addition, it is estimated the facility will require up to 100 general population inmates to provide services such as maintenance and meals.

During the 1997 legislative session, Department staff attempted, unsuccessfully, to initiate legislation that would allow the Department to establish funding for a facility that would house elderly and/or disabled inmates. Although the money for the facility has not yet been allocated, in March 1998, Corrections Board members opened the bidding process for a privately run geriatric facility. The funding and approval for a facility may be considered again by the Legislature, once private contractors have submitted bids and potential locations.

Challenges: Officials state that adequate staffing and training of personnel, rising medical costs and the lack of a facility to accommodate the elderly and special needs inmates as the most pressing concerns facing their Department in this area. They also would like to see more age-specific programs implemented.
**South Carolina**

<table>
<thead>
<tr>
<th></th>
<th>total inmates</th>
<th>total age 50 and over</th>
<th>percent age 50 and over</th>
<th>lifers</th>
<th>natural lifers</th>
<th>sentences 20 years or more</th>
<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>15,529</td>
<td>741</td>
<td>4.77%</td>
<td>1,258</td>
<td>33</td>
<td>3,154</td>
<td>4,447</td>
<td>28.64%</td>
</tr>
<tr>
<td>1997</td>
<td>20,604</td>
<td>901</td>
<td>4.37%</td>
<td>1,609</td>
<td>70</td>
<td>3,949</td>
<td>5,628</td>
<td>27.32%</td>
</tr>
<tr>
<td>percent change, 1991-97</td>
<td>32.68%</td>
<td>21.59%</td>
<td>27.9%</td>
<td>100%</td>
<td>25.21%</td>
<td>26.56%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Policies:** The South Carolina Department of Corrections evaluates inmates for assignment to a special handicapped unit. In addition, they provide a medical furlough program for terminally ill inmates and monitor chronic disease and medical programs requiring close supervision. Work assignments are provided for those who are able. There is a trial work release program for older, low-risk inmates, and a release training course has been established to aid them in adapting to life outside of prison.

**Facilities:** Some older inmates are assigned to the geriatric/handicapped unit at Perry Correctional Institution and the handicapped unit at the Broad River Correctional Institution. Perry’s assisted-living unit, housed in first floor cells, has a current capacity of 38 inmates, of which 15 are elderly (over 55 years of age). Broad River’s Handicapped Unit has a capacity of 31 inmates and currently houses 19 elderly inmates on both the first and second floors. The assignment to these facilities is based on health status and the need for medical care. Otherwise, older inmates are housed with the general prison population. Around-the-clock medical attention is available at these facilities.

Recreation, educational programs, counseling, and related activities geared toward the elderly are provided. Additionally, hortitherapy and arts-and-crafts programs are available.

**Challenges:** Officials with the Department have listed providing cost-efficient medical and mental health care, a safe and secure environment for older inmates to ensure they are not preyed upon by younger offenders, and adequate bed space as the biggest challenges facing their correctional system in responding to the special needs of elderly inmates. Providing services such as meaningful and appropriate work programs and the necessary training for staff in order to care for these inmates also was a concern.

Department officials would like to see further research on the impact sentencing law changes, including longer sentences and the increase of geriatric inmates in the future, have on correctional institutions.

The Department is currently studying and developing institutional missions, where inmates will be assigned to a segregation classification based on age, health status, and level of prior institutional experience.
### Tennessee

<table>
<thead>
<tr>
<th></th>
<th>total inmates</th>
<th>total age 50 and over</th>
<th>percent age 50 and over</th>
<th>lifers</th>
<th>natural lifers</th>
<th>sentences 20 years or more</th>
<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>8,380</td>
<td>619</td>
<td>7.39%</td>
<td>1,224</td>
<td>52</td>
<td>3,401</td>
<td>4,677</td>
<td>55.81%</td>
</tr>
<tr>
<td>1997</td>
<td>18,795</td>
<td>1,116</td>
<td>5.94%</td>
<td>1,235</td>
<td>73</td>
<td>4,398</td>
<td>5,706</td>
<td>30.36%</td>
</tr>
<tr>
<td>percent change: 1991-97</td>
<td>124.22%</td>
<td>80.29%</td>
<td>.9%</td>
<td>40.38%</td>
<td>29.31%</td>
<td>22%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Policies:** The Tennessee Department of Corrections provides increased medical attention, special diets, therapeutic programs and counseling to elderly inmates. While no formal recreational programs are provided, special exercise equipment is available, and those unable to work are not required to do so. In addition, a 50-bed unit at the Wayne Correctional Annex is available for inmates 55 years of age and older who are assigned to minimum custody, have minor medical needs and are capable of general work assignments.

**Facilities:** A special needs facility in Nashville houses a significant number of the State’s older and infirm inmates. The 100-bed, sheltered living unit at the Deberry Special Needs Facility houses the infirm with a need for close proximity to hospital, medical and mental health services. This unit is not restricted to older inmates, but contains a high percentage of them.

**Challenges:** Officials in Tennessee have listed as their major problems: the increasing need for medical care and staff-intensive programming; physical barriers posed to older and infirm inmates in older facilities; limited recreational and work opportunities for the medically-limited and mobility-impaired; and the need for separating the elderly from younger, predatory inmates.

In February 1998, Governor Don Sundquist recommended complete reorganization of the Tennessee Department of Corrections. This has the potential for developing an entirely new administrative program.
Texas

<table>
<thead>
<tr>
<th></th>
<th>total inmates</th>
<th>total age 50 and over</th>
<th>percent age 50 and over</th>
<th>lifers</th>
<th>natural lifers</th>
<th>sentences 20 years or more</th>
<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>49,316</td>
<td>2,153</td>
<td>4.37%</td>
<td>3,651</td>
<td>NA</td>
<td>20,301</td>
<td>23,952</td>
<td>48.57%</td>
</tr>
<tr>
<td>1997</td>
<td>132,394</td>
<td>7,923</td>
<td>5.98%</td>
<td>6,243</td>
<td>NA</td>
<td>33,191</td>
<td>39,434</td>
<td>29.79%</td>
</tr>
<tr>
<td>percent change: 1991-97</td>
<td>168.46%</td>
<td>268%</td>
<td>70.59%</td>
<td>NA</td>
<td>63.49%</td>
<td>64.64%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Policies: The Texas Department of Criminal Justice classifies all inmates according to medical history, health status, physical findings and age. Inmates receive classification restrictions that specify their housing, work or activity limitations whenever their health status indicates the need for such restrictions.

Through a partnership between the correctional system and two of the State's medical schools, Texas operates a comprehensive system of facilities designed to provide a complete range of care, from ambulatory clinic care provided at each prison facility to regional medical facilities, specialized psychiatric in-patient facilities and a full-service hospital. Texas also operates a prison hospice program that offers a full range of palliative care and has a special needs parole process that provides early release consideration for offenders who are terminally ill or meet other criteria specified by statute.

Facilities: The State operates a special geriatric center, staffs a regional medical facility that provides extended care and skilled nursing care services, and provides a separate housing area for mobility-impaired offenders. Texas also provides geriatric inmates access to a range of services and programs and has developed a facility specializing in providing chronic care. Texas operates a 60-bed geriatric facility located adjacent to a regional medical facility which supports the specialized health care needs of those inmates. The facility is a dormitory setting with wheelchair and walker access, a separate day room and its own recreation space. It has a self-contained food service line and dining area.

Challenges: Officials stated their primary concern in terms of dealing with aging inmates and their needs is the impact this growing population is likely to have on the health care costs of the system. Noting that these inmates have a disproportionately higher consumption of health care services due to a higher proportion of chronic diseases, coupled with longer sentencing practices, they stated their ability to predict and manage health care costs will be difficult.

In 1997, an additional prison facility was designated in the State to provide services to the geriatric population as it grows. As demands increase, services will be added to the facility to ensure it meets the needs of this population.
<table>
<thead>
<tr>
<th></th>
<th>total inmates</th>
<th>total age 50 and over</th>
<th>percent age 50 and over</th>
<th>lifers</th>
<th>natural lifers</th>
<th>sentences 20 years or more</th>
<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>14,507</td>
<td>851</td>
<td>5.87%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>1997</td>
<td>28,408</td>
<td>1,411</td>
<td>4.97%</td>
<td>1,605</td>
<td>80</td>
<td>7,141</td>
<td>8,826</td>
<td>31.07%</td>
</tr>
<tr>
<td>percent change: 1991-97</td>
<td>95.82%</td>
<td>65.8%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

**Policies:** The Virginia Department of Corrections offers special services to inmates, providing a complete treatment and rehabilitation program, including medical treatment, recreation, counseling, and special groups and activities. A leisure program geared to an older, disabled population has been implemented.

**Facilities:** Virginia has geriatric units for older inmates (aged 50 and over) who qualify for lower custody. These units are served by doctors, nurses, counselors, social workers, volunteer program coordinators, recreational staff and other volunteers.

**Challenges:** Officials with the Department responded that rising medical costs, safe management of these inmates in the general prison population, reducing depression/isolation, providing adequate hospice care for terminally ill, and a shortage of assisted-living programs were their biggest concerns. They also stressed the growing need for specialized or better trained nursing care for these inmates, especially in cases when inmates do not require hospitalization, but need supportive care in their daily activities.
### West Virginia

<table>
<thead>
<tr>
<th></th>
<th>total inmates</th>
<th>total age 50 and over</th>
<th>percent age 50 and over</th>
<th>lifers</th>
<th>natural lifers</th>
<th>sentences 20 years or more</th>
<th>number of lifers, natural lifers and 20+</th>
<th>percent lifers, natural lifers and 20+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>1,504</td>
<td>157</td>
<td>10.44%</td>
<td>160</td>
<td>120</td>
<td>30</td>
<td>310</td>
<td>20.61%</td>
</tr>
<tr>
<td>1997</td>
<td>2,755</td>
<td>235</td>
<td>8.53%</td>
<td>294</td>
<td>205</td>
<td>375</td>
<td>874</td>
<td>31.72%</td>
</tr>
<tr>
<td>percent change: 1991-97</td>
<td>83.18%</td>
<td>49.68%</td>
<td>83.75%</td>
<td>70.83%</td>
<td>1,150%</td>
<td>181.94%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Policies:** Officials from the West Virginia Division of Corrections state that they have no specific policies dealing with aged/infirm inmates. However, their contract with the medical providers outlines the types of medical services covered, based on need.

**Facilities:** Approximately 45 inmates over 50 years of age are housed in a medium-security, protective custody dormitory setting commonly called “The Old Men’s Colony.” Other older inmates reside in a special dormitory unit at Huttonsville Correctional Center. This unit is adjacent to infirmary and medical offices. Specialized programs are offered including counseling; dietary, medical and pharmacological services; horticulture and life-skills programs; and special education and religious services. Prosthetic devices and frequent medical services are provided as needed.

As of March 1998, the West Virginia Division of Corrections was in the process of taking over the Colin Anderson Center in St. Mary’s. They are converting the former retardation center into a 450-bed prison for older and infirm inmates.

**Challenges:** Officials with the Division stated that their most pressing concerns in dealing with these inmates are the rising costs of medical care and the difficulty of dealing with inmates who have serious medical conditions.
SUMMARY

An overview of the elderly inmate population in southern states’ correctional systems indicates that their numbers have increased both in absolute terms and as a percentage of the entire inmate population over the past decade. While inmates age 50 and older have increased 115.12 percent between 1991 and 1997, overall inmate population has increased only 83.69 percent. This trend is expected to continue into the future as prison sentences, on average, get longer and tougher. Along with this growth, states can expect more demands and costs in meeting the special needs of these inmates. This will be all the more difficult given the already outdated and over-crowded correctional facilities in many areas.

As prison populations get older, the problems facing corrections departments also will change. Older inmates’ needs are not only quite different from those of traditionally younger inmates, but they also are extremely diverse within the group. In addition to health care issues, depression, work assignments, co-payments, nutritional requirements, victimization from other inmates and appropriate staffing are concerns which may need to be addressed in accommodating this group of individuals.

The programs and policies corrections departments have in relation to older inmates vary from state to state. For the most part, southern states do not have specific written policies addressing the aged. However, if older inmates require special medical attention, their needs are addressed during the screening process. Most departments screen the inmate’s health upon admission, or on a routine basis, to determine housing, work assignment, security level and accessability to medical care and other services. They then assign inmates to programs and facilities based on those needs. Two states responded that inmates age 50 and older are given physical examinations annually, readjusting classifications as appropriate.

A few states do make policy decisions based solely on age. For example, in one, inmates age 50 to 55 receive classification requiring lighter, slower duties and inmates 55 and over are restricted from harder, heavier work, and may be allowed reduced work hours. In another, inmates may retire from work at age 65. Additionally, most states do offer some sort of “compassionate” leave for inmates with terminal illness and not believed to be a threat to society. Two southern states noted that they have incorporated hospice programs into their programs for the infirm if compassionate leave is impossible due to the nature of the crime or sentence.

In addition, states are increasingly housing infirm, special needs or disabled inmates apart from the general population and offering them unique programs or services. Although only two states responded they house inmates separately based solely on age, most do offer separate housing areas for the frail and elderly, affording them increased medical supervision, facility accessibility, and counseling. These areas range from ground floors or dormitories on the grounds of larger facilities, to smaller nursing or hospital units, to entire prison facilities. Frequently, these facilities are not centralized and older inmates are housed alongside younger, disabled ones in these areas. Some states have proposed building a single, centralized facility for the aged and infirm, and some are debating expanding smaller, disbursed facilities to meet demands placed on them. In many of these facilities, educational, counseling and recreational and rehabilitative programs

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have been expanded to accommodate the elderly. However, though expanding the specific policies, programs and facilities for elderly, geriatric and other impaired inmates still are in their developing stages. For example, few states have facilities specifically designed to house older inmates not requiring medical care, but who are in need of assistance with their daily activities.

According to respondents, the greatest challenge facing their corrections departments in meeting the needs of the elderly prisoner is providing for their medical care and the increased costs of that care. The second most frequently listed concern was the shortage of available facilities and programs to accommodate this population. Though many states do have such facilities, some are full or exceed their intended capacity. And finally, respondents listed the shortage of adequately trained staff as problematic in caring for elderly inmates.

Though there exists some public sentiment that providing special treatment or separate facilities in order to meet the needs of older inmates is not necessary, there are many who argue that doing so helps states reduce overall medical costs and liability. This also allows corrections departments to better utilize other institutions to house and guard younger and potentially more aggressive prisoners, which most facilities were originally designed to do.

Though it would be impossible to prescribe the solutions in meeting the demands of their respective state’s aging prison population to policymakers and corrections officials, it is hoped that this report has shed some light on several important issues in this area. As corrections departments enter into long-range planning activities, recognition of the increase in the older prison population, their special needs, and the potential challenges posed by this trend likely should be incorporated into those plans. Effectively meeting these and other challenges may not only be required by the ADA and/or past, pending, or future court rulings but, in many cases, doing so may allow states to more efficiently manage their corrections budgets.

Other Research
In responding to this report, correctional officials identified the need for additional research in the following areas:

- reducing the health care costs associated with providing services to older prisoners;
- identifying the average annual medical costs for aged offenders;
- assumption of financial responsibility for the medical treatment of these inmates through Medicare or Medicaid;
- policies and guidelines of nursing care facilities within the community for the purpose of adapting said guidelines and policies to the correctional setting;
- utilizing the cost-effectiveness of providing medical services through an HMO;
- security levels necessary for the protection of both the community and the elderly or infirm inmate housed within correctional facilities;
- impact of sentencing law changes which would mean longer sentences and an increase in elderly inmate population in the future; and
- identifying the costs of long-term incarceration of infirm prisoners and the potential risks of early parole or extended medical furlough for this population.
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FOOTNOTES AND REFERENCES


2 Comparing data from the 1986 Vital Statistics in Corrections, the American Correctional Association, and the 1997 Corrections Yearbook, the Criminal Justice Institute. These figures exclude Louisiana because figures for the state’s inmates, 50 years of age or older, in 1985 were not available.

3 Figures from the Corrections Yearbook, 1991 and 1997, the Criminal Justice Institute. For same reasons in footnote 2, Louisiana figures not calculated into entire percentages.


5 In Estelle vs. Gamble, 1976, the U.S. Supreme Court established that the government had an obligation to provide health care for prisoners and in Capps vs. Atiyeh, 1983, the Court laid out three basic requirements for correctional care, ruling: prisoners must be able to make their medical problems known, the medical staff must be competent to examine inmates and diagnose their illness, and staff must be able to treat the inmates’ medical problems or to refer the inmates to outside medical sources.


7 Virginia Department of Correction’s study, “Older Inmates: The Impact of an Aging Inmate Population on the Correctional System.”


11 Rationale and figures were cited from B. Jaye Arno, Ph.D. in Correct Care, National Commission on Correctional Health Care (Summer 1997, Volume 11, Issue 3), pp. 6-7.


18 This information was compiled both from South Carolina’s responses to the SLC survey and Judy C. Anderson and R. Daniel McGehee’s article “South Carolina Strives to Treat Elderly and Disabled Offenders,” Corrections Today (August 1991), pp. 125-126.


Oklahoma Board of Corrections, Feasibility Study on Geriatric/Handicapped Facility, (July 26, 1996).

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