Federal Probation

JUNE 1989

Federal Probation

A JOURNAL OF CORRECTIONAL PHILOSOPHY AND PRACTICE

Published by the Administrative Office of the United States Courts

VOLUME LIII JUNE 1989 NUMBER 2

This Issue in Brief

The Development of a Juvenile Electronic Monitoring Program.—Author Michael T. Charles reports on a research project concerning the juvenile electronic monitoring program undertaken by the Allen Superior Court Family Relations Division, Fort Wayne, Indiana. Reviewing the planning and implementation phase of the program, the author discusses (1) the preplanning and organization of the program; (2) the importance of administrative support; (3) the politics and managerial issues faced during program development, implementation, and management; and (4) the role and function of surveillance officers.

Morrissey *Revisited: The Probation and Parole Officer as Hearing Officer.*—Author Paul W. Brown discusses the Federal probation officer's role as hearing officer in the preliminary hearing stage of the parole revocation process. This role was largely created by the landmark Supreme Court case of *Morrissey* v. *Brewer* in which the Court indicated a parole officer could conduct the preliminary hearing of a two-step hearing process possibly leading to a parole revocation and return to prison. How this role was created in *Morrissey* and how it has been carried out by the Federal probation officer are examined.

Defense Advocacy Under the Federal Sentencing Guidelines.—This article sets forth the duties and responsibilities of defense counsel in effectively representing clients in all phases of the criminal process under Federal sentencing guidelines. Author Benson B. Weintraub offers practice-oriented tips on arguing for downward departures, avoiding upward departures, and negotiating plea agreements under the guidelines and discusses procedures to employ in connection with the presentence and sentencing stages of a Federal criminal case.

Federal Bureau of Prisons Programming for Older Inmates.—The "graying" of our society is creating a change in our prison populations. More sentenced offenders will be older when they enter the institutions, and longer sentences will result in more geriatric inmates "behind the walls." Balancing the needs and costs of geriatric care is a critical issue to be addressed. In this article, authors Peter C. Kratcoski and George A. Pownall discuss various attributes of criminal behavior of older persons and the distribution of older offenders within the Federal Bureau of Prisons. They also discuss the complete health care programming that correctional systems must provide to meet legal mandates already established in case law. According to the authors, significant programming adaptations have taken place in the past several years at the Federal level; more are anticipated in the near future.

Privatization of Corrections and the Constitutional Rights of Prisoners.—Many in the legal and corrections community have presumed that "private" correctional facilities will be held to the same constitutional standards as those directly administered by the state itself. Author Harold J. Sullivan

CONTENTS

118843

Federal Bureau of Prisons Programming for Older Inmates

By Peter C. Kratcoski and George A. Pownall*

Introduction

As the 20th century draws to a close, an ever increasing percentage of the U.S. population will be made up of elderly persons, and the criminal activity of persons age 50 or older will take on increasing importance. Criminal behavior involving older persons poses dilemmas far beyond the apprehension of offenders and the prosecution and disposition of their cases. Few options have been developed for treating and counseling older offenders. The problem is especially acute when an older person who is the perpetrator of a very serious offense must be institutionalized. In this article, we will consider the types of offenses which may result in institutionalization of older offenders and institutional programming used by the Federal Bureau of Prisons to meet the special physical, health, social, and psychological needs of these inmates.

Until recently, criminologists showed little interest in the involvement of the elderly in criminal activity. But, as they gradually became aware of the fact that a sizable amount of the crime in the U.S. can be attributed to older persons and that the amount will be likely to increase, the role of elderly as offenders has begun to emerge as a significant topic of concern.

In a recent report completed by the Federal Bureau of Prisons Office of Research and Evaluation, it was noted that 26 percent of the U.S. population is age 50 or older, and the figure is expected to reach 33 percent by the year 2010. As a result of the aging population, the number of older people in prison will increase even if crime patterns and sentence lengths remain the same as those which exist at the present time (Federal Bureau of Prisons, January 1989).

The *Uniform Crime Report, 1987*, categorizes the various types of crimes committed by older persons. Table 1 lists the total number of arrests in the Crime Index categories and the proportions of the arrests that fall into the older age categories.

As shown in Table 1, arrests of those age 50 and above constitute less than 5 percent of the total arrests for all offenses. When the specific serious offenses of the Crime Index are considered, the percentage of arrests for murder, non-negligent manslaughter, and aggravated assault for the 50 and above age group approaches 6 percent, while for property type crimes, the percentage of arrests of those aged 50 and above is 3.6 percent.

In Table 2, figures are given on selected offenses related to alcohol, drug abuse, and family related violence, which often is directly related to alcohol abuse. Arrests of offenders age 50 and above are quite high for the offenses of driving under the influence (8.5 percent) and drunkenness (12.4 percent). These figures tend to support research findings that much of the criminal activity of older offenders stems from violent conflicts with family, friends and acquaintances, and alcohol and drug abuse problems.

Explanations of Criminal Behavior by the Elderly

Determining the reasons why older people engage in criminal behavior is very difficult. Theories advanced to explain the onset of violence by members of this age group are varied and complex. Most of the factors which are important explanatory elements for any age group, such as poverty, environment, and drugs and alcohol, also apply to older offenders. In addition, there are some factors, such as the social and mental reactions to retiring, which may be unique to the older offenders. What appears to be of significance is the amount of violent crime committed by older people in which the victim tends to be a family member, relative, or close acquaintance.

A portion of violent criminal activity by the aged

*Drs. Kratcoski and Pownall are both professors of criminal justice studies and sociology, Kent State University. The authors wish to acknowledge the assistance of Harriet M. Lebowitz and Chris Eickenlaub, social science analysts, Office of Research and Evaluation, Federal Bureau of Prisons; Paul Horner, Corrections Program Division, Central Office, Federal Bureau of Prisons; Ron Hixson, unit manager, Comprehensive Health Unit, Federal Correctional Institution, Ft. Worth, Texas; Steve Dann, Chief of Operations, Health Service Division, Federal Bureau of Prisons; and Charlene Sobwick, planning specialist, Federal Bureau of Prisons.

TABLE 1. ARRESTS FOR SELECTED INDEX OFFENSES BY AGE, 1987

Offense Charged	Total all ages	Age 50-54	55-59	60-64	65 and over
Total	10,795,869	202,147	137,410	87,233	87,672
Percent distribution[1]	100%	1.9%	1.3%	.8%	.8%
Murder and Non-negligent Manslaughter	16,714	352	236	137	234
%	100%	2.1%	1.4%	.8%	1.4%
Forcible Rape	31,276	469	336	211	194
%	100%	1.5%	1.1%	.7%	.6%
Aggravated Assault	301,734	6,071	3,858	2,410	2,572
%	100%	2.1%	1.3%	.8%	.9%
Larceny-Theft	1,256,552	18,669	14,195	10,357	14,772
%	100%	1.5%	1.1%	.8%	1.2%
Violent Crime[2]	473,030	7,416	4,719	2,867	3,123
%	100%	1.6%	1.0%	.6%	.7%
Property Crime[3]	1,793,437	21,117	15,484	10,986	15,430
%	100%	1.2%	.9%	.6%	.9%

[1]Percentages have been rounded to one decimal point.
[2]Violent crimes are offenses of murder, forcible rape, robbery, and aggravated assault.
[3]Property crimes are offenses of burglary, larceny-theft, motor vehicle theft, and arson.

Source: Compiled from Federal Bureau of Investigation, *Crime in the United States, 1987*, Washington, DC: U.S. Government Printing Office, 1988, pp. 174-175.

TABLE 2. ARRESTS FOR SELECTED OFFENSES BY AGE, 1987

Offenses Charged	Total all ages	Age 50-54	55-59	60-64	65 and over
Other Assaults	671,938	11,458	6,922	4,379	4,518
%[1]	100%	1.7%	1.0%	.6%	.7%
Offenses Against Family & Children	48,002	877	482	229	245
%	100%	1.8%	1.0%	.5%	.5%
Driving Under the Influence	1,410,397	47,576	32,847	20,774	17,696
%	100%	3.4%	2.3%	1.5%	1.3%
Liquor Laws	505,021	5,351	3,795	2,400	2,037
%	100%	1.1%	.8%	.5%	.4%
Drunkenness	700,662	31,939	24,420	15,914	13,658
%	100%	4.6%	3.5%	2.3%	2.0%
Disorderly Conduct	599,622	9,679	6,429	4,246	4,148
%	100%	1.6%	1.1%	.7%	.7%
Vagrancy	32,518	1,058	775	440	372
%	100%	3.3%	2.4%	1.4%	1.1%

[1]Percentages have been rounded to one decimal point.
Source: Federal Bureau of Investigation, *Crime in the United States, 1987*, Washington, DC: U.S. Government Printing Office, 1988, pp. 174-75.

can be attributed to mental illness or deterioration. In their book, *Elderly Criminals*, Newman et al. (1984) cited various studies of the incidence of psychiatric disorders in persons charged with acts of aggressive violence. Research by Hucker and Ben-Aron (1984) found that the most frequent psychiatric diagnoses in their study of older offenders were organic brain syndrome, neurosis, personality disorders other than the antisocial type, and alcoholism.

Alcohol abuse is also a problem associated with offenses by the elderly. In many instances, alcohol abuse emerged as a problem late in the lives of these offenders, when excessive drinking was used as an escape mechanism to make more bearable the difficulties involved in aging, separation from the work force, financial difficulties, or illness or death of loved ones.

The disengagement process may be devastating for older individuals, particularly males, as they become increasingly isolated from persons and organizations outside the home after they retire. Feelings of uselessness and rejection can result, and tensions between spouses or companions can increase as they spend more and more time in each other's company. Living on a fixed income as the cost of living continues to increase may result in such criminal practices as shoplifting, fraud, or stealing by persons who were hard working, law abiding citizens during the years they were employed.

The inability to cope with stress has also been identified as a factor in criminal behavior by older persons. Violence is a possible outcome when the defenses against stress are inadequate. Such pressures as prolonged illness of one spouse, medical expenses that cannot be met, pain, fear of the future, and even hunger can build up stress. In addition, withdrawal from a large circle of friends and acquaintances makes an elderly couple or older persons who live together more dependent on each other for emotional support. This often creates a highly stressful climate.

In a study of elderly homicide offenders, it was found that in more than one-fourth of the cases the victim and assailant were married, and in only 11 percent of the cases were the assailant and victim complete strangers. Most of the homicides occurred in the home of either the assailant or victim, and the majority of cases occurred during or after a quarrel, with the victim often precipitating the hostilities. Alcohol use by either the victim, the offender, or both was evident in more than one-third of the cases (Kratcoski and Walker, 1988). In another study of elderly homicide offenders, it was found that only 16 percent had any record of criminal activity before the homicide event (Kratcoski, 1988).

A Profile of Older Inmates

Most of the older persons who are arrested as a result of their criminal activity do not end up incarcerated in long-term institutions. Even some of the more serious offenders, such as murderers and rapists, may be probated to mental hospitals rather than sentenced to correctional facilities. However, there are strong indications that the number of older offenders will continue to increase, and correctional administrators are now beginning to conduct the research and gather the data needed to properly plan for the types of facilities and programs older offenders need to make satisfactory adjustments to institutionalization. Rather than trying to summarize the programs and policies of each individual state, the authors of this article will limit their analysis and discussion of programs for older offenders (those 50 and above) to those offered by the Federal Bureau of Prisons. This system encompasses more than 66 institutions and has a daily population of more than 46,000 (U.S. Department of Justice, February 1989). All categories of offenders from murderers to tax evaders are housed in Federal institutions.

In a recent research bulletin, it was noted that in 1989 almost 12 percent of the Bureau of Prisons inmate population is age 50 or above, and it was estimated that in the year 2005 more than 16 percent will be age 50 or above. In the same study, it was also projected that more than 30 percent of the inmate population aged 50 or above will have some form of cardiac and hypertensive disorder which will require substantial medical attention (U.S. Department of Justice, January 1989).

Normally, a 50-year-old person is not considered to be "elderly." In a discussion of this matter with Steve Dann, chief of operations, Health Service Division, Bureau of Prisons, he indicated that typically there is a 10-year differential between the overall health of Bureau of Prisons inmates and that of the general population. Because of the previous lifestyles of the inmates (a large number of them having used drugs and alcohol to excess, poor eating habits, stress in life) they have aged faster than the normal population, and a 50-year-old will typically have the health problems of a 60-year-old person on the outside.

The characteristics of the inmates who had reached 50 years or older housed in various Bureau of Prisons facilities during January 1989 are given in Table 3:

TABLE 3. PROFILE OF INMATES AGE 50 AND OVER BUREAU OF PRISONS, JANUARY 1989 (N = 5522)

		Number	Percent
Sex:	Male	5,302	96%
	Female	220	4%
Race:	White	4,494	81%
	Black	932	17%
	Other	96	2%
Age Group:	50-54	2,616	48%
	55-59	1,515	27%
	60-64	841	15%
	65-over	547	10%
Present Committing Offense:			
Against Person (assault, kidnapping, robbery, homicide, rape)		707	13%
Larceny (auto, postal, interstate, other)		239	4%
Drug Related		1,862	34%
Counterfeiting, Embezzlement, Extortion Fraud, Income Tax, Forgery		957	17%
Firearms		181	3%
Other		811	15%
Unsentenced or No information		765	14%
Prior Commitments:			
None		2,144	39%
One or more		2,494	45%
No information		884	16%
Individual Inmate Security Classification (one is lowest, six is highest):			
one		2,564	46
two		667	12
three		730	13
four		864	16
five		178	3
six		46	1
unassigned		416	8
unsentenced or no information		57	1

Data provided by Harriet M. Lebowitz and Chris Eickenlaub, social science analysts, Office of Research and Evaluation, Federal Bureau of Prisons.

Most of the older inmates were committed for nonviolent types of offenses. Only 13 percent were perpetrators of crimes against persons. The largest number of inmates were institutionalized for drug related offenses. Of course, there is always the possibility that those involved in drug related activities and other types of offenses engaged in violent behavior while in the process of committing the offense for which they were confined. Nevertheless, it is apparent that the majority of the older inmates are not considered dangerous. Forty-six percent of them are classified in the lowest security level category, and almost three-fourths of the inmates are classified in the three lowest security levels.

Federal Bureau of Prisons Handling of Older Inmates

The Bureau of Prisons administration follows a policy of distributing the inmate population on the basis of security needs and regional considerations rather than on the basis of age. Fort Worth has the highest number with approximately one-fourth of the inmate population having reached 50 years of age. This is probably due to the fact that the Fort Worth facility has a long history of treating inmates with drug and health problems and has developed a comprehensive health unit. It is interesting to note that high security institutions such as Lewisburg and Leavenworth Penitentiaries, as well as medium security and low security level institutions, house a sizable number of older inmates. Not everyone is in agreement that the distribution of older offenders among the inmate population should be determined by the amount of security needed. There are those who have researched the problems of the older inmate and have concluded that they should be housed in separate facilities or at least in separate units because of their special needs. For example, Wiegard and Burger (1979) suggest that the educational, recreational, and vocational training programs followed in prisons are designed for younger offenders. Typically the older offender may have a hard time getting into these programs because there are limited slots, and they would tend to be reserved for younger inmates who it is believed could benefit most from them. As mentioned earlier, a fairly large proportion of the older inmates have health problems which reduce the likelihood that they can participate in strenuous recreational or work activities in the prison.

Sabath and Cowles (1988) researched the effects of factors such as family contacts, financial position, marital status, education, time served, and quality of health as they relate to the institutional adjustment of older inmates. They found that family contacts, education, and health had the most effect on positive institutional adjustment. The older offenders who were able to maintain contacts with their

families were found to be better adjusted than those who could not. Likewise, older inmates who had attained enough education to read and take part in institutional activities which required some education skills were more likely to have a positive adjustment. Health was also extremely important, because it not only contributed to the inmates' general feelings of well being, but indirectly enhanced or limited the range and number of activities in which the inmates could participate, such as work assignments and recreational activities.

Reed and Glamser (1979) advocated special facilities for older offenders because they believe these facilities are necessary to protect older inmates from being exploited and physically harmed by the younger, more aggressive inmates. Lincoln Fry (1988) found safety to be a major concern of older offenders housed in a minimum security prison with younger offenders.

For the Bureau of Prisons, it would be impossible and impractical to build special facilities for older inmates. Paul Horner, Corrections Program Division, Central Office, Federal Bureau of Prisons, believes "If the older inmate is in good health and ambulatory it is best to assign him to the appropriate classification institution within the region in which he resides." He stated,

> We want to keep them close to family and loved ones. If they receive visits regularly, it helps them maintain a positive attitude and, in most cases, is beneficial both psychologically and physically. Conversely, it would be counterproductive to establish facilities solely for the purpose of housing older offenders if it meant separating them from their families.

Mr. Horner believed that the older inmates are more dependent on the staff than the younger residents and thus demand more of the staff's time and energy. While the young inmates will tend to be drawn into the inmate subculture, the older ones tend to be loners or ones who select a few close associates within their age group. Thus, the older offender will turn to the staff to help deal with family crises or problems being experienced in the facility. "Just as a young inmate may adopt an older inmate as a surrogate father or mother, the older inmate may adopt a staff member as a surrogate son or daughter, whom he will confide in and turn to when in need of help" (Paul Horner, interview with author, January 1989).

The matter of younger inmates exploiting and physically harming older inmates may not be as important in Federal institutions as it is in state institutions. As noted in our statistics, the majority of older Federal inmates had been previously institutionalized. Rather than being naive about life in the prison they have had the time and opportunity to learn the ropes and know what it takes to get along.

Typically, the older offenders would be encouraged to take advantage of all programs. The more they become involved in the available social, recreational, and educational programs, the more likely it is that they will develop a positive attitude toward their institutional experiences. This in turn will help ward off both mental and physical health problems. The one exception to non-age differential programming is when the inmates' physical and mental health is so poor it becomes impossible for them to function in a general age distributed population. Most of the Bureau of Prisons administrators emphasize a holistic approach to positive health. Everything that happens in the institutions, including provisions of appropriate living quarters, balanced nutritious meals, and anti-smoking campaigns, is designed to promote good health. The older inmates are encouraged, along with all others, to participate in recreational activities and become health conscious. Although the older inmates may not be able to participate in basketball or football, they can walk, complete aerobic exercises, and take part in most other activities.

The policy determining how older offenders are to be classified and distributed throughout the Federal Bureau of Prisons institutions is not likely to change drastically in the near future. Thus, the offense and the region in which the offender resides will still be the most important factors determining the assignment. However, as the inmate population continues to grow older and a large proportion of the entire population is in the above 50's category, it will be necessary to devote more attention and resources to the needs of this group than is presently being given.

The health needs of the older inmates may force the Bureau of Prisons to develop more comprehensive health units in the facilities located throughout the U.S. In the *Estelle* v. *Gamble* case (97 S. Ct. 285, 291, 1976), inmates' right of access to medical care was confirmed. In this case, the court stated that: ". . . deliberate indifference to the serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." Consequently, correctional systems must supply a full range of health care services—medical, dental, nutritional, and acute and long-term care. It has already been established that the number of inmates who have reached the age of 50 or above will increase significantly each year. By the year 2005, approximately 16 percent of the inmate population will fall into this age category. In addi-

tion, due to changes in sentencing, convicted offenders will spend longer periods of time in prison. Many will become old while serving their time.

Another factor is that more women are being incarcerated than ever before. Women generally seek more medical treatment than males and can have more complex medical needs. If female survivor rates in prison mirror those in the general society, we may have proportionately more older female inmates than males requiring specialized treatment.

In addressing the issue of health care, the correctional system will have to deal with the various components before determining whether or not to create geriatric special units for inmates within the institutions. The ideal geriatric unit will need to provide services to address the following needs experienced by the inmate:

1. special diets, nutrition monitoring
2. special exercise needs for prevention of bone deterioration etc.
3. personal hygiene issues i.e. problems of incontinence
4. decline in sight, hearing and memory impairment
5. slowing of physical and mental responses
6. modified work and leisure programming
7. monitoring for special problems i.e. cardiovascular diseases, diabetics, digestive ailments etc.
8. modification of physical environment to facilitate walkers, wheelchairs, other physical aids
9. ultimately, constant bed care and intensive medical supervision
(U.S. Department of Justice, 1985, p. 39)

The Federal Bureau of Prisons has been working toward providing geriatric care within the institutions beginning in the late 1970's with the creation of a new model of a medical unit for male inmates who had chronic medical problems or required close medical followup on a temporary basis. Initially called the Comprehensive Health Unit, now termed the Dallas Unit, it is located at the Federal Correctional Institution, Fort Worth, Texas. In November 1986, the age range of the inmates was 25 to 77 years; 79 percent were 40 or older; 57.6 percent were 51 or older. There were more inmates in the category of 61 and older than in the 40 and under group (23.4 percent to 20.9 percent) (U.S. Department of Justice, 1987, p. 5). Only security levels one, two, and three are admitted to the Dallas Unit. More than 90 percent of the inmates in the unit were classified as level one security.

The Comprehensive Health Unit was originally designed to hold 147 offenders who must meet the following criteria:

1. Are otherwise appropriate for a level one, coed facility
2. Have some on-going medical/health problem which precluded conventional housing
3. Require 24 hour medical coverage
4. Have ambulatory problems
5. Have limited work ability
6. Require close proximity to both in and out patient services
7. Are able to attend to their own personal hygiene such as bathing, eating, dressing and cleaning their own room, not a hospital-type inmate
(U.S. Department of Justice, 1987, p. 6)

During an interview with Ron Hixson, the unit manager, it was pointed out that the Comprehensive Health Unit of Fort Worth had to be expanded to accommodate the number of inmates in need of specialized health services. The age of the inmates in the unit averages around 50. The inmates in the unit have a variety of physical disabilities and health problems. Most are ambulatory to the extent that they could eat and work out in the general population. However, more than 30 were in wheelchairs, and approximately 20 needed to take their meals within the unit.

Mr. Hixson mentioned that even inmates with rather chronic health problems are encouraged to participate in normal institutional activities to the extent possible. For example, almost everyone works. Those who have difficulty walking or are confined to wheelchairs work for a small UNICOR industry located in the facility. They mail out information on small businesses and catalogues of UNICOR products. Other chronically ill inmates work in food service, or at the school, or complete light janitorial work. Mr. Hixson believed the policy of keeping the inmates in the "main stream" regardless of their age and depending on the extent of their health problem is a good policy, observing, "The person does not lose interest in life and begin to vegetate." He projected that more health units will probably be needed in the future. Under the new Federal sentencing guidelines, parole has been pretty much eliminated. The inmates will serve longer sentences, and there will be more inmates who actually serve time under these guidelines. The older inmate population will increase proportionally.

The goals established for the unit for 1989 include maintaining a high level of sanitation and installing a wheelchair ramp in a section of the unit. Cleanliness and access are two of the major concerns of the staff members who work with chronically ill or handicapped inmates. The environmental design of the facility must allow for maximum mobility, and a clean living unit is one way to prevent the spread of disease within the unit. Special health oriented programs for the inmates include Stress Management, Health Wise, Drug Facts, and Positive Mental Attitude. A nurse/counselor is assigned to the reg-

ular unit staff for the purpose of medical monitoring and to give instruction in self health care and prevention medicine.

In February 1989, the Bureau of Prisons reported that the system is expanding the number of Comprehensive Health Units to two at the Fort Worth facility. The new unit will handle less severely handicapped and chronically ill inmates. Intensive medical oversight and special housing for higher security level male inmates is being handled at the institutions located at Rochester, Minnesota and Springfield, Missouri, while females are sent to Lexington, Kentucky. Because of the closeness of the renowned Mayo Clinic, the Rochester unit handles the more medically complex diagnostic cases and security levels three and four cases. Security levels four, five, and six cases are placed in the unit at Springfield, an institution which had a tradition of being a free-standing medical unit. Male inmates in need of intensive, constant bed care are again divided by security level and placed at either Rochester or Springfield; females go to Lexington, Kentucky. All Bureau institutions now house infirmaries as opposed to more complete medical units.

All evidence suggests that correctional systems will need to increase the resources allocated for the geriatric care of long-term inmates. The Federal Bureau of Prisons has begun to provide the needed care within the institutions it manages, which may be the more practical choice, given the rising costs and patchwork of community care for the elderly in the general society.

According to Steve Dann, chief of operations, Health Service Division, the Bureau will probably need several chronic health units similar to that in operation in the Fort Worth, Texas facility. A half dozen or so special units of this type will be located in all security level facilities and strategically distributed throughout the country. Inmates of all age categories could be assigned to the chronic health units, but it is likely that most of the assignees will be older inmates. These units would exist within the larger institution. Inmates would be assigned to the unit because they have special health problems. If the problem is eliminated, the person could be transferred out. The unit might house 50 to 60 inmates who would be involved in a structured living environment, quite different from that of the other inmate population. The inmates in these units who are capable would be employed doing important tasks which do not require a great deal of physical exertion to complete. Other special activities which might be required are that meals would be served on the unit and skilled nursing personnel would be available around the clock.

Steve Dann stated:

> Those correctional facilities which are conveniently located near high tech medical hospitals such as the facility at Rochester, Minnesota, are central to the plans the Bureau of Prisons has for meeting the health needs of inmates. Some of the inmates housed in these units may be at high risk to develop severe physical health conditions. Being close to the Mayo Clinic, the Bureau of Prisons has developed a cooperative arrangement with the hospital administration to accept referrals from the correctional center. Thus there is an assurance that the health needs of those who become severely ill will be met even if those needs exceed the Bureau's internal capabilities to provide the medical care through its own staff.
>
> (Steve Dann, interview with author, January 1989)

While an arrangement of this sort is already in effect at the Rochester correctional facility, it would be quite possible to institute similar arrangements in many other sections of the country. Although these special health units may not be specifically designated for older offenders, previous experiences from other institutions indicate that they would be filled predominately by the age group of 50 and above. The only factor mitigating against an inmate's admission to such a unit might be the inmate's security classification. Those inmates in the higher security classification may be excluded unless the units are located within appropriately secure institutions.

Steve Dann conceded that, as the inmate population gets older and longer sentences are imposed, the services needed for the older inmates will continue to mount. While some contracting of services, in particular in the medical area, will occur, he does not envision turning the whole program for the elderly over to private concerns.

Conclusion and Implications

In the past, administrators of correctional institutions were trained to plan for, supervise, and rehabilitate inmates who are young, aggressive, poorly educated, lacking in skills, and not highly motivated. Prison policies and programs were developed to accommodate this type of offender. Of course, administrators were aware that some older offenders were housed in their institutions, but these were generally the ones who were serving long sentences and were growing old inside. Since there were only a handful of them, they usually could be given some special work assignments to occupy their time. Thus, the administrators did not have to be too concerned about programming and providing for the special needs of the older inmate group. Prolonged thinking and planning did not occur on this matter until administrators became aware that the inmate popu-

lation has gradually grown older and that older institutionalized persons have unique problems and needs.

The Federal Bureau of Prisons recognized the need for special programming as early as the 1970's and has made considerable progress in providing for the special needs of the older inmates being sent to Federal correctional facilities. While older inmates continue to be housed in institutions with inmates of all ages, special programs were developed to serve their needs. Since adequate health care is mandated by law, and most older inmates return to the community, some seeking employment, others social security benefits, the Bureau of prisons has recognized that the older offenders may be in need of more assistance and support than younger offenders. The arrest statistics of older persons taken from the *Uniform Crime Report* and the committing offense statistics taken from Bureau of Prisons data also reveal that a sizable number of older offenders have alcohol and drug related problems. Even though the older inmate populations of most of the Federal institutions are only a fraction of the total, special programs for this group are necessary. While it may not be desirable to house the aged inmates in a separate unit, living quarters are designed to protect the older inmates from physical and health ailments, and appropriate heating, lighting, and easy accessibility to bathrooms and sleeping space are provided.

Vito and Wilson noted that "educational, vocational, recreational, and rehabilitation programs should be expanded to accommodate the needs of the elderly. The programs should be offered in locations which are physically accessible to the elderly. Older inmates should be encouraged to participate in these programs, and the programs should be structured to facilitate participation" (Vito and Wilson, 1985, p. 23).

Providing adequate health care as mandated by law will become more and more expensive. It would appear that this is an area in which the contracting of services with the private sector could provide a partial solution to the problem, and as indicated earlier in the article the Bureau of Prisons has already established several contractual agreements with private agencies to provide health services to Bureau of Prison inmates.

Finally, since inmate population projections suggest a larger proportion of older inmates for the future, consideration of the specific needs of this group are being incorporated into the construction plans when new facilities are considered. When institutional sites and floor plans are selected, the needs of the older inmates should be given consideration.

References

Estelle v. *Gamble*, 97 S.Ct. 285, 291, 1976.

Federal Bureau of Investigation. *Crime in the United States*, 1987. Washington, DC: U.S. Department of Justice, 1988, pp. 174-75.

Federal Bureau of Prisons. "Unit Plan for Comprehensive Health Unit, Fort Worth, Texas." Washington, DC: U.S. Government Printing Office, Sept. 1987.

Fry, Lincoln J. "The Concerns of Older Inmates in a Minimum Prison Setting." In Belinda McCarthy and Robert Langworthy (eds.), *Older Offenders*. New York: Praeger, 1988, pp. 164-177.

Hucker, S.J. and M.H. Ben-Aron. "Violent Elderly Offenders: A Comparative Study." In W. Wilbanks and P. Kim (eds.), *Elderly Criminals*. New York: University Press of America, 1983, pp. 69-81.

Kratcoski, Peter C. "An Analysis of the Victim-Assailant Relationship in Non-Justifiable Homicides by Elderly Offenders." In Frans Koenraadt and Michael Zeegers (eds.), *Trends in Law and Mental Health*. Utrecht, The Netherlands: Academy of Law and Mental Health, 1988, pp. 247-255.

Kratcoski, Peter C. and Donald B. Walker. "Homicide Among the Elderly: Analysis of the Victim/Assailant Relationship." In Belinda McCarthy and Robert Langworthy (eds.), *Older Offenders*. New York: Praeger, 1988, pp. 62-75.

Newman, Evelyn, Donald Newman, and Minday Gewertz. *Elderly Criminals*. Cambridge: Lelgeschlager, Gunn and Hain, 1984.

Reed, M.B. and F.D. Glamswer. "Aging in a Total Institution: The Case of Older Prisoners." *The Gerontologist, 19*, 1979, pp. 354-360.

Sabath, Michael J. and Ernest L. Cowles. "Factors Affecting the Adjustment of Elderly Inmates in Prison." In Belinda McCarthy and Robert Langworthy (eds.), *Older Offenders*. New York: Praeger, 1988, pp. 178-196.

U.S. Department of Justice, Federal Bureau of Prisons Office of Research and Evaluation. "Looking Ahead—The Federal Bureau of Prisons Population and Their Costly Health Care Needs." Washington, DC: U.S. Department of Justice, 1988.

U.S. Department of Justice, Federal Prison System. "Monday Morning Highlights," Washington, DC: U.S. Department of Justice, February 20, 1989.

Vito, Gennaro F. and Deborah G. Wilson. "Forgotten People: Elderly Inmates," *Federal Probation, 49*(1), March 1985, pp. 18-24.

Wiegand, N. and J.C. Burger. "The Elderly Offender and Parole," *The Prison Journal, 59*(1), 1979, pp. 48-57.