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ACQUISITIONS

This Issue in Brief

Guiding Philosophies for Probation in the 21st Century.—What does the future hold in store for probation? Authors Richard D. Sluder, Allen D. Sapp, and Denny C. Langston identify and discuss philosophies and goals that will emerge to guide probation in the 21st century. They predict that offender rehabilitation will become a dominant theme in probation but that it will be tempered by concern about controlling offenders to ensure community protection.

Identifying and Supervising Offenders Affiliated With Community Threat Groups.—Gangs and community threat groups have placed a new breed of offender under the supervision of U.S. probation officers. Are the officers adequately trained in special offender risk-management techniques to provide effective supervision? Author Victor A. Casillas analyzes gang and community threat group issues from a district perspective—that of the Western District of Texas. He defines and classifies community threat groups generally, relates the history of gangs in San Antonio, and recommends organizational strategies for identifying, tracking, and supervising offenders affiliated with community threat groups.

Community Service: A Good Idea That Works.—For more than a decade the community service program initiated by the probation office in the Northern District of Georgia has brought offenders and community together, often with dramatic positive results. Author Richard J. Maher presents several of the district's "success stories" and describes how the program has built a bridge of trust between offenders and the community, has provided valuable services to the community, and has saved millions of dollars in prison costs. He also notes that the "get tough on crime" movement threatens proven and effective community service programs and decreases the probability that new programs will be encouraged or accepted.

Community-Based Drug Treatment in the Federal Bureau of Prisons.—Author Sharon D. Stewart provides a brief overview of the history of substance abuse treatment in the Federal Bureau of Prisons and discusses residential treatment programming within Bureau institutions. She describes in detail the community-based Transitional Services Program, including the relationship between the Federal Bureau of Prisons, the United States Probation System, and community treatment providers.

The Patch: A New Alternative for Drug Testing in the Criminal Justice System.—Authors James D. Baer and Jon Booher describe a new drug testing device—a patch which collects sweat for analysis. They present the results of a product evaluation study conducted in the U.S. probation and U.S. pretrial

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Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates

By Ronald H. Aday, Ph.D.

Gerontology Program Director, Middle Tennessee State University

MOST RESEARCHERS and policymakers—some have suggested—deem the crimes of youthful offenders to be more serious and dangerous for society than the crimes committed by older people (Carlie, 1970). However, in recent years, crime and the elderly has emerged as an issue of increasing importance. While we are more accustomed to seeing the elderly as victims, attention has begun to shift to how the elderly are increasingly the perpetrators of crime (Aday, 1988; Alston, 1986; Cullen, Wozinak, & Frank, 1985; Goetting, 1992; Kratcoski, 1990). A common portrayal of the elderly offender has been the "victimless" felon writing bad checks or the senior citizen who shoplifts in order to survive or provoke some attention. The elderly are not only committing more crimes, however, but also more serious offenses which at one time were reserved more exclusively for the young. As a result, elderly offenders are presenting complex challenges to our Nation's prison systems (Aday, 1994; Anderson & Morton, 1989).

Approximately 381,000 persons ages 50 and older are arrested annually in the United States *(Uniform Crime Reports*, 1990). Of these, 15 percent are arrested for serious felonies such as murder, forcible rape, robbery, aggravated assault, burglary, larceny, motor vehicle theft, and arson. As more of the older population commits violent offenses, the likelihood that they will become incarcerated becomes apparent. *The Corrections Yearbook* reported in 1992 that 709,587 inmates were confined to state prisons nationwide including the District of Columbia. Of these prisoners, 35,032 were over the age of 50, representing a 50 percent increase in 4 years. This age group comprises approximately 5 percent of the total inmate population.

The Corrections Yearbook further reported that the Federal Bureau of Prisons housed 66,472 prisoners, of which 6,554 or about 10 percent were 50 years of age or over. By the year 2005, this prison population over 50 is expected to increase to 16 percent. Of course, as our state prison systems expand, so will our Federal prisons. The number of inmates will continue to increase and will exceed 100,000 by 1995. By the year 2000, a projected 137,000 inmates will be in the Federal system (Roth, 1992).

It appears that the population of older prisoners will continue to increase well into the 21st century. For example, Virginia currently has 15,000 prisoners in the general population, and 2,500 of these have special needs. This sector of the prison's population includes over 800 elderly inmates. By the year 2000, the prison population is expected to total 32,000 with 8,532 exhibiting special needs. Again, it is projected that approximately one-third in the special needs category will be those classified as geriatric. Numerous other states are also faced with similar increases (Aday, 1993).

Chaneles (1987) has estimated that by the year 2000, if present trends continue, the number of long-term prisoners over 50 will be approximately 125,000 with 40,000 to 50,000 over 65 years of age. This projection is based on new admissions and the fact that there are currently 13,937 natural lifers (life without parole), 52,054 lifers (parole possibilities), and 125,996 inmates serving 20 years or more. In addition, another 2,214 prisoners are currently serving time on death row. These groups comprise 22 percent of all inmates in state and Federal prisons (*Corrections Yearbook*, 1992).

Research Rationale

While the number of older prisoners is now manageable in most states, the trend toward an aged inmate population is raising questions that will significantly affect correction programs in the coming decades. Older offenders pose unique and costly problems for corrections departments already struggling to cope with outdated and overcrowded facilities. Many states are faced with an increased number of aging prisoners who are in need of acute or chronic medical care. It is estimated that elderly prisoners suffer from an average of three chronic illnesses (McCarthy, 1983). Many older offenders need corrective aids and prosthetic devices including eyeglasses, dentures, hearing aids, ambulatory equipment, and special shoes (Wilkberg, 1988). Correctional systems are faced with making necessary adjustments to accommodate the special needs of aging inmates. Issues such as providing special diets and round-the-clock nursing care, building new facilities or altering old ones, and restructuring institutional activities are becoming more frequent

 This article reports on a study supported by a faculty research grant from Middle Tennessee State University.

topics of discussion.

Older prisoners differ from younger inmates not only in their need for medical care, but also in their psychosocial needs. Walsh (1989) found that older male inmates expressed a greater need for privacy and for access to preventive health care and legal assistance than younger men. Older inmates are often unable to cope with the fast pace and noise of a regular facility (Anderson & Morton, 1989). Studies have also found that older inmates reported feeling unsafe and vulnerable to attack by younger inmates and expressed a preference for rooming with people their own age (Aday & Webster, 1979; Krajick, 1979; Walsh, 1989; Williams, 1989). Vega and Silverman (1988) also reported that abrasive relations with other inmates were the most disturbing incidents elderly prisoners had to cope with while incarcerated. Fifty-five percent of their respondents indicated that abrasive situations occurred daily. These factors, among others, often result in increasing stress for the older inmate.

The physical condition and structure of the institution also create significant problems for the elderly inmate. Prison systems are primarily designed to house young, active inmates. Older, frail offenders often find the prison environment cold and damp and the stairs and distance to the cafeteria difficult to cope with. Inmates with limited mobility may find many prisons' physical designs too stressful to negotiate, and they simply withdraw into an isolated state.

The purpose of this research is to provide a comprehensive description of the special policies, programs, and facilities for geriatric inmates in United States prisons. Another goal is to determine the most pressing concerns correctional systems face in responding to the special needs of the elderly prisoner. Other research questions focus on developing future programs and policies and identifying research topics useful for correctional officials in responding better to the needs of the aging inmate. Implications for policy and practice are also addressed.

During the first half of 1990, a nationwide survey was conducted soliciting information from the 50 states and the District of Columbia. An open-ended questionnaire and comprehensive prison program checklist was mailed directly to the administrator of health services for each state correctional system. Those corrections officials who failed to respond to the mailed survey were interviewed by telephone. A followup phone inquiry was conducted in June 1992 to allow each correctional unit to report any recent changes in program or facility development. The results reported here are based on a 100 percent response rate.

Survey Results

Policies and Programs

A shortcoming of the studies of older prisoners is the failure of both researchers and correctional officials to agree on what constitutes "elderly." Some authors define "elderly" as 65 years of age and older, some suggest 60 years, while others have reported 55 years, and many use 50 years of age or older. Likewise, states reporting special programs for aging inmates use a variety of ages to indicate special need. However, 50 years of age and older is the most common definition found in this study. Several correctional officials suggested that the typical inmate in his fifties has a physical appearance of at least 10 years older. In addition, the declining health of many inmates contributes to them being "elderly" before their time.

From responses to this survey, it is evident that most states do not have any specific written policies which address aged or infirm inmates. In practice, however, the needs of older inmates are addressed, to the extent possible, in the course of the classification process. Typically, all inmates including the elderly are screened in the admission process. Generally, housing and work assignments are made with regard to the inmate's health, security level, and location of family. In this regard, older inmates who possess numerous chronic health problems are granted special treatment based on their inferior health status.

For example, in the State of Washington, inmates with infirmities related to old age are likely to be transferred to the state penitentiary, where a number of cells in one unit have been designated for use by such inmates. Older inmates who require long-term inpatient care would be considered for transfer to the state reformatory, which has the largest inpatient unit in the system. Those who require special services, other than inpatient care, are transferred to the Special Needs Unit at Washington Correction Center.

A few states such as Texas, Alaska, Mississippi, and South Carolina make some policy decisions based solely on age. In Texas, the inmate is medically classified according to medical history, general health, physical findings, and age. Inmates 50 to 55 years of age receive a classification requiring lighter, slower duties. Inmates 55 and over are provided a classification which restricts the inmate from harder, heavier work and may allow for reduced work hours. Alaska reports occasionally providing a modification in sentencing for disease onset in the elderly. In Mississippi, inmates over 50 years of age are housed in geriatric units if their security classification permits. In South Carolina, inmates may retire from work at age 65. Numerous states also provide physicals annually for inmates over the age of 50, rather than every other

year as they do for the general prison population.

Although most states do not have a policy based strictly on age, they do provide compassionate leave for those inmates who are terminally ill or not capable of physically functioning in the correctional system. Generally, the prognosis is 6 months or less to live, and specific criteria with regard to custody classification and medical requirements must be fulfilled. In some states, nursing home placement is a practical alternative. However, nursing home administrators may not be favorable to the notion of accepting ex-prisoners who have life histories of crime and violence, even if they are quite ill.

When compassionate leave is impossible due to the nature of the crime, correctional policy, or lack of available alternatives, prisons are developing policies and programs to serve better the terminally ill. For example, McCain Correctional Hospital in North Carolina has incorporated the hospice concept into its geriatric/infirm facility. Family members are permitted to spend extended periods of time with the dying inmate, and hospice supervisors work closely with the inmate and his family.

Geriatric Facilities

As table 1 indicates, an increasing number of states do routinely house older inmates apart from the general population and offer them unique programming or services. In specific states (including Alabama, Georgia, Illinois, Kansas, Kentucky, Maryland, Michigan, Minnesota, Mississippi, North Carolina, New Jersey, Ohio, South Carolina, Tennessee, Texas, Virginia, West Virginia, and Wisconsin) elderly inmates are housed in special units often described as "aged/infirm," "medical/geriatric," "disabled," or simply "geriatric." Most of these units frequently mix older inmates with younger disabled ones. Whenever possible, same-aged inmates are grouped together in dormitory style cells. Generally, those states reporting some form of special housing have one or two facilities within their prison systems where older inmates are grouped.

Special considerations are usually given to accommodate safely the handicapped and less physically able. Stairs are minimal, and distances from various facilities in the institution (i.e., canteen, recreation room) are reduced. Educational, vocational, recreational, and rehabilitative programs have been expanded to accommodate the elderly. A few facilities now employ psychologists and counselors with professional training in geriatrics, so there is a greater awareness of the unique social, psychological, and emotional needs of these inmates.

One of the first and more comprehensive facilities to accommodate elderly inmates was developed in South Carolina. In 1970, prison officials began providing special facilities for the elderly. The state, renowned for its harsh sentencing practices, has always had a large number of long-termers growing old behind bars. Due to the need for more space, the state's prison for the elderly moved into a former tuberculosis hospital at State Park in 1983. The majority of minimum custody inmates are housed at the State Park Correctional Center, which has 100 male beds and 11 female beds for handicapped elderly. South Carolina is the only state which reported housing its older female prisoners in a special geriatric facility.

Twenty-four hour medical coverage is available at State Park. Thirteen nurses are on duty around the clock. A doctor is assigned to the facility full-time and writes an average of 925 prescriptions a month. In addition to providing two daily sick calls, pill line, and emergency and routine treatment, the medical staff provides educational programs geared to the needs of the residents. Those inmates on dialysis and chemotherapy are bused daily to a nearby hospital.

Some states are developing "nursing home-like settings" within the prison environment, which provide a greater degree of shelter. For example, Mississippi has a geriatric unit which houses 85 offenders. In 1987, the old hospital was remodeled and specifically designed as a nursing home in a correctional setting. In this type of unit, 24-hour nursing care is provided and sick call is available weekly. A physician checks with the unit daily. In addition to the nursing staff, a psychiatric assistant provides recreational activities, and a case manager is also assigned to the unit.

Special Concerns

Rising medical costs in conjunction with health care mandates are having a tremendous impact on a significant number of states. Thirty percent of the states listed rising costs as the most pressing concern (see table 1). An important issue for 26 percent of the state units is meeting the special needs of older inmates who are "aging in place" with numerous chronic health problems and limited Activities of Daily Living (ADL) functions. As one correctional health official stated, "A significant number of prisoners 50 years and over have a number of chronic illnesses that require long-term care. Another problem is lack of previous dental care requiring the provision of dental prosthesis and long-term dental care." Other problems listed by some states included a lack of community support and appropriate programming for the older inmate, in addition to the victimization of frail, aged inmates.

Planning for the Future

Numerous states indicate that they have future plans to implement special programming and/or facili-

TABLE 1. GERIATRIC FACILITIES, PROBLEMS, PLANS, AND RESEARCH NEEDS

State	Geriatric facilities or special programs for elderly inmates	Most pressing problems in responding to needs of aging/ infirm inmates	Plans to implement programs/ policies or build new facilities	Desired research information
AL	Maintains aged/infirm unit, special programming	Rising medical costs	Ongoing discussion about future needs	Physical/dietary needs
AK	Geriatric inmates with chronic health problems housed separately	Special medical needs	Assessing needs of older inmates	Health problems, increase in older inmates
AZ	New 23-bed facility for chronic/aged	Rising medical costs	None	None
AR	Geriatric inmates with chronic health problems grouped together	Chronic health problems, adequate housing	Long-range plans for skilled nursing unit	None
CA	None	General overcrowding of prison population	None	None
CO	None	None	None	Health costs
CT	None	Chronic health problems	None	Sentencing laws
DE	None	Rising medical costs	Planning stage	Impact of special housing/programs
DC	Geriatric units on limited basis	Expansion of facilities	Special needs office under development	Release policies, sentencing laws
FL	Medical facility and medium/ minimum security	None	Only discussions for programs/special units	None
GA	Housed at men's correctional institution	Space for those with chronic health needs	Conducting research on impact of long-termers	Health care costs
HI	None	Matching facilities and health needs of inmates	Trying to develop community- based program	Impact of elderly on prison population
ID	Two tiers in one unit with no restrictions	Rising medical costs	Special needs/medical unit being planned	None
IL	One 84-bed unit just for older offenders	Space, parole issues, and supervision	Policies currently being implemented	General needs of aged inmates
IN	None	None	None	None
IA	Grouped in some units	Rising medical costs	Conducting research	None
KS	Facility available for infirm/geriatric patients	Prison space, keeping elderly inmates busy	None	Parole policies
KY	Geriatric wing providing special care	Medical costs and adequate space	Converting dormitory to nursing home	Recidivism rates
LA	Two facilities have dorms for the aged	Rising medical costs	Appointed task force to set new policies for aged inmates	Impact of improved health care on longevity
ME	No facility, contracts with nursing home	Need geriatric unit	Discussion stage	None
MD	Special dormitory for aged and infirm	Space, short-term adjustment of new elderly offender	Remodeling facility	None
MA	None	Rising medical costs	Remodeling facility	None
MI	Facility provided for aged inmates	Meeting needs of inmates with limited activity functions	Additional beds recommended, research assessment recently completed	None

MN	Limited housing in one facility	Rising medical costs	Anticipating psychosocial needs	Special needs of aging inmates
MS	Two disabled units, one nursing home	Staff shortages, medical costs	Discussing policies and facility needs	Program needs, family support
MO	Infirm elderly are assigned to regional infirmaries	Increasing number of older inmates, rising medical costs	Remodeling facilities to meet handicap codes	Medical needs, nursing home care
MT	None	Handicapped access rooms, medical costs	Building plan for aged/infirm inmates	Geriatric needs
NE	None	None	None	None
NV	None	Care of aged and physically impaired, adequate housing	Long-range plans to build medical unit with nursing home	Cost effectiveness of screening tests
NH	Inpatient health facility utilized	Rising medical costs, health problems	Long-range objectives under discussion	Incarceration alternatives
NJ	Separate geriatric unit, programming	Prison space, medical costs, parole problems	Proposing secure nursing home facility	Special needs of older inmates
NM	Older inmates are housed in two units	Victimization, rising medical costs	None	None
NY	None	None	None	None
NC	Geriatric hospital, special programming	Meeting complex needs of older inmates	None	Management of chronic health problems
ND	None	Rising medical costs	None	None
OH	Large facility with elevator for infirm	Marked increase in older inmates	Plans to build new facility for aged	None
OK	No unit, contracts with nursing homes	None	Discussions only	Sentencing trends
OR	None	Rising medical costs	None	Release planning
PA	Older inmates with ADL problems placed close to services	Lack of community support, medical costs	Support services for geriatric offenders being considered	Projection of older inmates 55+ by the year 2000
RI	None	None	None	None
SC	Older inmates housed in several facilities with programming	Providing intermediate care, medical costs	Five-year plan to build large unit for special needs and aging inmates	Handling racial conflict
SD	None	Rising medical costs	Space for older inmates	Staff training
TN	Housed at reception center/special needs unit	Rising medical costs	Special needs unit recently opened	Adjustment of older inmates
TX	New geriatric unit recently opened	Medical staffing	Implement programs for older inmates	Crime careers, family relations
UT	None	Medical problems	None	None
VT	None	Inappropriate programs	None	None
VA	Elderly housed in special unit and smaller areas in others	Specialized care and equipment in timely, increasing numbers	New 100-bed unit for aged/infirm recently opened	Handling older inmates, awareness promotion
WA	Small area in one unit held for older/infirm	Providing services, increasing numbers	State-wide study on long-term care needs	None
WV	Protective custody section	Medical costs, staffing, adequate space	New facility with some provisions for aged	None
WI	Long-term care unit and minimum security near hospital	Chronic health problems	Treatment facility with nursing home section	Inmate profile for those over 60
WY	Try to segregate older inmates	Chronic illnesses	Plans for special treatment facility	Family relationships

ties for the geriatric and handicapped prison population. Responses to the survey question ranged from immediate plans to establish new facilities, to ongoing discussions or research, to long-range plans to build or remodel facilities, to no plans whatsoever. For example, Maine, Maryland, Kentucky, and Montana currently have building plans in place or are converting current structures for their elderly and infirm inmates. Other states such as Arkansas, Nevada, New Jersey, Ohio, South Carolina, and Wyoming have long-range plans to build nursing home-like facilities. Delaware, Georgia, Iowa, Michigan, and Washington have recently undergone major feasibility studies to determine better the needs of the ever increasing number of older prisoners. Arizona, Tennessee, Texas, and Virginia have recently opened new geriatric/special needs units. Pennsylvania reported the development of new geriatric services and support systems as well as special training for correctional staff. Finally, Texas is in the process of developing appropriate programming for its new geriatric unit.

Research Needs

As older prisoners become the focus of concern for many prison systems for the next generation, state prison officials do not have adequate research outcomes to help them in solving the problem. Prison officials surveyed in this study stressed that indicators are needed to help identify more clearly "model programs" which are adequately meeting the special needs of the elderly inmate. For example, while this survey discovered a variety of programs and facilities instituted in certain states, a need still exists to provide a systematic program evaluation of these efforts. Important questions remain regarding the effectiveness of such programs in meeting the needs of the aging prisoner. Research, in this case, would emphasize the (1) living environment or custodial care, (2) humanitarian care, and (3) therapeutic care. An evaluation research design would focus on how effectively these programs currently meet the physical, medical, social, and mental needs of the aging prisoner.

Other research information desired by correctional officials includes: (1) What are the general health care needs of this special population? (2) What is the average annual medical cost for aged offenders? (3) What incarceration alternatives are available for frail elderly inmates and what is the post-release success of elderly prisoners? (4) What is the nature of family relationships for those growing old in prison? (5) How will states determine who gets costly health care services and who does not? (6) What projections can be made utilizing data from states with life without parole concerning the size and cost of their older prison populations in the coming decades? (7) What are the typical coping strategies for those who enter prison later in life? Finally, correctional officials also expressed an interest in additional research information concerning sentencing and parole policies for the older offender.

Policy Implications

In many ways, geriatric programming in the prison setting is in a developmental stage. While it is obvious that correctional officials are becoming more sensitive to the special needs of aging inmates, barriers continue to exist which interfere with the ability of states to respond more effectively. For example, most states are faced with the rising costs of medical care and general overcrowding. In the past decade, the war on drugs and tough mandatory sentencing laws have doubled the number of inmates. Overcrowding, AIDS, and other issues have hindered many states from implementing special programming for the aging inmate. Currently, the prison system is demanding 1,100 new beds every week (Roth, 1992).

Although studies have found that older inmates express a preference for being housed with people their own age (Aday, 1984; Krajick, 1979; Walsh, 1989; Williams, 1989), opposing views still exist regarding the arguments favoring special treatment of elderly inmates (Cavan, 1987). Some correctional officials feel no need for or responsibility to provide special consideration to older offenders. Others feel older inmates provide a sense of stability to the general prison population and should not be housed separately. From this perspective, older inmates should be given housing and work assignments based on their health and the type of custody they require. Other considerations in placement should be work skills and family status. Placing an inmate in a special unit for the elderly hundreds of miles away from family could be detrimental to the inmate.

The older offender may also have a difficult time being assigned to facilities providing special needs because slots are limited. In particular, those states converting a small wing for older inmates may have a long waiting list. Also, there is still disagreement regarding the ethical obligation to provide inmates with such acute care as heart by-pass surgery or kidney transplants when others in society may not have access to or the money for the same level of care. Thus, due to lack of space, philosophy, or costs, some elderly inmates may not especially benefit from specialized programming. Of course, health access and care may vary from state to state.

A major problem in meeting the special needs of older inmates is that, in many states, there is still a very small number of aging inmates. For example, in Vermont, North Dakota, South Dakota, Hawaii, and

Maine, where there are few elderly inmates, separate facilities or programs cannot be justified. In states such as these, correctional units have little choice but to mainstream elderly inmates in the general prison system. This is particularly true for aging female inmates, as they typically make up a very small portion of the total female population.

Another barrier in responding fully to the special needs of the aging inmate is the lack of adequately trained prison staff. As one prison official confessed, "I know how to run prisons, not old-age homes" (Malcolm, 1988, p. 6). Moreover, not everyone who works in a correctional environment may have the aptitude or the essential skills needed to manage elderly people. 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. Prison staff needs to be specifically trained to understand more fully 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.

While states are responding by providing special units for older inmates, programming for elderly inmates has not kept pace. Although older inmates may be grouped together in a special needs facility, they often have nothing to do to pass the time. Physical activities popular with younger inmates may not be well-suited to many elderly inmates. Vocational training programs, a primary activity for much of the prison population, serve no purpose for long-term older offenders who are unlikely to return to the workforce. In most prisons, counseling is geared to rehabilitating younger inmates rather than coping with issues such as chronic illness or death. Instead of preparing the inmate for reentry as a productive member of society, wellness programs which aim to keep the individual alert and active are needed. Walking, gardening, woodworking, ceramics, low impact exercises, prison support groups, and other more passive recreational activities can prove successful among older inmates (Aday & Rosefield, 1992).

The diversity of the growing number of older offenders should also be recognized and incorporated into rehabilitative programs. For example, the elderly first offender should be integrated into prison life differently than the repeat offender. The first offender is likely to be more anxious, fearful, depressed, and suicidal than the chronic offender. Aging inmates coming into an institutional setting late in life with the realization that prison may be their final home may experience a tremendous shock to their system. Williams (1989) found that new offenders were more withdrawn and passed their time sleeping, watching television, or performing some other solitary activity. Other inmates imprisoned for long periods of their life may be fearful of returning to the free world.

In other situations, locating family members who may accept an aging inmate as well as provide necessary caregiving tasks may be difficult. Some family members also may be aged and in poor health. The nature of the crime may have created a conflict among family members, resulting in a break in kinship ties. Such inmates may have few or no visits from close friends or relatives on the outside. The lack of a supportive social network may adversely affect the incarcerated elderly, since significant others are key factors that serve to buffer the negative effects of incarceration.

In order to transfer elderly offenders back to the community, housing and financial assistance must usually be secured for inmates who have been imprisoned for long terms and who have lost all contacts in the community. Parole decisions should be handled on a case-by-case basis. Prison staff should maintain good relationships with a variety of social service agencies, such as social security officials and nursing home personnel. Older offenders will need assistance in getting their social security reinstated and in determining if they are eligible for Medicaid. Intervals for parole review of older inmates should be more frequent, especially in cases where terminal illnesses have been diagnosed.

Correctional officials are just beginning to grapple with the large number of elderly prisoners. The increased probability of longer sentences due to the increased use of habitual offender statutes with life without parole and mandatory minimum sentencing will pose unique and costly problems for corrections departments in the future. Additional research is needed to assist correctional officials in their decision-making processes and in the implementation of quality programs and facilities. Prisons, like other social institutions in society, must be prepared for the "graying of America."

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