

AGING IN A CONFINED PLACE:  
AN EXPLORATION OF ELDER INMATE HEALTH AND HEALTHCARE

by

LISA KITCHENS JENNINGS

A DISSERTATION

Submitted in partial fulfillment of the requirements  
for the degree of Doctor of Philosophy  
in the School of Social Work  
in the Graduate School of  
The University of Alabama

TUSCALOOSA, ALABAMA

2009

Copyright Lisa Kitchens Jennings 2009  
ALL RIGHTS RESERVED

## ABSTRACT

This qualitative case study investigates and analyzes the health and healthcare experience of elderly offenders. Four substantive areas which were examined included: 1) To explore how changes in an inmate's personal health and functional status influenced the healthcare process, 2) To explore how family relationship awareness and involvement affected prisoner health and healthcare, 3) To explore the influence of policy on prisoner health and healthcare and, 4) To explore the influence of the larger societal discourse on prisoner health and healthcare. The study was conducted within three theoretical frameworks: standpoint theory, Cantor's (2000) model of social care of the elderly, and the social construction of the aging inmate.

Face-to-face and phone interviews were conducted with sixteen participants. Four of the participants were elder inmates between the ages of 50 and 90 years of age, and had served time in the state of Alabama's only correctional facility designed for the aged and infirm male prisoner. The additional twelve collateral participants were correctional staff, medical personnel, family members, and church and community volunteers.

This research contributes to the literature on elderly offenders, and the understanding of experiencing health changes and healthcare in a correctional institution. The study concludes with several recommendations intended to better prepare prisons, healthcare providers and communities for the growing elderly inmate population.

## DEDICATION

This dissertation is dedicated to my husband Kevin who helped me and guided me through the trials and tribulations of creating this manuscript. Thank you for supporting me and believing in me throughout the lengthy journey of completing this project.

## ACKNOWLEDGMENTS

First and foremost, I would like to acknowledge the men and women who participated in this dissertation. I appreciate your time and willingness to share your personal experiences with me. I was granted a unique opportunity to visit Hamilton A & I - thank you to the Alabama Department of Corrections, Dr. Ronald Cavanaugh, Laura Day, MS, and Warden Butler. I am truly hopeful that the sharing of this knowledge will create an opportunity for change within the prison system for older adults.

I am pleased to have this opportunity to thank the many colleagues, friends, and faculty members who have helped me with this research project. I am most indebted to Lucinda Roff, the chairperson of this dissertation, for sharing her research expertise, support and wisdom during this process. I appreciate your patience and guidance - your mentorship to me has been wonderful. You have always given me sound, straightforward advice, and I am very grateful for this. If I can be half the gerontologist and professor that you have been, then I will certainly have accomplished great things in my life. I would also like to thank all of my committee members, Rebecca Allen, Wesley Church, Shadi Martin, and Debra Nelson-Gardell for their

invaluable input, inspiring questions, and support of both the dissertation and my academic progress. Becky, thank you for helping me coordinate the project! Wes, you kept me challenged with good questions, from the earliest stage of the project through the final defense. Shadi, thank your for your qualitative research support and guidance. Deb, thank you for listening to me for hours on end over the years! I appreciate your advice and ideas. Thank you for helping me become a better teacher; you have really inspired me in so many ways. Because of you, I now also know how to sew and I have run a half-marathon! I would like to thank Chris 'CBu' Bushey, Susan Broughton, and Sandy Wilson for their assistance in keeping me connected with the School of Social Work and in preparing the seemingly hundreds of pages of materials while I was so many miles away.

I want to acknowledge the support and guidance of the faculty and staff at the School of Social Work, University of Texas at Austin. Your willingness to support me and provide me with a 'home away from home' campus allowed me to complete my dissertation in a supportive academic environment. I am indebted to Jim Lubben, Nancy Morrow-Howell, and Ruth Dunkle of the John A. Hartford Gerontological Doctoral Fellows Program for the funding of the dissertation and continued education and support. I would like to thank Cohort VII of the John A. Hartford

Doctoral Fellows Program. I truly enjoyed meeting with you several times during the year at conferences and trainings. I hope that our support and collaboration with each other will continue in the years to come.

I would like to thank my family - Dad, Linda and Gran - who never stopped encouraging me to persist. You all are great examples to me of how to live life to the fullest and have a lifelong love of learning. I am so proud to come from family of social workers and teachers! And, Gran - yes, I 'finally made a 100 on my thesis'. Ally, you grew up while I was working on this and I can now answer your question: I am finally done with school! Finally, last but certainly not least, thank you to Kevin. I cannot tell you how much I have appreciated your love, support and cheerleading through this process! You have always encouraged me, and have helped me stay on track through this long journey. I truly could not have done this without you.

This research would certainly not have been possible without the support of my dear friend, colleague, and fellow graduate student, my 'cohort of one', Joshua Baldwin. I remember when we first discussed returning to graduate school and I can't imagine having gone through this long journey with any other cohort. I have truly appreciated your friendship and

support as a colleague over these past seven years! We managed to grow as professionals, teachers, and scholars, and still have fun. We agreed to embark on this dissertation road together, and with all of its ups and downs, I am so glad we did it. Our 'moment like this' is finally here!

LIST OF TABLES

3.1 Qualitative Participant Refusal Codes ..... 98  
4.1 Prisoner Participant Demographics ..... 117

## CONTENTS

ABSTRACT .....	ii
DEDICATION .....	iv
ACKNOWLEDGEMENTS .....	v
LIST OF TABLES .....	ix
CHAPTER ONE: INTRODUCTION .....	1
<i>Research Aims</i> .....	3
<i>Conceptual Qualitative Definitions</i> .....	6
<i>Evolution of the Study</i> .....	13
<i>Relevance to Social Work</i> .....	17
<i>Policy</i> .....	19
<i>Practice</i> .....	20
<i>Research</i> .....	22
<i>Summary</i> .....	24
CHAPTER TWO: LITERATURE REVIEW .....	26
<i>Conceptual Definitions</i> .....	26
<i>A Theoretical Perspective</i> .....	27
<i>Guiding Theories and Frameworks</i> .....	28
<i>Prison: From the Inside Out</i> .....	32

<i>The Prison as an Institution</i> .....	32
<i>The Prison Environment</i> .....	34
<i>Prison Health Policies and Programming</i> .....	36
<i>Prison Healthcare</i> .....	38
<i>Social Work in the Prison Setting</i> .....	50
<i>Perceptions of Healthcare</i> .....	54
<i>Older Prisoners</i> .....	57
<i>Communities and Volunteers</i> .....	59
<i>Peer Relationships in Prison</i> .....	61
<i>Family Members</i> .....	63
<i>Summary</i> .....	72
CHAPTER THREE: METHODS .....	74
<i>Aim</i> .....	74
<i>Method of Inquiry</i> .....	75
<i>Characteristics of Qualitative Research</i> .....	76
<i>Instrumental Case Study</i> .....	78
<i>Justification of Method</i> .....	80
<i>Case Study Strengths</i> .....	81
<i>Research Setting</i> .....	82
<i>The Alabama Prison System and Demographics</i> .....	82

<i>Researcher's Acclimation to Research Setting</i> .....	87
Data Sources .....	88
<i>Interviews</i> .....	88
<i>Fieldwork and Documentary Materials</i> .....	90
<i>Supplementary Document Review</i> .....	92
Data Collection .....	95
<i>Sampling Strategy</i> .....	95
<i>Maintenance of Collected Data</i> .....	99
Data Analysis .....	100
<i>Qualitative Software in Data Analysis</i> .....	100
<i>The Process</i> .....	101
Methodological Rigor .....	105
<i>Trustworthiness</i> .....	106
Summary .....	112
CHAPTER FOUR: RESULTS .....	114
<i>The Researcher's Philosophy</i> .....	115
<u><i>Part One: Stories from the Inside</i></u> .....	116
<i>Definitions</i> .....	118
<i>Vignette One: Hank's Story</i> .....	119
<i>Vignette Two: Will's Story</i> .....	124

<i>Vignette Three: Hubie's Story</i> .....	130
<i>Vignette Four: Charles' Story</i> .....	135
<i>The Network of Care</i> .....	139
<i>Correctional Facility and Healthcare Setting</i> .....	139
<i>Healthcare Providers</i> .....	142
<i>Social Work</i> .....	147
<i>Correctional Officers</i> .....	147
<i>Community Organizations and Volunteers</i> .....	149
<i>Family Members</i> .....	154
<u><i>Part Two: Weaving Stories into a Common Thread</i></u> .....	158
<i>Changes in Health and Functional Status</i> .....	159
<i>Family and Peer Relationships</i> .....	165
<i>Influence of Policy</i> .....	171
<i>Influence of Larger Discourses (Society)</i> .....	178
<i>Emergent Themes from Cross-Case Analysis</i> .....	183
<i>Demands: Prisoners, Healthcare Providers and Facility</i> .	184
<i>Expectations: Prisoners, Healthcare Providers and Facility</i> .....	185
<i>Barriers to Care</i> .....	188
<i>Making Changes</i> .....	190
<i>Education and Seeking Support</i> .....	193

<i>Conclusions from the Cross-Case Analysis</i> .....	195
<i>Summary</i> .....	195
CHAPTER FIVE: SIGNIFICANCE, DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS .....	196
<i>Significance</i> .....	197
<i>Acknowledging the Standpoint of the Elder Prisoner</i> ....	197
<i>The Elder Prisoner as a Social Construct</i> .....	198
<i>Discussion of Research Aims and Themes</i> .....	200
<i>Demands: Prisoners, Healthcare Providers and Facility</i> .	203
<i>Expectations: Prisoners, Healthcare Providers and Facility</i> .....	204
<i>Barriers to Care</i> .....	206
<i>Making Changes</i> .....	207
<i>Education and Seeking Support</i> .....	208
<i>Implications for Social Work</i> .....	210
<i>Recommendations: Where do we go from here?</i> .....	212
<i>Questions for Future Study</i> .....	212
<i>Evaluation of the Methodology</i> .....	220
<i>The Instrumental Case Study</i> .....	220
<i>Strengths</i> .....	220
<i>Limitations</i> .....	222

<i>Experiential Reflections</i> .....	223
<i>Conclusion</i> .....	224
<i>Summary</i> .....	226
REFERENCES .....	229
<i>Appendix A</i> .....	242
<i>Appendix B</i> .....	245
<i>Appendix C</i> .....	249

## Chapter One: Introduction

### *Overview*

It is critical to understand the importance and meaning of health in the older prisoner's life. The health of this population not only affects the individual, but also the prison system, the family, the institutional caregivers, and the larger community. Aday (2003) notes there are over 150,000 elder prisoners, age 55 and up, in state and federal correctional facilities. In Alabama alone, there has been an increase from 1,925 inmates in 2001 to over 3,167 inmates in 2006. Adults over the age of 50 now represent 11.3% of the total prison population in the state (Aday, 2003). While the older inmate population continues to grow, changes in the prison system funding, resources and support) have not kept pace at the same level. Over one half of these elder prisoners report their health as poor, and there is a prevalence of chronic health concerns in this population, including hypertension, diabetes, arthritis, cancer, heart problems, and sensory losses.

While the world outside the prison system is beginning to adapt to these changes and prepare for this growing segment of the population, prisons are lagging behind in their approach to

healthcare, staffing, and structural needs of the older adult. This burden is ultimately placed back on society at large in the form of increased healthcare costs for families, individuals, and the state prisons as they try to cope with this situation. Older prisoners with multiple medical problems and co-occurring mental health problems may tax an already over-burdened prison system.

As a clinician in gerontological social work, I have seen the influence of the unprepared community, family, and medical systems in working with older adults. Prisons will be facing a crisis situation with the older adult population if these issues are not addressed from the perspectives of policy, practice, and research.

The World Health Organization (1980, 2003) defines health as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Within the broad scope of "health as physical, mental and social well-being," several potential research issues present themselves for examination. The current study will contribute to a holistic understanding of the health of the older male inmate by addressing the 'sub-questions' or intricacies of the topic through the use of the case study method (Stake, 1995).

This research project will highlight the unique setting of a prison facility that accommodates and supports older inmates.

The purpose of this study is to explore the health and healthcare of older male prisoners. More specifically, the purpose is to understand how a small prison in Alabama handles the day-to-day care of elder prisoners with multiple medical conditions from the perspective of all the social actors involved: the prisoners, the correctional staff, the prison healthcare providers, the prisoners' families, and the community members who interact with the prison by way of church volunteerism. Do they view older prisoner health differently? How do they view their roles in the system?

#### *Research Aims*

In this study, I wanted to explore the health and healthcare of the older male prisoner from a social constructionist perspective. I believe this exploration can add to the body of knowledge of this issue in social work policy, practice, and research.

The study was based on four individual cases, each involving a prisoner as the center of the case. Additionally there was an exploration of the 'social network of care', which includes the social actors that encompass the layers of care in the healthcare process: the institutional caregivers (correctional and healthcare staff), families, church personnel, and community volunteers. Together, each case tells the story of the prisoner and his thoughts and perspectives on health and

healthcare, along with the stories of those persons who interact with elder prisoners. This study provides knowledge based on the multiple perspectives of those who receive the care and those who provide it. It is important to make the connections between these perspectives; understanding and change can come from the close examination of multiple truths.

On a larger scale, this study presents a unique opportunity to explore a prison that is specifically designated for older prisoners. There are few of these institutions in the United States, yet the older prisoner population is one of the fastest growing segments of incarcerated adults. Finally, exploration of this topic is an opportunity to fill a knowledge gap in the social work literature related to work with older prisoners.

By interviewing individual prisoners and the people involved in the prison healthcare system, and performing a comparative analysis within and across the cases, I expected to capture what it means to experience healthcare and its delivery as an older male living in a prison. As a professional social worker with many years of experience working with older adults in institutionalized settings, I recognized that this segment of the older healthcare population has received very little attention in terms of research, policy, and practice.

The following research aims were designed to explore prisoner health from several points of view from the personal to

the environmental. The research aims were:

1. To explore how changes in an inmate's personal health and functional status influenced the healthcare process,

2. To explore how family relationship awareness and involvement affected prisoner health and healthcare,

3. To explore the influence of policy on prisoner health and healthcare and

4. To explore the influence of the larger societal discourse on prisoner health and healthcare.

The first research aim reflected upon the elder prisoner's changes in personal health and functional status. Specifically, I wanted to explore issues surrounding access to care as an inmate's level of need (ability and/or disability changed; how healthcare needs were determined and what services and programs (food, exercise, social networks, spiritual support and emotional support) contributed to better health.

The second research aim I wanted to explore was the awareness and experience of the family member of an elder prisoner. Through the interviews I wanted to determine the level of involvement an inmate's family had in the inmate's healthcare process. Additionally, I wanted to inquire about the healthcare decision process and how the family was involved, if at all.

This research aim provided an opportunity for me to examine the influence of policy on the prison healthcare process.

Specifically, I wanted to explore how policy affected the design and implementation of prison healthcare for the elder prison. I wanted to examine how the participants perceived the healthcare policies, and how the policies have evolved in the Alabama prison system.

The final research aim provided an opportunity for me to explore the impact of the larger social discourses or the 'free world' understanding of the elder prisoner and prison healthcare. I specifically wanted to consider the impact of the public perception of this marginalized population in our society.

I used these areas of interest to explore the various systems that affect prisoner health and healthcare. I anticipated that delving into these areas would assist the interviewees in thinking about healthcare in ways they may not have previously considered.

#### *Conceptual Qualitative Definitions*

The following definitions will help clarify for the reader the concepts and qualitative terminology used in this study.

**Axial coding.** "The process of relating categories to their subcategories. The coding process occurs at the axis of a category, linking categories at the level of properties and dimensions" (Strauss & Corbin, 1998, p. 123).

**Audit trail.** \_A systematic, carefully maintained

documentation system employed by the researcher. It includes a statement that describes each step of the process from the inception of the project through the final written product (Schwandt, 2001).

**Bias.** An inclination or personal preference that inhibits impartial judgment.

**Bracketing or (epoché).** The process where the researcher "suspends judgment about the existence of the world and "brackets" or sets aside existential assumptions made in everyday life and in the sciences." It is then possible to "understand how social actors experience their world as real, concrete, factual and objective" (Schwandt, 2007, p. 24). This method is commonly used in qualitative research as a measure of trustworthiness and rigor in the research.

**Case study research.** A strategy for completing social inquiry. Yin (2003) states that case study research is used when the questions are *how* or *why* of a contemporary phenomenon in a social context. A particular type of case study, the *instrumental case study* (see below), can be useful in efforts to further understand a particular issue, concept, or problem (Stake, 1995). "Both Stake and Yin argue that case studies can be used for theoretical elaboration or analytic generalization" (Schwandt, 2007, p. 28).

**Coding.** Coding is essentially a way to categorize data with

tags or labels. It is "the process that disaggregates the data, breaks them down into manageable segments and identifies or names those segments. Coding requires constantly comparing and contrasting various successive segments of the data and subsequently categorizing them" (Schwandt, 2007, p. 32). The coding process is "to review a set of field notes, transcribed or synthesized, and to dissect them meaningfully, while keeping the relations between the parts intact" (Miles & Huberman, 1994, p. 56). Coding can be accomplished either in manual or electronic formats. Strauss & Corbin (1998) describe coding as "the analytic processes through which data are fractured, conceptualized, and integrated to form theory" (p. 3).

**Collective case study.** This is the process by which several cases in a single study are analyzed *collectively* to shed light on a particular issue or problem (Stake, 1995). "The choice of multiple case designs (permitting cross-case analysis) follows what Yin calls a replication rather than a sampling logic. Additional cases are chosen for study because such cases are expected to yield similar findings or contrary, but predictable, findings" (Schwandt, 2007, p. 56).

**Constant comparative method.** This is an analytic method developed by Barney Glaser and Anselm Strauss that generates more thoughts, concepts, and ideas through an inductive process of comparing coded data with data. Data can be compared at the

individual code level, the category level, or the concept/theme level. The analysis develops through each stage of comparison as relationships are formed in the comparison process (Schwandt, 2007; Charmaz, 2006). The process, according to Lincoln and Guba (1985) can lead the researcher to find both descriptive and explanatory categories. It can be used to take common questions and analyze different perspectives on central issues (Patton, 1990).

**Data management.** "An absolutely essential task for a fieldworker is designing a system for organizing, cataloguing, and indexing materials" for retrieval and storage during a project. This process allows for retrieval and use in different tasks (Schwandt, 2007, p. 61).

**Epistemology.** This is the theory of knowing. This is the branch of philosophy that studies the nature of knowledge. The epistemic stances of knowledge are for the purpose of revelation and for the understanding of social construction. Epistemology is the theory of knowledge and the assumptions and beliefs that we have about the nature of knowledge. How do we know the world? What is the relationship between the inquirer and the known?

**Field notes.** These are the notes recorded by the researcher about the people, places, and observations she makes while collecting data in the project (Schwandt, 2007). Notes taken during visits in the field can be coded and analyzed as part of

the project data. This is a running account of what happens while the researcher is in the field. This process should occur throughout the project to assist the researcher in capturing "the whole picture" of what is happening.

**Fieldwork.** Fieldwork is the process of collecting interview and other data in the field.

**Immersion.** This is the amount of dedication a researcher uses in the process of reading, synthesizing, analyzing, and interpreting qualitative materials in a project (Schwandt, 2007). It is the process by which researchers engross themselves in the data they have collected by reading or examining some portion of it in detail.

**Induction.** This is a type of reasoning that starts with individual cases and then extrapolates patterns to form larger conceptual categories (Charmaz, 2006).

**Instrumental case study.** "When case study is *instrumental* to accomplishing something other than understanding this particular person - then the inquiry is an instrumental case study". If we choose several participants, each is instrumental in learning about the effects of a particular subject, but there will be an important coordination between the individual studies (Stake, 1995).

**Memo-writing.** This is the process of writing memos as the researcher is analyzing data. The memos are written as she

develops thoughts and ideas about specific codes or a category in whatever way occurs to the researcher (Glaser, 1998). This process allows the researcher to actively engage with the data from the earliest possible point in the project and helps her increase the possibilities for abstraction of ideas (Charmaz, 2006).

**Objectivity.** Objectivity is “the ability to listen to the words of respondents and to give them a voice independent of that of the researcher” (Strauss & Corbin, 1998, p.35).

**Ontology.** This is the philosophy of existence and the assumptions and beliefs that we hold about the nature of being and existence. “Ontology raises basic questions about the nature of reality and the nature of the human being in the world” (Denzin & Lincoln, 2005, p.184).

**Open coding.** Open coding is “the analytic process through which concepts are identified and their properties and dimensions are discovered in the data” (Strauss & Corbin, 1998, p. 101).

**Peer review.** This is a secondary assessment of a project by a colleague with a similar research background. This process can assist the researcher in answering difficult questions and providing access to an alternative viewpoint.

**Reflexivity.** Reflexivity is the process the researcher undergoes as she examines her research experiences, decisions,

and interpretations. This activity allows the reader a chance to explore the motivations, interests, and suppositions that prejudiced the research. The researcher's reflexive work allows her to acknowledge her presence in the research process and product (Schwandt, 2007; Charmaz, 2006).

**Saturation.** This concept refers to the point in the analysis process at which coding ceases to reveal new insights into the data (Schwandt, 2007).

**Themes.** Themes are patterns in the analysis of data that offer a structure for explanation in qualitative research findings (Schwandt, 2007).

**Transcript.** This is a record of oral communication (audio-tape, digital recording, or video-tape) into a printed format (Schwandt, 2007).

**Transcription.** This is "a written account or text of what a participant or responder said in response to an interviewer's query. Transcription is the act of recording and preparing a text of a respondent's own words" (Schwandt, 2007, p.255).

**Triangulation.** This refers to the application and combination of multiple data sources and/or research methodologies in a research study.

**Trustworthiness.** This is "a term used to refer to establishing validity and reliability of qualitative research; qualitative research is trustworthy when it accurately

represents the experiences of the participants" (Streubert & Carpenter, p.318).

### *Evolution of the Study*

In order to explain my approach to this project, I will explain the life experiences that have brought me to this point. My interest in healthcare and older adults is rooted firmly in my professional social work practice over the past 14 years and my educational career during my doctoral program.

After completing my MSW and initially entering the field as a child welfare worker, I found that I was drawn to work with older adults. My first gerontological social work practice experience was with a small psychiatric outpatient office. I traveled around the state of Alabama to visit older adults and their families to interview them prior to entering nursing homes for the first time. I spent many hours in small rural communities and homes talking with people about their health, their healthcare challenges, and the interactions of the healthcare system with the family.

This experience prepared me for my next clinical job, a long and rewarding career as an inpatient, geriatric-psychiatric social worker in a small rural hospital. It was in this setting that I learned the value of a multi-disciplinary approach to healthcare. Ultimately, all of my work experiences shared common threads: older adults experience healthcare problems and

families are not prepared to cope with these changes; the system can be difficult to navigate; and there may be gaps between what healthcare providers would like to do for patients and what the system is prepared to provide.

When I returned to school to begin work on my PhD, I took a case study research methods class in the College of Education during my first semester. I knew from the first readings in that class that my approach to research would be from a qualitative perspective. In the class we explored the case study method and deconstructed research studies to find out what worked and what did not. Most importantly, we were introduced to the idea that valid, meaningful research can come from the voice of participants in a study. I also became convinced that this mode of research was a perfect fit for social work.

My initial research interests as a doctoral student centered on historical approaches to providing healthcare for older adults in the United States. I explored the poorhouse movement; it was there that I found the prison connection. The poor house often functioned as a part of a community where the poor, the physically and mentally ill, and the non-conformist members would be housed. It was from these early attempts to address the social problems in the United States that social institutions such as the nursing home and prison were designed.

As I continued work on a minor course of study in

qualitative research methods, I took a class with a colleague where we designed a small qualitative project. We took the opportunity to combine our research interests: older adults and incarcerated adults. Under the guidance of a qualitative social work professor, we conducted a small project interviewing older incarcerated men. Our first interview was with an older man who had spent most of his life in and out of jail and prison. His story focused on maintaining the multiple healthcare problems he had developed while incarcerated and his difficulty with receiving proper healthcare and maintaining good health. He talked at length about the good and bad aspects of institutional healthcare, the influence on him and his family, and the long-lasting effects of his health on his life and future.

After my colleague and I first presented our research at a gerontology conference, I knew that this was a topic I wanted to explore in greater depth. I had come full-circle with my gerontological practice experience, my career in healthcare, and my interest in older adults and families.

The topic of older prisoner healthcare is one that is important to address due to the increasing number of older adults in the United States prison system. Prisoners and the status of the prison healthcare system in general are often ignored by society.

Academic disciplines are only now beginning to recognize

elder prisoners as a potential crisis area for the prison system. Elder prisoners have specific healthcare needs that the current system is not equipped to handle. Prison facilities were built for younger, healthier inmates. Prison healthcare staff are not equipped to manage the multiple care needs of men who look less like 'traditional' versions of a 'prisoner' and whose physical and mental health status begins to resemble a nursing home patient. These individuals have numerous care needs requiring require complex levels of assistance that have not been addressed because they have not been described or explored (Aday, 2003).

Whether an older prisoner has committed a felony that demands imprisonment or a prisoner grows old serving his sentence, the physical and mental health of the *person* who committed the crime still undergoes the aging process and develops medical problems. Research indicates that the older prisoner likely has had poor health and little access to healthcare on the outside, only to come into a world where his health problems are likely to be exacerbated (Aday, 2003).

If inquiry into the healthcare of older prisoners seems unimportant to the reader, I only ask that he or she consider the number of older adults in the United States and the accelerating rate at which that segment of our population is growing. The number of incarcerated older adults is growing in a

similar fashion. The multiple costs of caring for older adults, whether they reside inside or outside of the prison system, are shared by all of us.

#### *Relevance to Social Work*

This study is useful to social work practice, policy, and research. Insight into the experience of the older male prisoner and those who are involved in his healthcare can help social workers better understand their work with this population. Specifically, in the state of Alabama, where social workers practice in the prison setting on a limited basis due to funding and to the structure of the system, it can be useful in demonstrating the need for full-time social workers in every prison in the state.

By exploring this issue, social workers can further understand health, healthcare, and the roles of the healthcare providers in this setting. There are also community linkages that can be better understood from a social work perspective. Social workers in this role could provide much needed connection to the "free world" and the services the prisoners and their families may need to contact when they are facing release from a prison term or compassionate release due to healthcare conditions.

Currently in the state of Alabama, social workers do not have a large presence in the correctional system. There are jobs

designated "social work", but those who hold them serve in an evaluative function and travel from facility to facility to review case records. This dissertation can be a call to the profession and to the state corrections system to incorporate social workers in a more active role. There are models in other states where social workers are recognized as a valuable part of the treatment team. They provide counseling and support, and coordinate discharge planning. The Westville facility in Indiana employs five full-time social workers in addition to the nurses, physicians, psychologists and staff psychiatrist (Zigmond, 2007). Additionally, there are two national prison health organizations in which social workers are actively engaged: The National Commission on Correctional HealthCare (NCCH) and the Academy of Correctional Health Professionals (ACHP).

Social work, if it sets out to do nothing else, is concerned with working to serve the oppressed in our society. The National Association of Social Workers (NASW) Code of Ethics states (NASW, 1999):

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

I believe this study has the potential to enhance social

work in three areas: policy, practice, and research. An overview of each area will highlight how this might be accomplished.

*Policy.* Inadequate, indifferent, or incompetent healthcare policies affect not only inmates but their families as well. The system is primarily modeled on men and, because male prisoners far outnumber women, standards of care are designed from this perspective. Nationwide, pain management is inadequate or nonexistent. Prisons sometimes medicate and/or operate on prisoners without informing them of their diagnosis or asking their consent (Fishman, 1999). Correctional policies can unintentionally contribute to adverse health outcomes. Incarceration itself can increase the risk of infection, sexual assault, and improper medical care or contribute to mental health problems. Communicable diseases may be transmitted to family members and others in the community by inmates who are released with untreated conditions and little or no participation in disease prevention programs (Restum, 2000). Financial hardships and burdens on the family and the community increase if an inmate is released with an undiagnosed or untreated disease or mental illness (Fuller, 1993; Fishman, 1991; Harris & Miller, 2003). Prisoners have a higher incidence of health problems connected with mental health, substance abuse, and communicable diseases. It is estimated that 25%-30% of federal and state inmates suffer from a physical condition,

mental health problem, or substance abuse problem (Hammett, Roberts, & Kennedy, 2001). While it may be difficult for the incarcerated adult to receive necessary treatment while in prison, families on the outside may be affected by the prisoner's health and substance abuse problems.

In 1996, the "One Strike and You're Out" law (P.L. 104-120, Sec. 9) was enacted, which allows federal housing authorities to consider drug and alcohol abuse and convictions by people and their family members when making decisions to evict them from or deny access to federally subsidized housing (Danner, 2000). Application of this law leads to additional hardship for the families of prisoners (Danner, 2000).

This study has the potential explore correctional policies and programs that have been instrumental in helping inmates continue to work, receive treatment for healthcare needs, and strengthen their family ties. I will also explore those policies that are potentially detrimental to the inmate-family relationship. My exploration specifically addresses those policies that address communication, visitation, healthcare, and discharge planning in the state prison system.

*Practice.* Social work practice with inmates and families has historically been approached from an ecological perspective (Carlson & Cervera, 1991). This focus takes into account individual, interpersonal, and contextual factors. However, the

use or non-use of social workers within correctional facilities appears to be strongly influenced by budgetary constraints and staffing concerns. Many programs that serve prisoners are community-based and are led by social workers, community mental health staff, and volunteers (Ingram-Fogel, 1993).

This dissertation is an opportunity to explore the issues surrounding incarcerated adults and their families from a practice standpoint. There are a few provisions in place that seek to reunite and strengthen families.

However, there are many more opportunities for creating a space for this kind of work to happen in the prison setting. The strengths perspective in the social sciences closely parallels the rehabilitation model used in corrections. Van Wormer (2003) notes that social workers, with their strengths and ethnic-centered awareness, have a major contribution to make to the field of criminal justice. The strengths perspective, as Kirst-Ashman and Hull (2001) note, assumes that power resides in people, and that we should do our best to promote power by refusing to label clients, avoiding paternalistic treatment, and trusting clients to make appropriate decisions. Social work texts, such as Generalist Social Work Practice: Empowering Approach (Miley, O'Melia and Dubois, 2006), incorporate the principle of strengths into every phase of the helping process. These texts have been a source of information for my exploration

of practice models with incarcerated adults and their families.

Central to the profession of social work is a concern with social justice. The National Association of Social Work's (NASW) position on correctional social work is one that focuses on preventative services, alternatives to incarceration, and an emphasis on prisoner rehabilitation. NASW states that appropriate and adequate services both inside and outside of the prison could reduce recidivism and strengthen families and the society as a whole (NASW Policy Statements, 2003-2006).

The values of contemporary society, however, are at times clearly at odds with the ideals and principles of social work. This dissertation will highlight a practice model within a small prison that has worked to address practice standards and best healthcare practice with incarcerated adults.

*Research.* There has been limited research in the area of incarcerated older adults and the relationships they have with their families. Families of inmates have been referred to as the hidden victims of crime (Carlson & Cervera, 1991). Family members of a convicted criminal describe being labeled as guilty by association and blamed for the mistakes their loved one has made (Sharp, 2005). Research has focused on parents of death row inmates, siblings of inmates, and children of inmates (Smykla, 1987; Dallao, 1997; Howard, 1994; Sharp, 2005).

Family members of inmates are typically poor, and may live

a great distance from the facility where the prisoner is housed. Economic stressors can lead to demoralization. Many families are forced to seek welfare assistance and may have an abrupt change in their lifestyle if an adult in the family is incarcerated (Howard, 1994). Families may have limited capacity to manage the multiple problems that are associated with maintaining supportive relationships with an incarcerated family member.

Families of older prisoners may have long-standing relationship complexities that impede the process of keeping the family connected with the prisoner.

Overall, there is great public demand for the abolition of inmate privileges and supports in the United States (Rodgers, 1990). It is largely unacceptable to non-incarcerated American citizens who fall prey to criminal acts to address the humanity of adults in prison and their extended families. A national "get tough" stance on punishing criminals is not overly interested in rehabilitating inmates, strengthening relationships with families, or developing alternative programs which may reduce recidivism rates. Contrary to public opinion, and in keeping with social work ethics and values, my efforts to understand the health and healthcare of older inmates are centered on "recognizing the central importance of human relationships in an individual's life and challenging social injustice on behalf of oppressed and vulnerable populations" (NASW, 1999).

If the profession does intend to uphold its ethics and values in working with the older prisoner population, then we must bring a voice to the table that demonstrates the challenges and successes of working with older prisoners. This can educate future social workers about the growing need in the practice and research areas, as well as potentially create effective change at a policy level.

This dissertation, conducted in a prison for older male inmates, will potentially provide an alternative view of the prison healthcare model. By using a case study approach and including multiple perspectives, this research can be helpful in bringing voice to the healthcare experience of the older prisoner, institutional caregivers, and family members. This study can assist in highlighting areas of the prison system that can be expanded to address elder prisoner needs more effectively.

#### *Summary*

In this chapter, I introduced the topic of health and healthcare of older male prisoners. I provided a rationale for my study and my choice of qualitative methods to complete this work. I defined the concepts and theories that are used in qualitative inquiry. Further, I explored my professional work history as a clinical social worker and my educational career as a new social work researcher that led me to explore the health

and healthcare experiences of older prisoners. Finally, I discussed the potential significance of this study for key areas of social work: policy, practice, and research.

## Chapter Two: Literature Review

### *Overview*

This chapter reviews the theoretical models relevant to understanding health and healthcare in the prison setting, as well as literature on the topics and concepts significant for this study. A review of the pertinent literature can provide a lens from which to view the case study.

While the review of all literature related to prison healthcare is beyond the scope of this dissertation, in this chapter I review the conceptual definitions, the prison model, and the theoretical perspectives that undergird my research: social construction, standpoint theory, and Cantor's model of social care. Additionally, I review literature that examines the prison from the 'inside': the internal prison environment, prison healthcare, and prison healthcare providers. My attention then turns to the 'outside' as I explore community groups and volunteers, which interface with prisons and families of prisoners.

### *Conceptual Definitions*

For the purpose of this study, a *state inmate* is an individual who is remanded to the custody of a state correctional facility and is the responsibility of the state

government. There are four types of state prisons in Alabama: minimum, medium, and maximum security, and work release/community corrections facilities (State of Alabama, Alabama Department of Corrections [ADOC], 2007).

An *elderly inmate* is any person who is serving time in the prison system and who is 50 years of age and older. Researchers continue to debate exactly how to define an elderly inmate, however, most studies (Aday, 2003; Koenig, et. al, 1995; Wallace, Loeffelholz & Sales, 1992) have used chronological age (50 years and older) to make this determination. Aday (1994, 2003) explains that researchers and correctional professionals have noted offenders in their 50s often display the physical appearance of a person who is ten years older than their stated age. Additionally, declining health in a high stress environment may result in prisoners' becoming aged and infirm before their time.

#### *A Theoretical Perspective*

In this section I will provide the theoretical context in which my study is situated. Then I will provide an overview of the salient points of the theory and how it relates to the older prisoner population. This is followed by a summary of Cantor's model of social care (Cantor, 1989, 2000).

### *Guiding Theories and Frameworks*

The framework guiding this dissertation is composed of three integral parts. First, I use an overall social constructionist approach; next, standpoint theory as a method for analyzing the inter-subjective discourses; and finally, Cantor's model of social care to explore connections in the social relationships related to health and healthcare.

*Social construction.* The social constructionist framework posits segments of society as positively or negatively constructed according to changes in culture, society, and the fluid nature of relationships of the various actors. Hogan (1997) noted that marginalized groups in society, older inmates for example, are negatively constructed as deviants and therefore are seen as less deserving of care and benefits. Hogan's descriptive case study of HIV/AIDS policy development in the prison system found that the social construction of the inmate was comprised of the following: restrictive health policies; funding concerns and budget constraints; questions about equity of care; questions about the security of the inmate, staff, and the larger community; and finally, the powerful political forces and leaders in society who will not tolerate criminally deviant groups. She further asserts the significant role power plays in the social construction of prisoners. Power-dominant groups use political agendas to

advance their own needs. In turn, this creates increased burdens for negatively constructed, powerless groups.

Social constructions of people are constantly in a state of change, however. Cultural images and perceptions evolve over time and interact with emerging social constructions. One method of changing the social construction of the older inmate is to place inmates' interests at the center of plans to design facilities and create healthcare programming and policies (Aiken & Mushenko, 1995, 2004). Closing the gap between marginalized groups' needs and those of the larger population is one potential result of a change in the social construction of the older inmate.

*Standpoint theory.* According to this approach, a standpoint is a place from which human beings view the world. It influences how the people adopting it socially construct the world. This theory posits that social group membership affects an individual's standpoint. Inequalities between different social groups create differences in standpoints (Harding, 2004).

Standpoint theory supports what Harding (1995) calls *strong objectivity*, or the notion that the perspectives of marginalized individuals help to create more objective accounts of the world. Noting these structural relations informed by hierarchy, Harding examines the role of marginality in making theory. She argues, "The problem is that we've had subjective accounts...or

ethnocentric accounts... So, strong objectivity is an issue, to put it in an extremely simplistic way, of learning to see ourselves as others see us... It's an argument for stepping outside of the conceptual framework, starting off research projects, starting off our thought about any particular phenomenon, from outside the dominant conceptual framework" (p. 347). Perspectives of traditionally marginalized groups provide opportunities for good critical inquiry into the values and epistemologies of hegemonic theory and practice.

Standpoint epistemology asks questions specifically related to the oppressed group in order to understand how aspects of the larger community are linked to (in this case) the older inmate. How are correctional policies, prison programs, community social service programs, healthcare policies, healthcare programs, and interaction with families and others affecting the older male inmate? Critical criminology, where crime is defined in terms of the concept of oppression, does not propose a single, unitary identity on which all research should be based. Rather, research should acknowledge its *standpoint*, and that standpoint should be on the side of the oppressed in the situation in question. This theory suggests that any power relationship (class, ethnicity, etc.) can give standpoint advantage to the oppressed. For this study, the oppressed group consists of older inmates; I have sought to convey and represent

the standpoint of these members of our society. This theoretical framework reflects the ethics and values explicit in social work practice and research: a commitment to social justice and to the protection of human rights.

*Cantor's model of a social system of care.* Cantor's theoretical framework demonstrates the linkages between formal and informal care of older adults (Cantor, 1989). In this model, the social system within which all older adults operate is part of a dynamic network of concentric circles, with the older adult located in the center. The circles represent a range of informal and formal sources of care. Informal sources of care (family, friends) are located in the innermost circle, while a second level includes friends and neighbors. The third level is the 'bridge' between informal and formal care (e.g., clergy, support personnel, maintenance workers) that provide support via their professional duties. The fourth level is formal care provided from medical and mental health professionals in institutions and the community. The final circle represents governmental agencies in policy and decision-making capacities that affect older adults. This macro-level model emphasizes the relationships and patterns of seeking care (Cantor, 2000; Shippy & Karpiak, 2005).

Cantor's framework suggests that the overlap and fluid nature of the circles are affected by economic and social trends. The health of the older adult is affected by and affects

the circular system as well. This framework demonstrates the critical value of informal care to an older adult's life. The circular model emphasizes the value and contribution of each component of social care in the larger paradigm; the holistic nature of care is shown as interrelation (Shippy & Karpiak, 2005). Cantor's model has a system-wide focus with formal and informal components, and the interactions between the elder person and the formal and informal components (Cantor & Brennan, 2000). The major questions this model asks are threefold: 1) Who is responsible for the care of the elderly?; 2) What is the role of the formal and informal components?; and 3) To what extent do formal and informal providers interact and complement each other in the provision of social care to the elderly? (Cantor, 1980, 1991).

#### *Prison: From the Inside Out*

##### *The Prison as an Institution*

Goffman's (1961) work, *The Total Institution*, characterizes an institution as a place of residence and where large numbers of individuals are cut off from "free" society for periods of time; these groups of people lead an enclosed, conventional, and highly regulated way of life. Goffman (1961) outlines five types of total institutions. The five types include: 1) Institutions that are designed to care for persons who are thought to be incapable and harmless (nursing home, orphanages);

2) Institutions that are designed to care for persons who are thought to be incapable of looking after themselves, but are also an (unintended) threat to the community (mental hospital);

3) Institutions that are designed to protect the community against persons who are felt to be intentional dangers (jails, prisons). In this type of institution, the welfare of the persons sequestered there is not an immediate issue;

4) Institutions that are designed to better pursue some work-like task, justifying themselves on purely instrumental grounds (boarding school, work camp);

5) Institutions that are designed as retreats from the world, often serving as training stations for the religious (monastery, convent).

The third type, as mentioned above, is organized to serve and protect communities, and it is here that he discusses prisons as a part of society. Prisoners are required to wear designated uniforms, follow precise schedules, and reside in an enclosed space surrounded by guards and an environmental structure that prevents them from escaping. Visits and interactions with people living in the community or 'free world' are regulated and limited. Daily activities in the total institution are highly regulated.

Goffman notes that a characteristic of institutions is symbolized by the barrier to communication with the outside world and the loss of the right to leave the institution at

will, often by physical enforcement (guards, gates, locked facilities, high walls, etc.). Rules and regulations are designed and implemented to address the goals of the institutions and are enforced by a hierarchy of official personnel.

Prisoners' perceptions of aging in prison may differ depending on whether they are incarcerated in a minimum, medium, or maximum-security prison. A 1972 study by Gillespie and Gallaher, found that elderly inmates felt bitter and resentful towards prison life because it made them age more quickly. The authors posit that offenders in their 60s and 70s felt that prison did not preserve their health and caused them to deteriorate both physically and mentally. Inmates in the study suggested that the anxiety from being incarcerated with 'trouble-maker' inmates led to an acceleration of the aging process.

#### *The Prison Environment*

The physical facility of the prison is often designed for the young adult prisoner, with the notion that young offenders will serve time, learn a trade, and then be sent back to society. Sentencing changes, however, have led to larger numbers of inmates who will never see the outside of the facility.

Because correctional facilities are generally designed for

the younger inmate population, management practices as well as the physical environment of the average institution often do not reflect the needs of the aging inmate. One way the system has tried to manage the aging population is through their segregation. Staff and inmates support a specialized unit or separate facility which can provide a level of protection and mobility for the older prisoner.

Older offenders have a difficult time in prison, due not only to the aging process, but also to their existence in a harsh environment. Researchers have noted that the physical structure of the prison creates significant problems for the older inmate (Aday, 2003; Moore, 1989; Rosenfield, 1993). Aday (2003) reports that aged offenders find prisons too cold and damp, and that many problems result from long walking distances to the various parts of the prison. Inmates with limited mobility may withdraw from daily activities due to the stress of the daily living environment.

An older inmate arriving at a prison for the first time may have increased problems with stress and anxiety. Vega & Silverman (1988) note that the abnormal nature of the prison environment is symbolized by regimentation, depersonalization, confinement, and sexual deprivation. Williams (1989) noted that new, elderly offenders withdraw from the general population and spend most of their time in solitary activities such as sleeping

and watching television. Researchers in prison have witnessed or experienced violence (Aday, 2003; Vega & Silverman, 1988). First time offenders are more likely than repeat offenders to experience increased anxiety, fearfulness, depression, and thoughts of suicide. Aday (2003) argues that due to these circumstances, the first time elder offender should be integrated into the prison separately from repeat offenders.

Another point of view, however, states that while segregation might have positive effects, it could be seen as a form of age discrimination (Fattah & Sacco, 1989). Inmates who are removed from the mainstream population may feel an increased sense of loss and inadequacy and may become institutionally dependent. Aday (2003) points to research that shows how the influence of the older inmate in the general population can have a stabilizing effect for both younger inmates and correctional staff.

#### *Prison Health Policies and Programming*

Few studies have examined policies and programming related to prisoner health. Aday's (1994) national survey of prison health administrators indicated that services for older adults were available in most correctional settings, but only three states (Alabama, New Jersey, and North Carolina) had specific programming for older adults. Additionally, the study found that although most prisons reported screening for special needs

during the inmate intake process, most states had no specific policies to address older inmates' needs.

Prison programming historically has been approached in the same manner as the design of the facilities, with an emphasis on the younger inmate. Aday's research (1994, 2003) highlights a gap in correctional policy. Most facilities do not have an efficient plan for those inmates who will be serving long-term sentences. The 'get tough on crime' stance in the public will continue to have an impact on the increasing numbers of inmates in American prisons. Programming and policy development should reflect the needs of the long-term inmate. A few institutions do have geropsychologists and other specialized staff trained in geriatric health. Overall, Aday supports the notion that the prison environment should adapt to meet the needs of the aging population. Coordination of services provided by the correctional staff and community, together with well-defined policies, can minimize the problems the older inmate may face in a long-term setting.

Kratcoski and Babb (1990) reported that the older inmate cohort would participate in specialized programming and services if they were offered to them. This study also noted the need for programs designed specifically for the first time older offender. Possible programming could include regular, productive activities to alleviate boredom and provide social

stimulation. Older inmates could benefit from a mandatory exercise program and the monitoring of dietary restrictions.

Several studies acknowledge the need for specialized training for corrections personnel related to the elder prisoner (Aday, 2003; Kratcoski & Babb, 1990; Marquart, et.al. 2000; Reviere & Young, 2004). Training models suggested included sensitivity training for corrections officers and staff and the addition of a dedicated healthcare professional trained in gerontological issues. A suggested model for training was to observe 'free world' assisted-living facilities and nursing homes to understand how age-specific techniques were utilized in an effective manner.

#### *Prison Healthcare*

Discussion of prison health and healthcare in the United States is a relatively new topic. Before the 1970s, prison wardens directed healthcare in state and local correctional facilities. There were no standards of care and no consistent monitoring of the care process.

In 1972, the American Medical Association (AMA) surveyed medical services in prisons and jails in the United States. Both the AMA and the American Public Health Association detailed numerous inadequacies in a report that led to the creation of medical care standards (American Medical Association, 1973). By 1975, the Association of Correctional Health Services (ACHS) was

formed to create a manual of a healthcare delivery system for correctional institutions.

In 1976, the United States Supreme Court ruled "that deliberate indifference to the serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain...whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with treatment once prescribed" (American Public Health Association [APHA], 2003, p. xvii). Subsequently, three basic healthcare rights for prisoners were established: 1) the right of access to care, 2) the right to care that is ordered or prescribed, and 3) the right to a professional medical judgment (Poster, 1992).

Currently, there are multiple national groups addressing the issues and needs of the correctional healthcare system: the American Correctional Health Services Association (ACHS), the National Commission on Correctional Healthcare (NCCHC), and the American Correctional Association (ACA). The ACHS describes its mission as "to serve as an effective forum for current issues and needs confronting correctional healthcare" (ACHS, 2006).

The NCCHC describes its mission as one that aims "to improve the quality of healthcare in jails, prisons and juvenile confinement facilities" ([NCCHC](#), 1996). The NCCHC created *The*

*Standards for Health Services in Prison*, which suggests methods to ensure quality medical treatment, standardization of medical records, and administrative consistency, and addresses medical-legal issues for correctional facilities. The ACA first created "*The Standards for Adult Correctional Institutions*," in 1990 to serve as a framework for internal review and quality assurance (Faiver, 1998).

It is important to note here that healthcare services, standards, and models for the general public are quite different than those for the prison population. Researchers suggest that correctional healthcare organizations might join 'outside' healthcare organizations in developing quality assessment programs and tools to minimize medical errors and increase patient satisfaction (Stone, Kaiser, and Mantese, 2006).

The prison system faces a unique dilemma in providing healthcare: how does the system balance the healthcare needs of inmates with the mandate to maintain order and security in the facility? Additionally, prisons may have inadequate budgets to address medical needs of their specific populations. As a result, McDonald (1995) notes, the larger community (hospitals, physicians, and contract services) provide many of the prison healthcare services.

*Cost of prison healthcare.* One of the most critical issues in corrections today is healthcare and the associated

expenditures (Aday, 2003). Several factors have influenced the rise in healthcare costs for prisons: the increasing numbers of inmates, inmates coming into the system with serious medical needs, pressure from the court system to improve medical conditions, a higher incidence of infectious diseases in incarcerated populations, and the graying of the prison population (McDonald, 1995; NIC, 1997). Between 1995 and 2003, the number of inmates nationwide aged 55 and older rose from 32,600 to 60,300, an increase of 85 % (Caverley, 2006).

Research has demonstrated that medical needs for the aging prisoner are numerous and costly. The older prisoner will likely have multiple, chronic medical conditions, and many will require daily nursing care and medications. Aday(2003) reported older prisoners consume the majority of the healthcare services in corrections. They have significantly higher medical costs and treatment needs due to higher incidences of hypertension, high cholesterol, diabetes, emphysema, various forms of dementia, and other chronic conditions (Fazel, Hope, O'Donnell, & Jacoby, 2004). The estimated cost of housing and caring for a prisoner for a life sentence is more than \$1 million (Aday, 2003). Baker (2001) reported that men, in general, display poorer health and are less likely to engage in positive self-care activities. In turn, these factors lead to increased personal and societal costs and increased healthcare costs for the correctional

system.

In Alabama specifically, the ADOC noted several factors that have driven correctional healthcare costs: 1) increasing numbers of inmates; 2) increase in severity of illness and degenerative diseases in the inmate population; 3) lack of 'free world' healthcare coverage; 4) increased use of technological services; 5) federal mandates to provide improved levels of medical care to prisoners; and 6) the physical facility limitations of the institutional healthcare units that require dependence upon costly 'free world' medical providers. From 2002 to 2007, inmate health expenses in Alabama rose from \$44.1 million to \$82 million annually and constituted 22% of the total corrections expenditures for FY2007 (ADOC Annual Report, 2007).

Discussion of prison healthcare expenditures is one that sparks heated debate. There are arguments about the allocation of resources and funds that should be available for inmate care. Prisons serve a primary function of 'punishment' in the United States, and administrators must provide healthcare that is legally mandated but that does not appear to the general public as exceptional (Aday, 2003). A comment by Texas State Representative Ray Allen, R-Grand Prairie, chairman of the House Corrections Committee, further illustrates the public debate about this issue: "The Supreme Court has already dealt with physical healthcare issues, and we're now living under law that

says inmates have a constitutional right to adequate healthcare treatment, that is not enjoyed by people on the street who are in many cases (members of the) taxpaying public. My mother-in-law has less availability and access to healthcare than inmates in the prison system" (Lomax, 2004).

Understanding how prison health services are paid for can be a complex issue. In the state of Alabama, for example, the majority of the Alabama Department of Corrections annual operating budget is determined by appropriated funds by the state legislature. In FY2007, 90% of the operating budget for ADOC was allocated from the state's general fund. The remaining 6.5% of the budget was generated from operations of the ADOC and fees from the work release program. The corrections budget was 2.6% of the state's overall budget for fiscal year 2007 (FY2007). Alabama ranked 49<sup>th</sup> in the United States in percentage of state budget spent on corrections according to the Pew Trust report (Pew Center on the States, 2008). The state spent just \$39.46 per inmate, per day.

In contrast, the national average of all state general fund spending was 6.8% or \$44 million spent on corrections. According to the most recent special report on corrections expenditures, the average cost per day to house a state inmate was \$62.05 per day. Among facilities operated by the Federal Bureau of Prisons, the cost was \$62.01 per inmate per day (Stephens, J., 2004).

Older adults in the 'free world' may be entitled to Social Security Disability (SSD), Supplemental Security Income (SSI), and Medicare and/or Medicaid benefits. A prison inmate is not eligible to receive any of these services. Social Security guidelines clearly state social security benefits cannot be paid to a person convicted of a crime that causes a sentence of over one year, regardless of actual time spent in prison (Federal Bureau of Prisons, 2002). There is no provision for back pay for time spent in prison. Further, for those inmates who are preparing for release, the process of re-establishing benefits or obtaining benefits for the first time can be a very lengthy process. The BOP notes that an inmate can file for SSI and/or SSD three months prior to release if they have a documented work history. At the federal level, each individual institution must have a pre-arranged agreement with the Social Security Administration that permits inmates to file prior to release. States vary widely in correctional facility discharge planning, public assistance payments, and level of welfare benefits. The process to access needed services after an inmate leaves the prison system can vary substantially.

*Medical services in prison.* Medical services available in prison facilities vary according to state. Zigmond (2007) explored the onsite medical services in the Indiana prison system. The state implemented electronic medical records

throughout the system. In the Westville facility, the prison included an urgent-care clinic and three dental clinics. The director noted, "There is no service, modality or medication available to the public that isn't available here" (p.2). The author further noted that each prison in the state has a healthcare administrator, physicians, nurses (RN and LPN), nurse practitioners, social workers, psychologists, and full-time psychiatrists.

The state of Texas, however, has had different experience in its ability to provide medical services. The medical director of the Texas Department of Criminal Justice (TDCJ) noted in 2004 that "major salary issues" and the inability to provide 'free world' incentives made it hard to offer competitive salaries to potential healthcare providers (Lomax, 2004). Additionally, the medical care provider shortage nationwide, Lomax noted, extended from the 'free world' into the correctional healthcare system. Both Texas Tech University and the University of Texas at Galveston provided medical care services to the prison system in their respective parts of the state. From a budgeting standpoint, the university system is not able to offer bonuses and incentives 'free world' competitors are able to provide. Another problem is the Texas State legislature's promise to the university system to allow them to keep the surplus income generated from taking over prisoner care. Any generated funds

have returned to the general state revenue (Lomax, 2004).

*Hospice care in prison.* Craig and Ratcliff (2005) found the hospice model was successfully implemented in prisons across the U. S. Programs generally used the following practices: volunteers (community and inmate), family involvement, interdisciplinary teams, individualized care plans, pain management, and bereavement services. The environment of the hospice units were designed or adapted to provide a comfortable space for the inmate.

One of the primary concerns prison hospice staff noted was the limited or non-existent use of medical parole and compassionate release for terminally ill inmates. Although most states have this option, it is not used to the full extent to benefit dying inmates and their families. On the other hand, it can be difficult to find outside placement for inmates, and the cost of caring for a terminally ill patient can be cost prohibitive to families (Cohn, 1999).

An in-depth review of a Florida hospice program in the Broward County Jail system suggests an effective way to address hospice care in the correctional setting (Bauersmith & Gent, 2002). Prison Health Services (PHS) oversees the hospice program. Services are provided by a local accredited hospice organization in conjunction with PHS staff, social workers, medical personnel, and volunteers. Intensive training is

provided for the correctional staff, medical personnel, and volunteers. Training includes the hospice philosophy and the plan of care. The program provides thorough evaluations, interdisciplinary team meetings, counseling for inmates and family members, spiritual support, and comprehensive care plans. Although incarcerated persons are not eligible for Medicare or Medicaid, jail social workers work closely with outside agencies to establish these benefits or reestablish them as quickly as possible.

*Prison healthcare providers.* Healthcare providers in the prison setting consist of nurses, physicians, psychologists, dentists, optometrists, and in some settings, social workers. The nursing staff provide the majority of care services on a daily basis in the correctional setting.

Providing healthcare in prison has a unique set of challenges that are not present in the 'free world.' Zigmond (2007) noted the "heightened sense of concern" among health care providers working with prisoners and found that, in the prison setting, the primary concern is custody of the inmate. Any healthcare interaction in the prison setting requires that a security officer be present. Additionally, the required paperwork in prison healthcare can be quite extensive. Healthcare employees required education about the standards set by the American Correctional Association (ACA) and the National

Commission on Correctional Health Care (NCCHC). One administrator noted staff must "be able to strike a balance between what is medically necessary and what is medically convenient" (NCCHC, 1996, p.3.) Healthcare provision in prison is complicated by the fact that efficient and effective healthcare does not necessarily equal efficient and effective incarceration. Efficient and effective healthcare provision includes multiple treatment options, specialized services, full-time healthcare providers and timely follow up care for patients. Efficient and effective incarceration limits these services and options.

*Nursing care in prison.* Registered nurses (RNs) are the largest group of healthcare professionals in the United States (National Quality Forum, 2006). In 2002, healthcare organizations employed over two million nurses. In the prison setting, the key members of the healthcare team are the nurses. They may be RNs or licensed practical nurses (LPNs) and may have additional board certifications. Nurses have the responsibility of providing 24-hour care to the prisoner, as opposed to single-visit care by a physician or contract service provider (Norman & Parrish, 2002). Nurses provide the direction and coordination of all health services and work with other team members to ensure that care is provided consistently and appropriately. The nurse is the link to the 'outside' service providers, such as

dental and eye care providers, which interface with the prison.

*Contract medical service providers.* As mentioned above, the physical limitations of correctional institutions often create difficulties in providing needed medical services. Most facilities do not have healthcare units that allow for onsite long-term or advanced-care services. Use of 'free world' providers to provide specialized dental, medical, and surgical care is costly. Added expenses accrue due to transportation and security coverage that is required for each trip outside the prison.

Zigmond (2007) explored the issue of how states attempt to provide high quality, affordable healthcare services to prison inmates. Practice varies widely from state to state. Some states outsource for prison healthcare services with large public or private health management organizations. Others have multiple contracts with primary care and specialty care providers. Additional options are partnerships with academic institutions or some combination of all the above. Arizona has 10 prison complexes, and all healthcare providers are state employees. The state of Texas partners with two universities, Texas Tech and divisions of the University of Texas, to provide inmate healthcare.

Three of the larger private-sector healthcare providers are Correctional Medical Services based in St. Louis, Missouri;

Prison Health Services based in Brentwood, Tennessee; and Wexford Health Services based in Pittsburgh, Pennsylvania. Outsourcing healthcare services, according to one provider, allows state correctional facilities to focus on their primary responsibility of "custody, security, and control of inmates" (Zigmond, 2007, p.53). Other possible benefits of private sector contracts include the ability to recruit better-qualified staff and more efficient management of healthcare resources. Care is also outsourced to reduce the legal liability against states in an increasingly litigious medical care environment (Zigmond, 2007).

#### *Social Work in the Prison Setting*

Severson (1994) found that fragmented community mental health care following the dismantling of psychiatric hospitals in the 1960s and 1970's led to the shift of a large percentage of the mentally ill population to the prison system. The author found that a majority of the clinical and support positions in jails and prisons are held by social workers. These professionals are often the only voice advocating for inmate rights and fair treatment. He further notes that there are differences in the types of services social workers are able to provide in the jail and prison settings. Jails are generally time-limited placements. The social worker can identify mental illness and emotional and family problems, and also provide

crisis intervention services and discharge planning. In prisons, social workers can provide a wider range of services. Social work can include setting goals with inmates that are consistent with treatment needs and institutional guidelines. In either situation, social workers must have an adequate understanding of the demands of the correctional system and how to find ways to practice according to social work values. Social workers must demonstrate a strong commitment to advocacy for both the inmate and the institution.

Coutourier (1995) reviewed successful social service programs for inmates and families in Pennsylvania and found there are many factors that made family service programs successful. Inmates are trained to work as volunteers in family visitation programs, structured recreational activities, and an incarcerated father's support group. There has been successful coordination with outside services for transportation, counseling, and other supports. Use of internal and external support (volunteers, inmate volunteers, student interns) can provide free labor and expertise. Family support services can foster a positive social climate and reduce recidivism by nurturing the family relationship.

Showalter and Jones (1980), who studied counseling programs for inmates preparing for parole, found that families and inmates were very responsive to therapy. Correctional staff

noted that concern for maintaining family relationships can overcome lack of motivation. Motivation for increased opportunities for visits with families was high. Inmates were generally eager to participate in programs that allow more family interaction. Social workers as therapists are keenly aware of a person in his environment and the impact of other relationships. The inmate's family can be utilized as a tool to help him realize the need for behavioral changes.

Carlson and Cervera (1991) suggested several areas where social workers could effectively influence the incarceration process for inmates and families. Use of an ecological perspective allows the social worker to work with the family and consider the personal, interpersonal, and contextual factors related to the prison experience. Social workers assist correctional staff in understanding the strengths and liabilities of the extended family. Finally, social workers minimize negative aspects of imprisonment and offer inmates and spouses positive ways to build social support networks as they work through the experience of incarceration.

The Federal prison system actively employs social workers in its thirteen facilities across the United States. The Federal Bureau of Prisons (BOP) views social workers as "necessary in the consultant role as part of the pre-release program staff...they provide discharge planning and assist with an

inmate's transition to the community" (Federal Bureau of Prisons, 2002). This statement acknowledges that most inmates, whether federal or state, are released to the community after either serving their sentence or receiving early release for a health-related issue. Clearly established functions of the social worker are provided by the BOP:

- The social worker will ensure proper community support is in place before an inmate is released.
- The social worker will promote healthy social interactions between the inmate, family, and the community.
- The social worker will assure human service organizations are responsive to provide for an inmate's needs.
- The social worker will advocate and mediate on behalf of his/her clients.

Programs designed to serve inmates and families can be controversial. Correctional professionals may not want to see families more than at the standard visiting hours. The general public has expressed concern about inmates' living too comfortably and is wary of spending money on programs and services. Practitioners and researchers continue to identify a

need for enhanced inmate and family services in the prison system.

#### *Perceptions of Healthcare*

Several studies addressed prisoners' concerns about the prison healthcare system (Aday, 2003; Gallagher, 1990; Roth, 1992). Overall, prisoners stated that their healthcare needs were not met. Roth's (1992) study noted that over 5000 prisoners over age 55 (43 %) in medium- and maximum-security facilities stated that their health was worse at the time of the study than it was when they entered the prison system. In the same study, however, Roth found 59% of participants claimed their health was excellent and related this to participation in daily activities (educational and religious). The most recent study of the dimensions of religiousness, spirituality and mental health among older inmates (Allen, Phillips, Roff, Cavanaugh & Day, 2008) also reported increased daily spiritual experiences was associated with decreased depression and less desire for an inmate to have a hastened death.

Kratcoski and Babb's (1990) study of the adjustment of older inmates found that medical professionals in corrections noted improvement in an inmate's healthcare status due to changes in eating and exercise. Perceptions of healthcare from the point of view of the inmate and the medical professional tend to be different. Three studies found older prison health

decreased during incarceration (Koenig, Johnson, Bellard, Decker, and Fenlon, 1995; Marquart, et. al. 2000; Cosher, et. al., 1992). Two of the studies included inmate self-report measures and physician report measures.

Aday's (1994) study found that several inmates feared the point in their lives when they could no longer care for themselves and had to depend on providers for care. Inmates expressed increased anxiety about this level of personal dependency. Others noted a fear of dying in prison. Several elderly offenders stated that dying in prison would have a negative influence on family, with comments such as "I would like to die a free man. That's why I won't go up for parole. I want to be a free man when I go out of here" (p.87). Inmates expressed concern about how the dead were treated in the prison setting. One respondent noted, "I've seen a few die here and I wouldn't want to...This idea of handcuffing the corpse when they take them out of here is not for me" (p.87). He discussed that even though the inmate had died, his body was still treated as if he was a living prison inmate, subject to the incarceration policies of the facility.

In a study conducted in a southern jail, Gallagher (1990) found that on average, older inmates visited the prison health center more than eight times per month. Fifty-six percent of those who visited the prison healthcare provider rated their

services as good or excellent, compared to 32% of younger inmates. When there were specific complaints, the most common ones prisoners noted were their inability to receive high quality healthcare at night, problems with access to care, limited chances to see a dentist or optometrist, problems with medical staff 'attitudes' towards prisoners, and being viewed as 'drug-seeking.' Inmates were additionally asked how the system might be improved. Common suggestions were improved health screening tools, improved communication, better medical staffing procedures, and access to counseling services.

Loeb and Steffensmeirer's (2006) pilot study of relationships between health status, self-efficacy beliefs, and health-promoting behaviors found inmates with greater self-confidence in their health self-management ability were more likely to report better health and health strategies. Because 85% of older inmates have two or more major illnesses, this is an important finding related to personal health behaviors. The authors support the need to develop educational interaction opportunities for older prisoners to increase health knowledge and change health behaviors. Proper planning during incarceration, the authors noted, is one way in which the healthcare providers can take steps to improve older inmate health and increase the chance for continuity of care (Kratcoski & Babb, 1990).

## *Older Prisoners*

The elder inmate population is projected to persist due to several factors: the 'three strikes' laws, mandatory minimum sentencing guidelines, and increased numbers of older adults committing serious crimes (Marque, Merianos, & Doucet, 2000). Fazel (2001) noted the decrease in numbers of inmates being paroled and aging of baby boomers as additional explanations for the increased elder inmate population.

Research suggests that the elderly offender can be classified into four distinct types: first offender, chronic offender, prison recidivist, and one who has grown old as an inmate (Neeley, Addison, & Craig-Moreland, 1997).

The first offender is maladjusted in society, with poor coping skills. Sixty-one percent of these inmates have committed sexual crimes. He is a high risk for suicide and violence against other inmates and has poor mental health. He would benefit from living in a space segregated from the general population.

The chronic offender has a predilection for criminal activity but has not been confined previously. He has the ability to socialize with others, but can be violent at times. He displays little concern that he has been 'labeled' as a criminal. He experiences stress related to long-term incarceration.

The prison recidivist knows the system well and easily adjusts upon re-entry. His primary concern is about dying in prison. He may have chronic health problems. He can be a benefit to other older inmates, potentially helping first and chronic offenders adjust to prison.

The final type, the inmate who has grown old in prison, is the least volatile of the four types. He has a daily work/activity routine, a successful work history in the institutional setting, and can be a source of support for new inmates.

Aday (2003) reported that the typical older prisoner has an accelerated aging process, and has the characteristics of persons as much as 10 to 15 years older than his chronological age. He noted there were several factors contributing to this process: lifestyle prior to entering prison, high levels of stress, poor diet, and use/abuse of alcohol and drugs.

Consistently across studies, researchers agree that if an individual enters prison at an advanced age or grows older in prison, he will experience healthcare problems (Aday, 2003; Loeffleholz & Scales, 1992; Gallagher, 1990; Roth, 1992). Inmates may live with multiple chronic healthcare problems including diabetes, heart disease, high blood pressure, Parkinson's disease, arthritis, asthma, and after-effects of cardiovascular attacks (strokes). In McCarthy's (1990) study,

inmates' self-report of health status ranged from "poor and going downhill" in the age 55-64 group, to those persons age 70 and above describing their current health as "poor." Kratcoski and Babb (1990) found neglect of health due to lack of knowledge of healthcare and self-care and lack of or minimal access to care on the 'outside,' along with no concern about the physical body, increased the chance the older prisoner would have poor health.

#### *Communities and Volunteers*

Communities and volunteers play an active role in the prisoner's life. There are community support organizations and religious organizations that provide services to the inmate as well as the family on the outside.

Zigmond (2007) noted that one way a community can become more actively involved in the prisoner's life is by the establishment of post-release healthcare support organizations. The article stressed the needed transitional services for inmates' healthcare needs. Community Oriented Correctional Health Services, in Oakland, California, is a non-profit agency providing healthcare services to former inmates. The agency seeks to help communities around the country by establishing continuity of care services between correctional facilities and local healthcare providers. Presently working with four states, the funding for the outreach is sustained by partnering with

local philanthropic organizations. Self-care education is a primary goal, and the author noted that the first step is to teach former inmates to go to community health providers rather than the emergency room for healthcare needs.

Religious organizations, chaplains, and volunteers are a large presence in the United States prison system. Coutourier (1995) stated that the value of the volunteer in the prison system should not be underestimated. The presence of volunteers and supportive programs are likely to improve the social climate in the institution and provide connections with the outside world. If local organizations (churches, mental health centers, and social service agencies) that provide community services to the families of inmates can connect with correctional facilities, then internal programming can be strengthened.

Tewksbury and Collins' 1995 study of prison chapel volunteers found that volunteers connected with religious organizations often have a long history of volunteering in corrections. These volunteers additionally report high levels of satisfaction with their work. When asked why they choose to volunteer in the prison setting, over 50% reported that they were 'called by God'. Twenty-two percent described volunteering as a viable opportunity to share their belief with others. In a later study, Tewksbury and Dabney (2004) found forty percent of participants described the importance of mentoring as a reason

to volunteer in corrections.

Local colleges and universities can provide training, support groups, consultation services, and interns as part of the volunteer work in the prison setting. Eisenman's 1994 survey of college students volunteering in prison found utilizing appropriately trained college interns as volunteers was not only a benefit to the inmates, but also increased the number of supportive services a prison was able to provide.

#### *Peer Relationships in Prison*

An individual's social world consists of an extending and contracting circle of "nodes" (individuals, groups, agencies, or formal organizations) connected by informal social bonds and formal relations (Lieberman, 1990; McPherson, 1990; Novak, 1988). Additionally, a social network can provide a setting for the exchange of social support across the life course.

Goffman (1961) explains that an inmate's social world is directed by the guidelines of the prison. The prison defines the inmate's relationships with other people, both inside and outside of the facility. For example, prisoners are assigned to their cells or dorms and have a limited number of outside personal contacts that have to be formally designated in their files. In this setting, inmates create their own social networks that provide social support. Social interaction is a method of coping with the prison environment (Aday, 1994; McShane &

Williams, 1990; Wooden & Parker, 1980). Aday (2003) explains that visiting and sharing among older inmates is a primary coping mechanism. When he inquired whether inmates shared stories about sensitive topics, more than half of the respondents indicated they had shared intimate conversations with others. Discussions included information about families, financial problems, health and illness, and about feeling bored or isolated. He noted that offenders were less likely to discuss feelings of loneliness, religion, or shame. Aday also found that elderly inmates living in smaller dormitories had close relationships that served to provide emotional and personal support.

Vega and Silverman's (1988) study indicated that while older offenders have relationships with peers in prison, they also have concerns about mistrust. Participants in this study reported they had good relationships with correctional officers and other prison personnel.

Respect for older inmates is important and is often demonstrated by younger offenders. (Aday & Webster, 1979) found that elderly offenders receive respect from younger prisoners because of their life experience and wisdom. Hierarchy in the prison setting is often determined by status or seniority. Wiltz (1973) reported the older prisoner might serve in a leadership role due to his familiarity with the prison setting and system.

### *Family Members*

For the majority of elderly inmates, maintaining close relationships with family may be difficult. Studies on incarceration and its influence on family life indicated that the number of visits from relatives decreased because the visitation process was highly structured and monitored (Roth, 1992; Vega & Silverman, 1988). Vega and Silverman's (1988) study found that 57% of elderly offenders did not receive visits from their relatives. Inmates specifically noted that family members were angered or upset by the imprisonment. However, 90% of those offenders interviewed stated they did try to stay in touch by written or phone contact.

Contrary to some findings, several studies reported that prisoners stated their family relationships were close prior to imprisonment and remained close during incarceration (McCarthy, 1980; Wooden & Parker, 1980). Visitation with family members was noted by over 40% of participants. However, most participants (70%) noted that contact was maintained by written correspondence. Kupers (2002) conducted a brief literature review of research (25 documents) on family visitation of inmates. The review is organized into three categories: effects on inmates, effects on families, and effects on communities. Collectively, he noted, the better the quality of the visitation and education programs within the prison system, the greater the

positive effects on inmates and families in the areas of institutional admission (the initial adjustment process), post release adjustment, and community reintegration.

Holt and Miller (1972) suggested that continued, regular visitation with at least two family members may reduce recidivism. Glaser (1964) found similar results with a study of federal prisoners, with a 71% successful parole rate related to regular visitation. Depending on the study reviewed, the recidivism rate for inmates was 5-15% for those who had visitation/education while incarcerated compared to over 60% for those who did not receive visitation/education. Schaefer's (1991) prison visitor survey found that successful parole was related to maintenance of family relationships. Jacoby and Peak's (1997) study of 27 mentally ill inmates released from Ohio prisons indicated a higher quality of life post-release if the inmate received support (visitation, groups, and counseling) and family education, along with quality visitation time, during incarceration.

The most common methods of contact between inmates and their families were phone calls and letter writing. Aday (1994) noted that the majority of elder offenders had contact by telephone with family members. Letter writing was viewed by the inmates as both a positive and negative experience. Letters were generally a welcome part of an inmate's day, however, if an

inmate/or family member could not read, then letter writing was not an option.

From an historical point of reference, Brodsky's (1975) study of 140 prisoners in the Illinois correctional system defined the importance of relationships in an inmate's life and described the processes and policies associated with visitation. Letters are described as the primary means of regular contact between prisoners, friends, and families. The author references *Going To Jail* (Levy & Miller, 1971) as a guideline for the newly incarcerated adult. The text suggests preparing a list of persons to maintain contact with, keeping in mind the prison policy of censorship. Letters were not to mention adverse treatment, conditions, or institutional information, or the inmate could risk disciplinary action. Brodsky also cites a checklist from the American Correctional Association (ACA) that detailed specific reasons why an inmate's letter might not be mailed out. The list included reasons such as: recipient not on approved list, offensive language, begging for money or gifts, discussion of criminal activities or prison gossip, and criticism of the institution or public laws.

Brodsky's (1975) research suggests that, historically, there have been restrictions on visitation and contact between inmates, friends, and family members. Visitation policy and structure is generally set up for the convenience--and at the

discretion of--the facility, to ensure security and control. Visitation under these terms leads to uncomfortable and often forced conversations between inmates and visitors. Fishman's study of wives of incarcerated men (1999) found that the average visitation period in the two prisons was two days per week. Visitation length varied according to offender status and prison policy. Common visitation issues surfaced in most of the interviews with the women: lack of privacy, time restrictions, lack of freedom of movement, 'artificial' emotional encounters, lack of emotional/physical closeness with their partners, multiple distractions, and episodes of crying and fighting. Overall, the interviews illustrated that while visitation strengthened the relationships the women had with their husbands, prison policies surrounding visitation led to some unintended consequences for the women: increased financial strain, emotional stress, and the women's willingness to engage in illegal activities (introducing contraband into the prison).

Prison administrators, policy makers, and academics are looking for the most effective ways to meet the goals of both the correction system and the general public in terms of treating inmates. There are often conflicts between the goals and the public perception of how prisoners should be treated. Seymour and Hairston's study of effects of incarceration on families (2001) reported mail and phone calls restricted in ways

that would benefit the correctional system and harm the family. Phone calling was restricted in terms of cost to the family and in time limitations. Communication by mail was found to have unintended social costs as letters and packages from prisoners were found to be marked with stamps that indicated they were from a correctional institution. This public labeling of correspondence was particularly a problem for families where the incarceration of a family member was not discussed.

Weil's 2005 study of federal court decisions related to violation of prisoners' First Amendment rights found conflicting rulings on phone call restrictions in correctional settings. He noted phone calls are usually limited in frequency (how often per week) and duration (calls limited to 15 minutes). Additionally, phone calls are limited by the billing process, usually collect calling or direct dialing through a contract service provider.

From the institutional perspective, Weil (2005) noted communication with the outside in any form (written, verbal, or packages) presents an opportunity for increased criminal behavior and social unrest. Conversely, Hairston and Seymour (2001) found communication and contact with the 'free world' is important to inmates and families as a way to strengthen relationships and support.

Visitation programs are erroneously perceived to not be

costly or difficult to manage. Previous research (Fuller 1993; Tewksbury & DeMichele, 2005) however, demonstrates that there are increased financial and logistical burdens placed on facilities and families to manage visitation programs. The most common barriers to successful visitation programs are the expectations, experiences, and perceptions of the inmates and their families.

Aday's research specifically asked older prisoners if they had difficulty in maintaining relationships with family and friends on the outside. Participants stated that visits from family members and friends were impacted by geographical location, ability to obtain transportation, financial burden, personal health problems, and crimes committed against family members (1994). Prisons are typically located in rural areas, and inmate placement is usually not determined by geographic proximity to family members. For those family members who are able to travel, the expense and organization of the trip can be too much for the family to undertake. Aday did note, however, that if elder inmate family relationships could be maintained, this had a positive influence on prisoner's life.

Ties to the elder prisoner's family can be diminished due to deaths, illness, and distance from family. In particular, Aday (1994) noted that coping with the death of family members on the 'outside' was difficult for the elder prisoner. Study

participants noted they received support from fellow inmates when they learned of a family member's death.

Arditti's (2002) conceptual/exploratory study of a family's personal experience coping with a significant other's imprisonment, defines incarceration as a disruptive process with significant primary and secondary losses for the family. Family in this study consisted of spouses and children. The primary loss is the family member's incarceration. Secondary losses include loss of income for the family, caregiver strain, loss of parenting support, and social stigma. Incarceration creates an uncertainty in familial relationships, which is directly related to personal guilt, shame, and the policies governing the inmate's ability to maintain any established relationships on the outside. A more far-reaching complication of shame associated with imprisonment is lack of extended community and social supports for the family.

There can be significant economic risks for families. One-half of the participants in Arditti's study received public assistance, with most stating they began receiving services after the family member was incarcerated. The participants identified several economic risk factors. Most stated they were 'worse off' financially and had child support problems and increased expenses due to incarceration. Family members stated that attorney fees, collect calls from the inmate, and the

process of sending money and supplies to the prison left them financially drained. Demographic data indicated that at least half of the participants were living below the poverty level prior to the prisoner's incarceration. Participants had little or no understanding of available resources for families of inmates.

Arditti (2002) also found that family relationships and family health suffer when a member is incarcerated. Forty-two percent of participants believed incarceration negatively affected the parent-child relationship, both for the inmate and child, as well as the primary caregiver. Forty-eight percent of respondents described their health as poor or in decline since their family member was incarcerated. Several families indicated children were also suffering physically and mentally due to the strain of having a parent in jail. Over 81% of those interviewed believed incarceration had created problems for the whole family.

Emotional stress and caregiver strain were common complaints among the participants. One interviewee stated, "I'm struggling all by myself to handle this." Another indicated, "I feel like I'm in jail." Even though most expressed a pronounced feeling of stress, some family members thought the jail experience could actually benefit the inmate and the family. One interviewee stated, "I am just hopeful that prison might teach

him a lesson, and get him off the streets.” Other families believed that the strict visitation policies had helped the families connect in ways they had not previously experienced.

Despite twenty years of research acknowledging damage to families by the prison system and its policies, change in public policy and public perception has been minimal. Several conditions make this issue difficult to address (Genty, 2003).

1). *The effect on family is not part of the punishment.* The law does not consider family as one of the ‘rights’ an inmate loses once incarcerated. Support services for families may not make special accommodations for those who have a head of household who is incarcerated.

2). *Prisons are built in rural areas.* In the 1980s as the United States was experiencing a growth in the prison population, prison expansion in rural areas was viewed as potentially beneficial from an economic standpoint (King, Mauer, & Huling, 2003). As Genty (2003) noted, prisons are generally in areas where the public does not have to acknowledge the presence of inmates in the community. Consequently, these rural locations are often inaccessible for the families of inmates.

3.) *Distance can be a barrier to services.* Family resource programs are often unable to provide services to families and inmates due to location and costs.

4.) *There is often a lack of policy coordination between*

*the criminal justice system and the welfare agencies.* Criminal justice decisions may be made without regard to impact on the family, and the welfare agencies may make decisions for children and families without consideration of the incarcerated parent.

Furthermore, these factors impact elder prisoners and families in similar ways. Distance from the elder prisoner can damage the few family connections that may be available. Lack of policy coordination between outside agencies and the correctional system may prevent elder prisoners from making a transition from prison to home.

Precise data regarding families of incarcerated adults and elder adults must be collected to increase public awareness of these issues and to assist in the creation of more effective, informed public policies and sentencing guidelines.

#### *Summary*

This chapter provided an overview of the literature specific to my dissertation topic. I reviewed literature to examine the theoretical aspects of social construction, standpoint theory, and Cantor's model of social care. I described the general aspects of the prison environment, including the structure and the day-to-day interactions of the correctional staff and the prisoners. An overview of prison healthcare was provided from an historical point of view as well as from the modern concepts of healthcare in the prison setting.

Specific attention was given to the provision of healthcare for the older prisoner. This includes a section on prison healthcare providers. I then reviewed the literature that addressed the older prisoner to provide the reader a better understanding of who this inmate is. Finally, a descriptive review of those persons who interface with prisoners is important in understanding the care of prisoners. Descriptions of churches, communities, volunteers, and family members provide an important overview of the core people involved in a prisoner's life.

In sum, to better understand the health and healthcare of the older prisoner we must be able to understand the social actors in and outside of the prison setting, as well as the process of care in the prison environment. A review of the literature underlines a gap in prison research knowledge: the older prisoner is rapidly becoming a greater part of the prison population and the system is not adequately prepared to address his needs. I hope that this research will provide insight into an identified need in the prison system and will contribute to the body of knowledge in this area.

## Chapter Three: Methods

### *Overview*

This chapter discusses the method of inquiry, research setting, data collection, and analysis for this qualitative research study. Because the qualitative researcher is “the primary instrument” for data collection and analysis (Merriam, 1998; Padgett, 1998), I have included a description of my background as researcher. The criteria and process for selecting the participants are discussed. Additionally, I detail the data collection process and primary data sources, including interviews and observations. Data analysis is described, including an explanation of the use of qualitative research software. Finally, I discuss project limitations, methodological rigor, and trustworthiness.

### *Aim*

This study employed a qualitative, case study method to explore the health and healthcare experiences of elder male prisoners, and the ‘social network of care’ for elder prisoners. The study was based on four individual cases, each involving a prisoner as the center of the case. Additionally there was an exploration of the ‘social network of care’, which includes the social actors that encompass the layers of care in the

healthcare process: the institutional caregivers (correctional and healthcare staff), families, church personnel, and community volunteers. Together, each case tells the story of the prisoner and his thoughts and perspectives on health and healthcare, along with the stories of those persons who interact with elder prisoners.

Overall, I hoped to detail the health and healthcare experiences of older male prisoners who were incarcerated at the Hamilton Institute for the Aged and Infirm in Marion County, Alabama, at the time of data collection. The description of this phenomenon through the use of specific cases included not only the inmates' current health status, but also their previous experiences with healthcare services while incarcerated. In addition to the prisoners, healthcare providers, correctional staff, family members, and clergy who work in the correctional facility were interviewed. The study explored the health and healthcare experiences of older prisoners from the multiple perspectives of the: prisoners, healthcare providers, correctional staff, family members, and clergy who volunteered in the prison.

#### *Method of Inquiry*

Qualitative research, at its most basic level, is an opportunity for the researcher to explore a case or phenomenon in an in-depth fashion to open up opportunities for creating a

space for understanding a human issue. The data are comprised of the words of the participants, the observations of the researcher, and the researcher's view of the community at a particular point in time. This project may not be generalized to a wider population, but it can provide an opening for further research by closely examining very specific issues.

Qualitative research begins, Merriam (2002) writes, with the assumption that "meaning is socially constructed by individuals in interaction with their world. The world, or reality, is not the fixed, single, agreed upon, or measurable phenomenon that it is assumed to be in positivist worldview." Healthcare is a personal and varied experience based on an individual's health history and access to care. Qualitative research provided me an opportunity to utilize the voice of the interviewees to explore this topic in an in-depth manner. By using 'thick description' (Geertz, 1973), I was also able to characterize the experiences within the context of particular circumstances.

#### *Characteristics of Qualitative Research*

To better understand how my study is best suited to a qualitative research approach, I present the generally understood characteristics of qualitative research in the social sciences:

- Occurs in the natural setting, near the studied group

(Creswell, 2003; Lincoln & Guba, 1985; Patton, 2002).

- Utilizes a number of interactive methods in order to engage the participants in data collection (Creswell, 2003).

- Results in a product that is richly descriptive (Lincoln & Guba, 1985; Patton, 2002; Yin, 2003. "Words and pictures rather than numbers are used to convey what the researcher has learned about a phenomenon" (Merriam, 2002, p. 5).

- Uses the researcher's interpretation of data to develop descriptions, to analyze the data for categories or themes, and to decode the categories into theory or propositions (Creswell, 2003; Yin, 2003; Merriam, 1998).

- Strives to understand "the meaning people have constructed about their world and their experiences" (Merriam, 2002, p. 4).

- Views social events in their totality within a larger context (Creswell, 2003).

- Results in findings that are "highly contextual and case-dependent" (Patton, 2002; Wolcott 2001).

Within the qualitative research tradition, I chose to adopt a case study design. Case studies have been used extensively in social science research (Mertens, 2005) to study a variety of topics, including families, healthcare, gerontology, and cultural change (Serafeimidis & Smithson, 2000). In a 1995 work, Stake says that a case approach is appropriate when "the case is

a specific, complex, functioning thing” (p. 2). Yin (2003) defines the case study research method as an empirical method of inquiry that examines a contemporary phenomenon within its actual context.

Given these various characteristics of qualitative research, and the case study in particular, I found that this method was the most appropriate fit to begin to explore the health and healthcare of older prisoners.

#### *Instrumental Case Study*

Because prisoners’ health remains a largely unexplored area of research, the Hamilton Institute for the Aged and Infirm (Hamilton A & I) provided a unique opportunity to examine closely this topic with a case study approach.

Instrumental case study research is an appropriate method of inquiry for a study of health and healthcare of older male prisoners because it allows the researcher to capture and describe the complexity of real-life events (Stake 1995, Yin, 2003). Case study research represents a disciplined mode of inquiry, which can be organized around issues. According to Stake (1995), the case study researcher has the responsibility of conducting an in-depth analysis of a case (or cases). The researcher must provide the opportunity to emphasize the “episodes of nuance, the sequentially of happenings in context, the wholeness of the individual” (p.xii).

This study provides holistic and meaningful descriptions of prisoner health and the process of healthcare in the prison setting, along with the combined experiences of each of the case study participants as indicators of what strengths and what deficits the prison healthcare system possesses. It also provides a summary representation of the common and varied personal experiences that emerged from the data.

An instrumental case study can be useful in understanding the experiences of health and healthcare from the standpoint of the older inmate and the various social actors who are involved in his care network. Zucker (2001) illustrates the case study methodology as an alternative to the traditional approaches of exploring healthcare experiences. She posits, "The patient's perspective is central to the process. This level of analysis combines notions of personal experiences and meaning within the context of everyday life." (p.1). Yin (2003) describes the instrumental case study as one in which the exploratory and descriptive nature of the process will allow for an extensive examination of a particular case. Bound in time and/or place, an instrumental case study includes contextual material about the setting of the case. Extensive material from multiple sources develops an in-depth picture of the case (Creswell, 1998).

Participants' reflections of their personal experiences included in my study form a holistic view of each older inmate's

perspective of health and healthcare. I chose not to interject a method of causal explanation, but rather used the participants' voices to describe and define health and healthcare, and to explain the experiences of older prisoners and those working with them.

As Devers and Frankel(2000) noted, *nested*, multiple perspectives that are hierarchical in relation to the primary research participant further enhance the research. By drawing upon the experiences of the primary actors associated with the elder prison population, the researcher can explore the connections between the various parts of the formal and informal care network. Using this method of nested perspectives to increase understanding, I developed each case as a series of interviews to include the older inmate, employees of the correctional facility, medical service providers, social service providers, clergy members, and if possible, family members of the inmate. In this area of research, 'family' can be described as people residing outside the prison (biological or legally defined) or it may mean an inmate's 'prison family.' Additional components of the cases included my observational notes, my field notes, and textual analysis of any available supplementary documents.

#### *Justification of Method*

Prison healthcare and the personal experience of health in

a prison setting are complex, multi-layered processes that can be best described through the use of the instrumental case study. Merging individual cases and applying a cross-case analysis approach can lead to a second layer of analysis (Miles and Huberman, 1994). The researcher can potentially achieve a further level of understanding by listening to the healthcare stories of prisoners. Additionally, by interviewing care providers, family members, and correctional staff and outside persons who interact with elder prison population related to their healthcare, a picture of the healthcare process is drawn. This dissertation may provide beneficial insight to states and correctional facilities in (a) designing improved healthcare programming and (b) coordinating use of support personnel and families in the larger community to better address the needs of the growing older inmate population.

#### *Case Study Strengths*

Using a case study has a number of advantages (Stake, 1995; Yin, 2003; Merriam, 1998). Because a case study is based in the current reality of a unit of analysis, it has immediate application to real life experience, and can help readers develop a better understanding of a complex situation. Merriam (1998) writes, "A case study design is employed to gain an in-depth understanding of the situation and meaning for those involved" (p. 19). Also, case studies offer rich, detailed

information about a situation or experience that can often reveal "important variables or hypotheses that help structure further research" (Merriam & Simpson, 2000, p. 111).

The research questions in this study were designed to obtain a deep understanding of a personalized and complex experience within a specific setting. Thus, the case study approach provided the most appropriate means of gathering data in order to explore this life experience.

Utilizing a cross-case analysis approach further enhanced this study. Miles and Huberman (1994) described cross-case study as a means of comparative study. I chose cross-case study analysis as a secondary level of exploration because this methodology allows the researcher to compare and contrast the processes and themes across different cases. Complex and sophisticated descriptions and more powerful explanations provide better understanding of the phenomenon under study. In the present study, each of the four instrumental cases was studied as a single case and then combined with the other three cases in a matrix to generate common themes and outcomes in a cross-case analysis process.

### *Research Setting*

#### *The Alabama Prison System and Demographics*

From the time the first correctional facility was built in Wetumpka, Alabama in 1841, the state's prison system has grown

into a medium-sized correctional system that incarcerates more than 30,000 inmates and employs more than 3,500 employees (State of Alabama, 2008). The Alabama Department of Corrections (ADOC) operates 29 facilities. Five facilities are listed as maximum security: Holman, Kilby, St. Clair, Donaldson, and Tutwiler (the one women's facility in the state). Ten facilities are medium security; four are minimum security; and ten are work release/community corrections facilities. According to the Pew Charitable Trust Performance Safety Project report for 2007, Alabama spends more than \$540 million annually on corrections, despite having the lowest cost per inmate rate in the United States (Pew Center on the States, 2008). The State of Alabama Department of Corrections (ADOC) Annual Report for fiscal year 2007 (FY2007) reported the state's inmate population increased by 6,478 or 23% from FY2000 to FY2007. According to the (ADOC) monthly report (August 2007), at the time of the study, the total prison population (men and women) in the state of Alabama was just over 29,000 individuals. African-American men were disproportionately overrepresented in Alabama's prison population: 16,412 or approximately 56.3%. White males made up 36.1%, or 10,587 of the total state prison population. Alabama's total prison population was 27,987 (25,985 of those were identified as male prisoners). Statewide, 14.9% (4,187) of the total prison population was between the ages of 51-60 years.

This age group experienced the second highest percentage of growth in the system for 2007, following 36-40- year-olds. Within these ethnic groups of incarcerated men, 2801 (9.6%) were aged 51-60 years; there were 918 prisoners age sixty and above. The breakout between older males and older females is unavailable from this source. The average education level of the Alabama prisoner is 10<sup>th</sup> grade, and over 60% do not have a high school diploma. On June 30, 2007, 48.8% of Alabama's prison population was sentenced for personal crimes (crimes against persons), 28.2% were sentenced for property crimes, and 23.1% for drugs and other crimes (ADOC, 2008).

The typical occupancy rate of Alabama Department of Corrections (ADOC) is double the number of inmates that the facilities are actually designed to house. The ADOC refers to this as the "overcrowding index"; it was 191.7% for FY 2007. Alabama ranks third overall nationally in the overcrowding index (facilities that have been overcrowded for ten years or more), just behind California and Oklahoma (ADOC, 2008).

During fiscal year 2006, the annual cost to house an ADOC inmate was \$13,417.40 or \$36.76 per day. According to the Pew Center on the States, this is one of the lowest cost-per-day rates in the country (PCOS, 2008). During the same time frame, the cost-per-day rate in the Federal Bureau of Prisons was \$68.28.

Hamilton is located in Marion County, approximately one hour's drive on a two-lane highway from Tuscaloosa, AL. This part of Alabama lies at the foothills of the Appalachian Mountain range, which stretches from northern Alabama to Maine. Hamilton is located along the Buttahatchee River, a tributary of the Tombigbee River.

In 2000, there were 6,786 people, 2,695 households, and 1,800 families residing in the city of Hamilton, AL. The racial makeup of the city was 90.41% White, 7.59% African-American, 0.32% Native American, 0.49% Asian, 0.03% Pacific Islander, and 0.49% listed as from other races. Hispanic or Latino residents represented 1.71% of the population. In the city, the population distribution included 19.8% under the age of 18, 8.9% from 18 to 24, 29.0% from 25 to 44, 25.9% from 45 to 64, and 16.5% who were 65 years of age or older. The median age was 40 years. The median income for a household in the city was \$27,489, and the median income for a family was \$34,485. The per capita income for the city was \$17,505. About 12.0% of families and 17.8% of the population were below the poverty line, including 23.7% of those under age 18 and 19.6% of those age 65 or over (U.S. Census Bureau, 2000).

The Hamilton Aged and Infirm Center (HAMILTON A & I), the prison where this study was conducted, is situated in the rural northwest Alabama community of Hamilton. My research setting was

Alabama's only prison designated for the aged and infirm older male inmate. The facility was the first of its kind in the United States, and is still one of only four specifically designed to house the aged and infirm prisoner. Originally designated as a work farm, this prison was built in 1981. It was re-designated in 1985 as a specific facility for the increasing aged and infirm male inmate population in Alabama. According to the Alabama Department of Corrections, Hamilton A & I is located on a five-acre property surrounded by a security fence. It is classified as a medium custody facility for inmates who are aged and/or infirm. Medical care services are provided on-site for the inmates as needed by rotating staff physicians, ten full-time nursing staff, and a full-time and master's level psychologist. 'Free world' contract providers provide medical care services that cannot be offered on-site. In addition to the A&I inmates, a staff of minimum custody inmates provide facility upkeep and complete community service work in the Hamilton area.

The original physical design capacity for the Hamilton prison was 123 beds. Currently there are 300 beds in the facility. At the time of the study, 294 inmates resided within the prison. Hamilton A & I is typical of other Alabama prisons in that African-Americans are overrepresented in its census. At the time of the study, the most common medical diagnoses of the inmates were hypertension and diabetes. There were over thirty

men who required 24/7 full-time, skilled nursing care and fifty-eight men who required bedside meals and feeding assistance.

Hamilton A & I is authorized for 47 correctional staff members, but had 43 actually employed at the time of the study. The ratio of correctional officers to inmates is 6.8, one of the lowest correctional officers to inmate ratios in the state. Fifty-four other personnel (administrative and medical) make up the remaining onsite staff. The prison is authorized for an additional five non-correctional employees. There were no social workers employed in the prison. One of the authorized-- but not filled at the time of the study--positions was that of prison chaplain (ADOC, 2007).

#### *Researcher's Acclimation to Research Setting*

Ms. Laura Day, the Director of Psychological Services for Hamilton A & I, was directly responsible for my acclimation to the community of Hamilton and to the prison facility itself. Her day-to-day responsibilities require her to wear many hats: case manager, therapist, discharge planner, intermediary with families and facilities, and group leader and educator to the nearly 300 male inmates in the facility. She provided my direct link to the community at large and also negotiated the process of preparing my presentation to the warden, the correctional staff, and the state officials. She helped me acclimate not only to the community but also to the day-to-day routine in the

Hamilton A & I. The nature of her work in the facility made her a natural gatekeeper for those persons who would eventually participate in my study.

### *Data Sources*

Data for this study came from a variety of sources: (a) digitally recorded, semi-structured interviews with older male prisoners, prison healthcare staff, clergy, and prisoner family members; (b) field observations and notes; and (c) supplementary documents (e.g., newspaper, library historical documents) and reflective summary by the researcher. Data sources that contained proper names were replaced with pseudonyms. Data from each source in this study were complementary and helped me obtain a holistic picture of the participants' conceptualization and experience of prison healthcare. Following is a description of each data source.

### *Interviews*

The primary means of collecting data for this study was individual in-depth interviews. Merriam (1998) classifies interviews by the degree of structure present. She presents a continuum from highly structured/standardized to semi-structured to unstructured /informal (p.73). Creswell (1998) describes the interview as a process that allows the participant to voice his perspectives, and in way that empowers him to create opportunities for responding.

There are several strengths inherent in the interview process. At its most basic, an interview has been called "a conversation with a purpose" (Dexter, 1970, p. 136; as quoted in Merriam, 1998). The purpose of an interview is for the researcher "to enter into the other person's perspective...to find out what is in and on someone else's mind, to gather their stories" (Patton, 2002, p. 341). Also, interviews are useful tools in qualitative case study research, as the researcher attempts to assemble a rich description of the case (Merriam, 1998; Yin, 2003).

The nested, multiple perspectives of the interviews in this study provided a source of comparison and contrast among participants. I used a semi-structured, reflective interview approach for this study. I created an interview protocol as a guide that allowed me to introduce verbal prompts for further conversation if a topic required additional discussion. This protocol helped me follow a semi-structured path to gain understanding of the prison healthcare experience from multiple levels. In addition, discussions with prison personnel, social workers, and outside family members guided me in understanding the role health and healthcare played in their lives, as well as their perceptions and personal experiences of the healthcare process.

By using a reflective approach, I worked to place the

participants at ease and encourage them to have an active part in the interview. Bosworth, Campbell, Demby, Ferranti, & Santos (2005) noted that through an intellectual and personal exchange, social researchers become advocates for prisoners and give them voice in ways that might be otherwise unobtainable. A complete interview protocol is included in Appendix A of this document.

#### *Fieldwork and Documentary Materials*

Qualitative researchers typically use field observations, memos and supplementary documents concurrently in the data collection process (Creswell, 1998). In addition to prisoners' perspectives, this project also focused on the impact of the physical space of the prison itself on inmate health. My field observations of the prison facility and its impact on the experiences of all involved provided an increased contextual understanding of health for the older inmate.

I completed daily field notes and journal entries to address my role, thoughts, feelings, and observations. The use of field notes and journaling allowed me to be constantly aware of my personal biases towards the participants and acknowledge these throughout the process. Additionally, the journaling and note taking presented an opportunity for me to examine my growth process as a qualitative researcher, and the development of the project over time.

I used both a written journal and digitally recorded memos.

By observing the participants in the prison and interacting with correctional personnel, I gained a better understanding of the daily routine within the setting where they live and work. Part of the time spent in the field observation process was simply due to the time frame I had in between the interviews. I often had to wait for a staff member to take a scheduled break to meet with me, or an inmate may have had tasks to complete before he was allowed to meet with me. Certainly my presence in the correctional facility had some effect on the daily routine, but I tried to disrupt the routine as little as possible. I was able to observe some staff in their daily routines, and I was able to observe the inmate participants as they worked in the front of the prison. Due to the safety concerns of the warden and correctional staff, I did not observe any activities beyond the front part of the facility.

I had the option to work within a small, windowed room in the lobby area. This allowed me to watch interactions between correctional staff and inmates, and observe without disturbing the process. I arrived fifteen to thirty minutes before each interview session. This enabled me to keep more detailed field notes. By observing how the inmates and correctional staff interacted with each other and by taking field notes, I was able to capture small details of how daily life in the public area of the prison proceeds on a basic level.

Additionally, my field observations and journaling extended to my work in the larger community. I used the observations to gain an understanding of the small, rural community where the prison is located. Field memos allowed me to reflect on the interviewing process and organize my thoughts and feelings related to the research.

#### *Supplementary Document Review*

The third data collection method this research utilized was supplementary document review. This type of review includes "a wide range of written, visual, and physical material relevant to the study at hand" (Merriam, 1998, p. 112). These materials can exist independent of the actual research process (Creswell, 1998). Documents can include personal memos, formal policies, photographs, journals, videos, and virtually any other physical embodiment of information. Documents are widely used in qualitative research, because, as Guba and Lincoln (1981) write, "The first and most important injunction to anyone looking for official records is to presume that if an event happened, some record of it exists" (p. 253, quoted in Merriam, 1998). This type of data may be copied or scanned and placed directly in the data file for analysis (Richards & Morse, 2002).

Document review does have some limitations, however. Yin (2003) points to the possibility of reporting bias, the possible difficulties of retrieval, and the possibility that all relevant

documents may not be accessible. Merriam (1998) also reminds researchers to remain cautious because documents may not be constructed in a useful form, or may be incomplete. Finally, researchers may have difficulty establishing documents' authenticity and truthfulness.

My research design included additional materials for use as archival and support data. News reports (written and visual) helped provide a view of older inmate health from the perspective of the community and the media. Documents reviewed for this study included information produced by the Alabama prison system concerning the historical development of the prison system in the state, the strategic and financial challenges the system has faced, prison campus improvement plans, and the requirements of individuals who were to be housed in the Hamilton A & I. I specifically looked for indications in the documents that might reflect a shift in how the prison system at Hamilton A & I changed over time to serve a mostly older, medically compromised male population.

Additionally, as I spent time in the local community near the prison, I was able to visit the local library to explore historical documents that further described how the prison was first built in the area. I also was able to explore detailed information from a community perspective about the prison's changeover to a facility specifically for the aged and infirm

male inmate. I collected archived newspaper clippings, old photographs, and editorial summaries from the local library. From a collection of these supplementary materials, I was able to construct how Hamilton A & I is represented in the larger community. In addition, examining the editorial summaries helped me to understand how the community members understood the role of the prison in their community and in the state of Alabama.

There are several strengths to incorporating supplementary material into the case study method. Wolcott (2001) presents a visual representation of the various approaches to gathering qualitative data as a tree. He describes the central part of the tree as the primary structure from which the core activities evolve. Each major branch of the tree provides a focus for each major part of the study. One major branch is dedicated to the examination of materials provided by others: archival and documentary data. These materials provide a source of triangulation, an historical perspective, and that helps bind the research to a particular place and time.

Field notes and journals, on the other hand, record the everyday actions of the researcher, the participants, and the world in which they both exist. It is important for the researcher to take the time not only to observe the participants and their setting - but also to acknowledge the presence of herself in the research. Journaling provides the researcher an

opportunity to record thoughts, feelings, interactions, and reflections of the work.

### *Data Collection*

According to Morse and Richards (2002), qualitative data collection comprises a number of strategies, all of which are flexible and are conducive to working in a natural setting. These strategies assist the researcher in describing the cultural norms, perspectives, and patterns of the data collected. In the instrumental case study method, the data are collected in a variety of ways. The researcher will use observational data (field notes, journals, photographs, etc.), interview data (in this case, digitally recorded and transcribed), and the researcher's own notes about the research process (in the form of a diary or journal). The collected data are "detailed descriptions of situations, events, people, interactions, and observed behaviors; direct quotations from people about their experiences, attitudes functions as the primary instrument for data collection and analysis" (Merriam, 1998).

### *Sampling Strategy*

Padgett (1998) notes, "One cannot study everything and everyone...therefore clear rationales for sampling strategies are needed." All sampling is done with some purpose; in this study, I specifically wanted to understand the experience of health and

healthcare for the older male prisoner. Weiss (1994) states that a qualitative sample seeks to “capture depth and richness, rather than representativeness.”

Initially, the sampling approach was guided through an established gatekeeper in the facility. I provided written information about the project and openly sought volunteers to participate in interviews. Additionally, I found gatekeepers in the community and informed them regarding the project in an effort to seek volunteer participants from the community level. From these starting points, I used a purposeful sampling strategy known as *maximum variation sampling* (Creswell, 1998). This allowed me to document diverse variations and identify important common patterns. Maximum variation sampling in case studies provides a display of multiple perspectives about specific cases within the larger study (Creswell, 1998; Yin, 1995).

The case study used the ‘information-oriented’ selection process, specifically seeking maximum variation among cases (Flyvbjerg, 2006). This strategy allowed me to accomplish several tasks: 1) To maximize the utility of information from a small sample, 2) To select cases based on informational potential, and 3) To obtain cases that fell along a health status continuum.

Older male prisoners (age 50 and above) who had health conditions, ranging from minimal to multiple, that required daily medical care were considered for participation in this study. A list of possible participants who met the criteria was provided to me by Laura Day, the psychologist and identified gatekeeper in the facility. Each inmate was informed of the opportunity to participate in the study and I explained that they would be discussing their personal health and healthcare experiences. Ultimately, four of the prisoners, who fell along the health status continuum of minimal, moderate and chronic care needs, agreed to be interviewed for this study.

Due to security concerns and the size/number of inmates in the infirmary, I was not able to interview infirmary patients for this study. The four elder prisoners in the study, however, represent the largest segment of the elder prison population. They are those men who have care needs that fall between the extremes of no physical health problems and the prisoner with a terminal medical condition. Collateral participants for each case included correctional healthcare providers/staff members, clergy, community volunteers, and family members.

Staff members were approached on an individual basis about their availability and willingness to be interviewed about their work with the prisoners. There was no currently employed prison chaplain, however, I was able to interview two clergy and three

community volunteers who provided volunteer services to the facility. Three family members were interviewed. Permission from each individual prisoner was gained prior to contacting any family members for participation in the study. Specific consent forms for prisoners to grant permission for collateral contact were developed.

A total of twenty-one persons were contacted and sixteen participants were interviewed for the study. The five who were contacted but chose not to participate, declined for various reasons. Table 3.1 provides some examples of reasons participants declined.

Table 3.1  
*Qualitative Participant Refusal Codes*

<b>Preliminary labels</b>	<b>Final code</b>	<b>Definition</b>	<b>Example</b>
Lack of interest	Disinterested	Any response where participant is not interested	"I don't care to be involved" Please don't bother
Time issues	Timing	Bad timing	"not time"
Skeptical of strangers	Concerns about research	Not comfortable with research	"Don't want to share, it's personal."

The final sample size of sixteen is appropriate for the instrumental case study design. Yin (2003) notes that case study work involves exploring the multiple realities of the various perspectives in each case. The richness, contextualization, and detail of the participants' experience can be obtained with a minimal number of cases and interviews (Creswell, 1998; Miles and Huberman, 1994).

Maintenance of Collected Data. I conducted ten face-to-face interviews and six phone interviews, all of which were digitally recorded. I maintained a data collection matrix to track and record the interview and data process for each case. This matrix was extremely helpful in keeping track of the data and notes. I kept a field journal for pre- and post-interview notes and personal reflections.

I also collected documentary materials to support my work and the narratives, in the form of newspaper articles; historical documents about the development of the prison, and a description of the process of the healthcare routine in the facility; editorial cartoons from the local community newspaper; and photographs of the community.

An experienced transcriptionist recommended by a qualitative researcher via the QUALRS-L list-serv group (qualitative research list-serv maintained by The University of Georgia) transcribed the interview data. I transcribed my self-recorded audio and hand-written field notes. Original copies of all materials were maintained in my office in a secure storage area according to the university IRB protocol.

The interviews, documentary materials, and field notes were coded using the Hyper Research 2.1 and Nvivo7 software packages. The codes were derived from an open coding process and organized into themes.

## *Data Analysis*

Data analysis in qualitative research leads the researcher to the process of abstract thinking. This process allows the researcher to begin to make meaning of the data. Data are then transformed from a written document to larger categories and concepts. This abstraction leads to generation of theories in some cases (Richards, 1993). It can also lead to a common way to express individual experiences, such as Glaser & Strauss' 1971 study of cancer ward patients' hospital experiences.

Qualitative research requires that the researcher be receptive to any emerging concepts and ideas and that she be able to understand and undertake the appropriate analytic strategy (Morse & Richards, 2002). Wolcott (2001) states that careful description of the data analysis process can help other researchers who may be studying a similar area learn how to best work with their field notes, experiences, and data sets.

### *Qualitative Software in Data Analysis*

I chose to use a combination of two qualitative software packages for my analysis: Hyper Research 2.1 and Nvivo7. Hyper Research 2.1 provides a simple and effective means of preparing and doing initial coding work of transcribed data. Nvivo7 is designed to further code and develop complex ideas from qualitative interview data. Nvivo7 integrates coding with qualitative linking, shaping and modeling. Ideas are flexibly

stored in annotations and rich text memos that can be coded, linked and searched (Richards & Morse, 2002).

### *The Process*

Data analysis is described by Padgett (1998) as a "cerebral and solitary pursuit" the researcher undertakes. Further, she describes it as a process in which the researcher must think on a creative and conceptual level. It is important to remember that the qualitative researcher is not only the instrument of data collection, but also the instrument that conducts the data analysis. Keeping these points in mind, I chose to use a reflective process to review the interviews and the documentary materials. I used a step-by-step process, as described by Creswell (2003). The steps included: initial reading and coding of data; developing the individual case; illuminating emergent themes and ideas; categorization and restructuring; immersion; reflection on each case a whole, then as a part of a larger series of cases; and finally reflection on the documentary data to present an additional view of health and healthcare.

(1) *Initial reading and coding of data.* "Any researcher who wishes to become proficient at doing qualitative research must learn to code well and easily. The excellence of the research rests in large part on the excellence of the coding." (Strauss, 1987, p. 27). Coding is the process whereby the researcher can simplify and focus on the more particular characteristics of the

data (Morse & Richards, 2002). It allows the researcher to become familiar with the data on many levels: from the demographic and descriptive data to the most detailed nuances.

In this study, I created categories for codes using an open coding process, and then themes and categories were developed as they emerged from the data analysis process. The units of coding were not limited to a phrase, sentence, or paragraph; the basis of a unit was developed on complete thoughts, preventing the researcher from taking respondents' thoughts out of context and/or interrupting the flow of their stories.

(2) *Constant comparative coding process.* After all of the data from my interviews, field journal, and supplementary documents were collected, I began to build categories of possible answers to the research questions using a "constant comparative method" (Merriam, 1998, p. 179; Glaser and Strauss, 1967). At its most basic form, this type of data analysis can be described as a "continuous comparison of incidents, respondents' remarks, and so on, with each other" (Merriam, 1998, p. 179). Units of data--bits of information--are literally sorted into groupings that have something in common. A unit of data is any meaningful...segment of data...[It] can be as small as a word a participant uses to describe a feeling or phenomenon, or as large as several pages of field notes describing a particular incident or setting" (Merriam, 1998, p. 179).

This technique is appropriate in this study, because Creswell (2003) suggests data analysis for a case study includes detailing a "description of the setting...followed by analysis of the data for themes or issues" (p. 191). I was able to refer back to the documentary materials and my field notes for verification and linkages to the interview data.

(3) *Developing the individual case.* Each individual case in this study has a primary participant, the prisoner. Additionally, the case includes those persons who interact with him related to his health and healthcare: the correctional healthcare staff, the family, the clergy, and community volunteer members.

(4) *Illuminating the emergent themes and ideas.* Themes and ideas are generated as the researcher begins to infer connections and patterns within the data. Padgett (1998) points out that these may emerge immediately in the process, or they may develop slowly over time. Ultimately, the goal is to link the themes and ideas back to the literature and the knowledge base about a particular topic. In this study, themes that emerged from the data were compared with the healthcare, prison, and gerontological literature.

(5) *Categorization and restructuring of the data.* The categorization and restructuring of the data took place over time. It began with the first steps of data collection, as I

kept a journal entry about each interview and how the participants responded to the questions. This process continued through the data analysis as I was able to group codes and themes into a picture of prison health and healthcare of the older male prisoner.

(6) *Immersion process in the data.* Marshall and Rossman (2006) state, "Reading, rereading, and reading again forces the researcher to be intimately familiar with the data." During this process, the events, the people, and the situations move through the researcher's thought processes. The immersion process allows the researcher to give very focused attention to the data and to be open to the meaning and detail of the social event being studied.

Additionally, by immersing myself in the data, I was able to streamline the data. I developed a matrix of codes and themes, along with an overall picture of my journey working in these data. I reflected upon on the conceptual framework of the overall study and considered various ideas about the study of older prisoner health.

(7) *Reflections: Single cases and across cases.* I located thematic comparisons between and within cases to identify common areas. These primary themes, concerning the experience of health as an older male inmate, constructed the view of each of the four cases. I compared themes with existing literature

regarding inmates and health. Together with field notes and documentary support materials, I was able to draw inferences about health and healthcare for older prisoners.

*(8) Reflections on supplementary documents.* As I developed the social construction of older inmate health from the viewpoint of the cases, I was able to assess health within the context of the social, economic, and political factors surrounding the issue. I sought to highlight the various perceptions of inmate health and healthcare, and the linkages between inmate and service provider needs, funding, and governmental policies that guide prison healthcare. Additionally, I attempted to address societal attitudes towards older inmates.

#### *Methodological Rigor*

Padgett (1998) discusses rigor not only in terms of comprehensive strategies that strengthen qualitative research methods, but also in terms of the relevance of the studies themselves. Morse and Richards (2002) note that any study is "only as good as the researcher." To simplify the term "rigor," they describe the process as "getting it right and knowing if it's wrong" (p. 169) Overall, the preparation of the researcher, the management of the data collection process, the level of data analysis, and the researcher's skill in interpreting results ensure rigor from the earliest stages of the research.

## *Trustworthiness*

A discussion of methodological rigor would not be complete without addressing the concept of trustworthiness. Validity and trustworthiness are key aspects in all research projects, both qualitative and quantitative. The overall goal is to provide credible information about a particular topic, in this case, the older inmate. By using multiple methods and a variety of data sources, dependability and consistency of results can be increased (Lincoln & Guba, 1985; Merriam, 1998). Baxter and Jack (2008) outlined several specific steps for the case study researcher to follow to ensure maximum opportunities for validity and trustworthiness. The researcher must be responsible to a) develop a clear research question; b) demonstrate that case study design is the best fit for the intended research; c) use purposeful sampling strategies; d) collect and manage the data in a systematic fashion; and e) ensure that the data are analyzed correctly.

My plan for methodological rigor in this study was derived from a combination of strategies described by Creswell (2002), Padgett (1998), and Morse and Richards (2002). It included appropriate preparation, pacing, prolonged/intense engagement, triangulation, peer consultation, review and support, project histories, an audit trail, and reaffirming through implementation.

*(1) Appropriate preparation.*

Appropriate preparation is a way to describe the skill and knowledge of the researcher. These skills can determine not only the quality but also the depth and breadth of the data collected and interpreted. Prior to designing this research study, I completed a fifteen-hour research minor in qualitative methodology. I also participated in a qualitative pilot study of a similar incarcerated population in the south. I have had extensive experience in both research interviewing and clinical social work interviewing. Finally, my clinical social work practice has primarily been with older adults, their families, and paid caregivers in institutionalized settings.

*(2) Appropriate pacing of the project.*

Morse and Richards (2002) describe pacing as the *synchrony* of the data collection and data analysis. It is important to move through the project at a pace that ensures appropriate attention to each phase of the process. Moving too quickly from step to step could leave the project open to incomplete work and insufficient time for analysis. To achieve this step in methodological rigor, I carefully paced the time between beginning the interviews and through each step of the data analysis process. This provided me the opportunity to begin coding and analyzing my data right away, and to begin to formulate ideas and questions.

*(3) Prolonged/intense engagement.*

Prolonged or intense engagement refers to the amount of time spent in the field during the research study. Wherever possible, Padgett (1998) recommends the time be structured in a way, which allows the researcher to have ample opportunity to interview participants, observe participants and the setting, and to document this process. A key part to working in the field is establishing a level of trust between the researcher, the gatekeepers, and the study participants.

In this study, I was given an agreed upon timeframe in which to conduct the interviews within the prison facility. During this timeframe, I was given ample time and space with the participants to interview them at a pace that was comfortable to them. I had the support and flexibility of the warden and correctional administration to interview everyone in a secure, yet confidential environment. Additionally, I chose to stay overnight in the community while I was conducting the interviews. This allowed me to reflect on the process and to have an opportunity to experience aspects of the small southern town where the prison was located. Collateral interviews were conducted by phone at a time most convenient to the participants.

*(4) Triangulation.*

Triangulation, as defined by Merriam (1998), is "using

multiple investigators, multiple sources of data, or multiple methods to confirm the emerging findings" (p. 204). Padgett (1998) notes triangulation is a preferred method of achieving rigor in case study work. She further describes various types of triangulation:

**Theory triangulation** - the use of multiple theories and perspectives in data interpretation.

**Methodological triangulation** - multiple methods used in a single study.

**Observer triangulation** - use of more than one observer in a single study.

**Data triangulation** - use of more than one source of data.

**Interdisciplinary triangulation** - collaboration of more than one type of researcher within a study.

The research plan for my dissertation included two of these types of triangulation: *theory triangulation* and *data triangulation*. I incorporated the use of multiple theories (Cantor's model of social care and the theory of social construction) and perspectives in data interpretation. Additionally, I used multiple interviews (various sources), a review of the supporting literature in aging and criminal justice research, my observational field notes, and my research journal. I included information from local newspapers that

provided a perspective on public opinion about older inmates and the impact this prison has had on the community at large.

(5) *Peer consultation, review, and support.*

Another method I used to provide methodological rigor to my study was involving another researcher with a qualitative research background to assist with consistency in coding and analyzing data. The use of peer review and support is a hallmark of qualitative research. Peer support allows the researcher a chance to discuss the process, as well as exchange thoughts and ideas. The researcher is the instrument in both the data collection and analysis process; she may become tired in the process. The peer support process allows her to step back and have a fresh pair of eyes view the data.

As defined by Creswell (2003), the peer review process is one in which colleagues comment on the findings that emerge from the data. In addition to the social support aspect, the peer review "keeps the researcher honest," by addressing issues of researcher bias (Lincoln & Guba, 1985). In this study, I enlisted the assistance of a colleague who is a social worker familiar with the correctional setting to review and discuss each step of the study. For this inquiry, I worked closely with a fellow qualitative researcher and doctoral student from The University of Alabama, Joshua Baldwin. He has social work practice experience and qualitative research experience with

incarcerated populations. Over the course of the study, we met to discuss project development, fieldwork, coding, and the emergent themes in the research. Some meetings occurred in person while others occurred by telephone, and we had frequent communication by electronic correspondence. I found this process to be quite helpful at several stages in the development and data analysis process.

*(6) Project history and the audit trail.*

It is important for qualitative researchers to be able to track back through their data to “discover and report the history of” the data analysis (Morse & Richards, 2002). The use of a dated and detailed project history allows the researcher to “say how they got there” when asked about the overall claims of the study. This study included the use of a written journal for field notes and the recording of memos during the data analysis process. Each of these steps allowed me not only to track and manage the data, but also to understand the generation of ideas and themes from the study.

The establishment of an audit trail (Merriam, 1998) or chain of evidence (Yin, 2003) also added to the study’s dependability and consistency. In order to establish an audit trail, I chose to “describe in detail how data were collected, how categories were derived, and how decisions were made throughout the inquiry” (Merriam, 1998, p. 207). The use of the

data collection matrix, aided me in this process.

(7) *Reaffirming through implementation.*

This final step in the research process ensures that the study information is disseminated to others. Morse and Richards (2002) note that implementing changes from a study can lead to further exploration of an idea, or recommendations for a particular intervention. I intend to present the findings from this dissertation in article format to be submitted to appropriate journals for publication. A copy of the manuscript will be placed in the library at the Hamilton prison. Additionally, I would like to present the findings to the Alabama Department of Corrections in an effort to identify areas for potential change in the state prison healthcare system.

#### Summary

This chapter includes the detailed processes of methodological approach and procedures I employed to explore inmate health and healthcare. I have included a description of qualitative research, specifically the case study method. I have included my rationale for using the case study and my choice of methods. My clinical social work experience and background relative to this study were also described because my role as researcher does influence my interpretation of the data. I addressed the data collection and data analysis processes. Specific procedures for analyzing the data were described along

with an explanation of the choice to utilize both Nvivo7 and Hyper Research 2.1 research software as data management tools. Lastly, issues of methodological rigor and the techniques used to enhance validity and trustworthiness were discussed.

## Chapter Four: Results

### *Overview*

Qualitative researchers gather information that is “textured, rich, insightful and illuminative” (Shank, 2006). The narrative data obtained from the four inmates who provided the central components to each case, along with the twelve collateral participant interviews, were rich and informative in providing an understanding of elder inmate healthcare. It was my concern that the exploration of the men’s lives and those persons who work with and are part of their lives be presented in a format that would best tell their stories. In order to accomplish this, I chose the case study format. Therefore, elder health and healthcare are explored using four specific vignettes that illustrate the different experiences of male prisoners at Hamilton A & I.

Each vignette tells a story of a personal experience of health and healthcare from a specific point of view. The vignettes include contextual information: descriptions and dialogue that help provide a picture of the inmate in his current situation. Following the vignettes I have included a section entitled the ‘Network of Care,’ which includes the social actors that encompass the layers of care in the

healthcare process: the institutional caregivers (correctional and healthcare staff), families, church personnel, and community volunteers.

A second part of the results section reflects a more global approach to exploring the research aims across the four cases. In this section, I explore the major research aims and then present a cross-case analysis of emergent themes and subsequent conclusions. As Creswell (1998) notes, the data analysis process seeks a collection of instances from the narrative data that have issue-relevant meaning. By looking for established patterns within and across the cases, I had the opportunity to further validate the study's findings (Yin, 2003). Themes that emerged across all of the vignettes are discussed following the individual stories.

#### *The Researcher's Philosophy*

I view the world through a personal philosophical lens that parallels the constructivist paradigm. In other words, my ontological view of the world is one in which multiple realities exist, and individuals socially construct them. My epistemological view is that knowledge involves interpretation of meaning of context through understanding individuals' lived experiences. I agree with Mertens (2005) that qualitative methods assist researchers in understanding the meaning that individuals attribute to an issue by constructing reality based

on interpretation of data.

Bracketing my thoughts as a researcher is an extremely important part of the qualitative research process. I understand that values are based on biases and subjectivity. Employing this reflexive process allows researchers to recognize that they are 'a part of the social world they study' (Ahern, 1999). A researcher can then turn her focus to the productive process of trying to understand a participant's experience. Bracketing within the first part of the chapter addresses interview-specific issues. Throughout the second part of the chapter, I bracket my thoughts as they relate to the results discussion. Bracketed material includes excerpts from my field notes and journal.

*Part One: Stories from the Inside*

The following section provides a description and a current story of each of the prisoners who were central to the four cases. After each case is presented, the social network that is part of each case is described. Table 4.1 presented below provides a brief health continuum and age cohort description of each prisoner participant.

Table 4.1  
*Participant Demographics*

<b>Prisoner participant</b>	<b>Age Cohort</b>	<b>Health Continuum</b>	<b>Health Concerns by self-report</b>
Hank	52	Chronic care	Type II Diabetes, Adult On-set, Hypertension, high cholesterol, recurring 'stomach problems' Dental problems
Will	68	Moderate care	Hx of enlarged prostate Significant and frequent dental problems, vision problems
Hubie	77	Minimal care	Age-related health concerns: vision loss, hearing loss, dental problems. 'Stomach problems', Stress due to incarceration
Charles	89	Chronic care	Newly diagnosed blood sugar problems. Hx of heart attacks, triple bypass surgery, cataracts, multiple bouts of pneumonia since incarceration

Bracketing:

I chose not to ask questions related to the circumstances related to prisoners' incarceration directly. I did not want to create a level of bias between the participants and myself that reflects personal judgments or concerns I personally might have

about why they were incarcerated. Additionally, I noted in my conversations with the medical staff that they operated under the same professional guidelines. They saw their roles as 'care providers' and not as individuals who could judge *how* care was given based on a patient's life history.

### *Definitions*

There are certain terms that are specific to the prison system; to assist the reader, I have included a list of definitions here.

**Camp** - Camp is the shortened form of the phrase 'prison camp'. Both the elder inmates and the people who worked in the facility referred to Hamilton A & I as a camp.

**Chain** - a term meaning that an inmate is leaving ('catching the chain'), a group of inmates coming in ('the new chain') or the bus used to carry inmates ('chain bus').

**CNA** - a certified nursing assistant.

**DOC** - the shortened form to refer to the state department of corrections. The Alabama Department of Corrections is alternately referred to as 'DOC' and 'ADOC.'

**Free world** - life and the world outside of the prison; also street or street-life.

**Frequent flyer** - an inmate who frequently signs up for medical/sick call.

**Jacket** - an inmate's institutional record.

**LPN** - a licensed practical nurse.

**Nurse practitioner** - a registered nurse with a master's degree in nursing who is licensed to diagnose illness and disease. An NP can function as an independent primary healthcare provider.

**Pill call** - the process by which daily medications are administered.

**RN** - a registered nurse.

**Sick call** - the process by which inmates can request to be seen by the nursing staff.

*Vignette One: Hank's Story*

***"Being in here, you know, you would like for everybody to care about you - whether you are in here or out on the street."***

Hank, age 52, was the youngest of the inmate case participants. On the health continuum he would be considered in the chronic care range: he had three chronic medical diagnoses that required daily medications and monitoring. He did not self report any mental health conditions or medications. He was a very soft-spoken, African-American man with a slight build. He appeared younger than his stated age. First incarcerated before he turned thirty, he had spent most of his adult life in prison, *"I got a little over 22 years worth of time - and I go up for parole in 2010. (Whether he would be released) well, that is up to the discretion of the parole board."* He had been remanded to

several institutions in the state and at the time of the interview, he had been imprisoned at Hamilton A & I for just over two years. He talked about the over-crowded prisons in the state and stated that transferring from one facility to another was commonplace, *"Well, the prison system is so over-crowded big time - so sometimes they just move you at random."* As one of the younger inmates with good behavior, he was transferred to Hamilton A & I as part of the population who has work detail on the camp. *"I think they just needed some workers - some guys whose jackets are clean."* When he gave some thought to how this prison camp compared to the others, he was quick to note, *"The location is probably the best I've been in - as far as the location itself."* He clarified this in his further description, *"I'm a lot more comfortable here than any other institution I've been locked up in 'cause you don't have to shower with 15-20 other guys. We only have 300 guys and most camps have 1600-1800 guys."*

Hank was quick to note, however, that the facility had its drawbacks, *"The downside of it though - it kinda depresses you because you do have so many elderly and sick people - unlike the other camps. You have people who have some physical problems in every camp, but nothing that compares to this camp here. Sometimes that kinda gets to you."*

Like other participants, Hank had some military experience

prior to being incarcerated. He described his Army life as a time when he was *"exposed to a lot of things, I was in there a good while, and you just see a lot of stuff."*

Hank grew up in a single-parent household with a younger sister. He reported having few family members whom he was still able to contact. *"I have a sister, but most of my people have been deceased since I got locked up. She's a couple of years younger than me and is married with a family."* He had an adult daughter who was in her thirties with whom he had limited contact, primarily due to the exorbitant expense of placing phone calls from prison. *"It is VERY expensive to make phone calls. My daughter lives in \_\_\_\_\_ state and it is gonna cost twenty-five dollars just to call her and talk for fifteen minutes!"* Typical of the prison inmate experience, distance prevented much family interaction. Hank's sister lived more than a six-hour drive from Hamilton A & I, and his daughter lived in the Eastern U.S. *"They don't visit because of the distance, you know, it is expensive to come down that far!"*

Hank had developed several health problems while incarcerated. At the time of the interview, he had hypertension, high cholesterol, diabetes, recurring stomach problems, and dental problems. Prior to moving to Hamilton A & I, Hank had been diagnosed as a Type II Diabetic.

*I got a diagnosis at \_\_\_\_\_ and I really liked to have had a stroke! Cause you know I was feelin' great and I had ate some chocolate chip ice cream. I ain't really a big size, but I eat like I was 200-300 pounds! (laughs) I eat a lot! For some reason they called me to the health call and took some blood from me and found my blood sugar was too high and that's how I found out.*

He described how as he had learned more about the diagnosis of diabetes, he recognized he was exhibiting all of the classic signs, "I had been losing weight, urinating a lot and I was thirsty. I just didn't know I had **that** problem!" Hank was very self-aware and knew details about his health conditions and understood the need for health management:

*Right now, I am a Type II diabetic, I have high blood pressure and high cholesterol. And I just take care of it all the best I can. I take my medications regular, and do my exercises. I eat pretty decent...well, I don't eat all the right food (laughs). Lot of times you just eat what you get!*

At the time of the interview, he was having a recurrent stomach problem that had not been diagnosed. He had taken the steps to be seen by the medical staff and was waiting for his doctor's appointment. He also had a tooth that needed to be filled, but he was not certain when, or if, he would be seeing a dentist for a follow-up visit. He reported he managed his tooth pain as well as he could, "You know, I stick tissue paper or whatever to keep it closed (the hole in his tooth) cause there's a nerve down in there and I think it's live!"

Hank's experience with healthcare in the prison system was

more extensive than the other participants', if for no other reason than the amount of time he had served. He stated that he was able to give health history details to the medical staff and he thought that made him a more informed patient. *"You know, I can let them know that I had a similar problem when I was at \_\_\_\_\_ or \_\_\_\_\_ and they tried this medication or that. Or if they prescribed me some pretty good medications for it."*

Hank utilized both religious activities and meditation as part of his self-care. His professed faith was Protestant, *"I'm Baptist. I go to (church services) like once a week or so - sometimes it's only once a month. I always read the scriptures and I probably should be going more...but I don't know."* He further stated, *"You know I believe that God will at some point - will work things out. And sometimes I want to rush him to do...and that will get me down."* At the time of the interview, he had just completed a ten-day Buddhist meditation retreat, Vipassana, with a small group of inmates. Vipassana is a form of Buddhist meditation, which originated in India more than 2,500 years ago. The term means "insight" or "to see things as they really are" (Coppola, 2007). This program has been implemented at both Donaldson Prison and Hamilton A & I since 2005, as a potential method to reduce the number of incidents and disciplinary actions. Additionally, it was used as a potential smoking cessation program.

Hank described his thoughts about the retreat,

*I don't know if I could say I enjoyed it, but it was very interesting. It was like a vacation in a way - cause the only people you came in contact with was the guys who were the teachers and that people that brought you your medications.*

He further described the personal benefits of meditation,

*I even meditated before I participated in that - but what I learned was the technique. That was very effective to keep your focus - especially if you got the runaway mind! The part that they call Anapana - that keeps you focused and that's primarily what I use now to help me meditate. It has its good points.*

Less certain for Hank, was his post-incarceration future.

He knew that he was up for parole in a few years, but the actual parole decision would not be made until that time. Consequently, after spending the majority of his adult life in prison, he was less able to discuss what he might do in the 'free world.' He talked of wanting to rebuild a relationship with his adult daughter and maintaining the one he had with his sister. "It's (trying to rebuild relationships on the outside) *important you know, cause I grew up in a home where I didn't have a dad, and I always felt like something was missing.*"

*Vignette Two: Will's Story*

***"I don't plan on rollin' over and playin' dead!"***

As an African-American male in his late 60s, Will admitted that a poor choice in later adulthood resulted in his spending his elder years in prison. On the health status continuum, Will fell into the moderate care range: he had significant dental

problems and a recently diagnosed enlarged prostate. He was required to have a PSA (prostate specific antigen) test to monitor him for prostate cancer. He stated he did not have any medications or treatment for mental health problems at the time of the interview. By his self-report he thought he would be at least 81 years old by the time he was released. This did not deter him from having a positive outlook on the future: *"I think there is a lot of living, a lot of living left to be done."*

Will had been incarcerated at Hamilton A & I for over eight years at the time of the interview. In the 'free world' he had worked for many years as an electronic technician for a large automobile corporation. His self-reported health was *"reasonably good. You know I am able to get out and walk about 4 miles a day, and I work out with the weights too."*

He noted that had he not gotten involved in certain activities on the 'outside,' he might be in better health than he currently was. He was unable to describe specific health concerns he had in the 'free world,' but described several health problems he had encountered in prison: frequent dental problems, an enlarged prostate, and vision problems. His dental issues significantly affected his speech at times during the interview, however, it seemed that he had learned to cope with this situation. Will's overall view of the prison healthcare system was generally positive,

*"Well, they are friendly enough, and I guess it is alright, and I never had any problems, except for when I need to get things done!"*

A distinction Will made was that although he had been in the prison system for several years, most of his interaction with the prison medical services had been since he had moved to Hamilton A & I. At the time of the interview, he was having regular interactions with the medical staff about an enlarged prostate and ongoing dental problems. He stated that, although he was seen by the medical staff frequently, he was not always certain why he was being treated.

*It's kind of hard (not knowing all the medical information). They woke me up at 12 o'clock at night to come up to the infirmary and I go up there and they say we got to draw some blood. That's all I know. They got some blood, told me I could go back to sleep. (laughs) I don't know why they drew it. I don't know what the results was or anything.*

Bracketing: This is consistent with the elder prisoner research in two areas. First, research suggests that older prisoners require more frequent and more involved medical care than their younger counterparts (Aday, 2003). Secondly, researchers have noted that elder prisoners have expressed dissatisfaction with medical service provision, medical service information, and the responsiveness of healthcare providers (Aday & Nation, 2001; Schaefer, 1998).

In my observation, there is some debate about the notion of provision of healthcare information. The prison operated more in

a nursing home, medical-model approach, so on the one hand, from a clinical perspective I could understand a prisoner-patient having a medical procedure at what might seem like an unusual hour. The other side of this issue, however, is the question of whether the men are actually receiving information about their healthcare. This could be a perception issue, a communication issue, or a time issue.

Social interaction and social support were important to Will. He shared a dorm unit with six other inmates. He described this as a positive part of his life in Hamilton A & I, *"Let's just say I wasn't exposed to this (a dorm setting) in other camps."* When asked about how this was different, he stated, *"Well it's pretty good. The group that we're together, cause everybody gets along and somebody's always joking, telling a joke."* He noted two of his roommates appeared to have worse health problems than he did, but that they all helped each other out when they needed assistance.

His family consisted of an adult daughter and son and several grandchildren. He stated his contact with them was monthly by phone and that they wrote letters frequently. Will's face brightened as he talked about his extended family. When asked about their involvement in his healthcare, he stated he told them general information, but that he thought they understood what was happening with him. He had concerns that his

time to communicate with his family was quite limited, and he did not choose to spend that time discussing negative issues. He spoke at length of his relationship with his son and his hopes to maintain this relationship when he was released.

Another important aspect of Will's prison life was his involvement in the church activities. He acknowledged that his religious beliefs and group involvement were important to his coping while in prison. He stated that there were three to four weekly church activities (from various denominations), but *"nobody is as regular as the Protestant church."* Every Sunday he led a Bible study class and he appeared to have quite an interest in talking about and preparing for his class. At the time of the interview, his group had been discussing the breakdown in the Protestant church over doctrine and views about homosexuality, *"There's a lot of splits on this, and a lot of discussion there."* His involvement in this group allowed him to spend purposeful time to read and prepare for the group discussions. He appeared to enjoy the variety of opinions on the change in religious doctrine, and looked forward to the weekly meetings.

Similar to another participant, Will had private health insurance in the 'free world' along with a retirement income. He noted he was Medicare eligible prior to his incarceration.

*"I have ah, a health insurance outside, from*

\_\_\_\_\_ (large company). After this (period of incarceration) I don't know how it's gonna work out (laughs) but I think we still have it. Man, I was on ah, Medicare, so I would have that. So, it's pretty well set I think. Plus I'm retired military too so, so I've got a few options that I could take."

Bracketing: Federal programs such as Medicaid and Medicare are automatically discontinued for an individual upon incarceration. Private insurance coverage, however, is a different situation. I spoke with a consumer representative with the State Insurance Department of Alabama about this issue. Private insurers have the option to have a coverage clause that can 'restrict' the parameters of coverage, but coverage cannot be cancelled simply because a person is incarcerated. If a prison inmate has an arrangement for a person on the 'outside' to pay his premiums, then personal coverage can continue. The representative noted that the restriction of coverage might include denying a claim if one were made, or that the terms of coverage might be restricted. He stressed that this would be a case-by-case situation, as there was not one general statute that governed what private insurance companies could do if an insured person was sent to prison.

Based on my conversation with Will about this issue, I believe it was important to him to see himself as a person with

a 'free world' life, and maintaining his insurance on the outside, whether it was practical or not, reminded him he was not going to be in prison forever.

Will stated that he often thought about what he would do when he got out, "*I think there's a lot of living to do be done.*" He considered himself fortunate because he thinks a lot about getting out and what he will need to do when that time comes.

*Vignette Three: Hubie's Story*

***"There ain't a day passin' that I don't pray."***

Hubie represented a segment of the older inmate population that is on the rise: the first encounter with the prison system as an older adult. At the time of the study, he had served three years of his sentence, and by his self-report, still had 10 more years to serve. In the 'free world', Hubie was retired from military service and had worked as a farmer and rural preacher in his small southern community. On the health status continuum, Hubie was in the minimal care range: he had age related health problems (described below) and had infrequent visits to the infirmary for self-described 'back and stomach problems.'

Hubie's appearance as he walked into the interview room was that of a frail, thin, nervous man. His physical appearance was much older than his stated age of seventy-five. He was a

European-American man who had closely cropped white hair, a wide but wrinkled smile, and it was easy to see that he was missing several lower teeth. Throughout the interview he exhibited repetitive hand motions, nervous blinking, and was constantly wringing his hands as he spoke.

He entered prison with several age-related health problems (hearing loss, vision loss, dental problems) and had developed some new health concerns since his incarceration; some appeared to be specifically related to the stress of his imprisonment. *"Well my health is pretty fair, you know it's not great - but pretty fair."* He said that most of his problems in prison had to do with his stomach and his back, *"It's the little sick problems. You know my stomach and my back give me trouble pretty much and I go to the doctor for it, and they doctor me"* He could not recall if he had been diagnosed with a mental health condition, and did not report taking any medications for anxiety or depression.

He was able to distinguish some differences between care he received in the 'free world' and in prison.

*When I was on the outside, I got signed up to the VA and they would doctor me. Every time that I needed them and I call they got me the appointment. They give me glasses - they just took good care of me. You know if I was on the outside, I could still go."* While in prison, *"They can do some of the same here. I had my eyes checked and the doctor he give me a pair of glasses. But he said my right eye is in real bad shape, but he didn't set no date to fix it or nothing."*

In general, he gave the healthcare system at Hamilton A & I praises,

*They (the nursing staff) take care -well, I can say this much - they are taking care of the people here. They's just real nice to you! They got several nurses here and a head nurse that work here. Well, they all - they are really nice to you.*

He described his personal experiences with the healthcare staff as very positive.

Bracketing: My interview with Hubie was one of the longest interviews I conducted, and this was due in no small part to some of the difficulty he had responding to very specific probes about his health circumstances. He spoke in very general terms about his health, and I noticed over the course of our interview session he repeated stories (his war history) and information several times. I did not have access to his mental health records, but from my years of experience of working with older adults in an institutional setting, I surmised that Hubie was in the early stages of some form of cognitive decline.

Even though he had been at Hamilton A & I for three years, during the interview Hubie noted at times he was still adjusting to the prison environment, *"Well, it's different being in prison. Locked up, it's a lot different. It's not as feeling, you don't feel as happy as you do on the outside. I think about it a lot."* He continued to refer to his experience as his first time in prison, *"Yes ma'am - that's what makes it different."*

*Being all locked up and never had been in jail before. Just (long pause) - well, it's just messed up.*" He expressed genuine surprise, however, when he reflected on his experiences in prison, *"It sorta surprised me bein' in prison, you know, about inmates. I never have met whatcha' call a real bad inmate - cuss you out or nothin'. But they say they're out there (laughs) but I never met them!"* He mentioned frequently that he got along well with his 'bunk-buddy', *"Well, me and him, we used to work together on the outside, and he came in around '97. I got brought in about three years ago. We walk (around the outdoor walking track) all the time - some as much as five miles at a time!"* Hubie referred to both other inmates and the correctional officers as his 'good friends'.

Family was an emotional topic for Hubie. Several times during the interview, particularly when he discussed his relationship with his wife of over fifty years, tears would come to his eyes. *"... My people, well they been pretty nice comin' to see me. I told my wife - you don't have to come every time - just come when you can."* Although his brother and sister visited regularly, his wife had perhaps seen him only once or twice during his incarceration. *"My wife - well, this (Hubie's incarceration) just all hurts her, I mean it hurts her so bad. She won't talk about it. She would be pretty hurt over all of this if she talked about it."* His siblings, both in their

seventies, were dedicated visitors and remained Hubie's regular contact with the 'free world.'

Bracketing: For clarification here, the circumstances that resulted in Hubie's incarceration were particularly devastating to members of his family. Although our conversations were limited to his health, healthcare, and prison experiences, I noted as a clinician that his past behaviors had fractured some interpersonal relationships.

The subject that entered every part of our conversation was Hubie's faith. His strong belief in God and his connection with the Church of Christ were very important to him. His religious expression and interaction with the church were positive health and mental health coping skills. *"Even while I'm in here...I ask God to help and protect me. And I need him to give me health and strength."* He described his military service in the Korean War as another time when he felt lonely and sad and needed the comfort of his faith. *"I was telling (a correctional officer) the other day that it was so hard there, and I prayed Lord just help me get out - and I made it through."* Hubie stated he read his Bible often and attended church services and activities that were offered to the inmates, *"We have Bible study and preachin' about three times a week, and I go to every one of them!"* When asked how this helped him, he stated, *"I like to hear the word of God and that's why I go."* Hubie strived to live his life as

much like his 'outside' life as was possible. He described a strong connection and friendship with the pastors and volunteers who visited from the churches, "I got one preacher that comes in from Haleyville and we got to be good friends. He comes and he's just thrilled to see me! (laughs and has tears in his eyes)...and I'm thrilled to see him." Hubie was a self-described 'rural preacher' and he stated he depended on his family to maintain the church he served in their community.

*Vignette Four: Charles' Story*

**"A good soldier is an informed soldier!"**

Charles was one of the oldest inmates in the facility proudly nearing his nineties at the time of the interview. Yet his physical appearance, demeanor, and approach to life made him appear to be much younger than the other participants. He was a tall, sturdy European-American man and was enthusiastic about meeting with me to discuss his health and healthcare. He was the most verbal and affable of the prison participants. He was quite vocal in his opinions about what worked and what needed improvement in the facility. Prior to his incarceration, he had hobbies that were related to working outdoors and in the garden. Due to the somewhat unique setting of Hamilton A & I, Charles was able to utilize these skills, which benefitted him personally, and were a benefit to the facility, the correctional staff, and his fellow inmates.

Prior to his incarceration, Charles had a lengthy career in the military, serving in World War II and then working for many years as a civil service employee. His area of expertise was communications, and this came up frequently in our interview. In his younger years, he was a talented water-ski enthusiast, coach, and tournament judge. Charles was atypical in this case study, as he noted several times, "*money is no object,*" when discussing care needs and issues that might be challenging for an inmate with no personal financial resources. He stated, "*I have an excellent retirement on the outside and resources so I use them.*"

At the time of the interview, he was the prison's primary gardener and took care of the extensive and beautiful flowerbeds on the prison camp grounds. This was his primary source of work, relaxation, and time outside of the confines of the dorm unit. He estimated that if calculated yearly, he spent four to five hours per day gardening. He was quite proud of his work, "*If you think the flowers look good now, you should have seen them in their prime in early spring!*"

Charles had resided in the prison for just over three years at the time of the interview. By his self-report, this was his first incarceration, and he had been in the system for just over a total of five years with stays at two other facilities in the state, Kilby and Easterling. He stated that he entered the

first prison as part of the intake process.

Bracketing: Each male prisoner who enters the correctional system in Alabama first begins his incarceration at Kilby Correctional Facility in Montgomery. The intake process Charles referred to in his discussion is where an inmate is initially evaluated to determine what level of custody he will be given (minimum, medium, maximum). He is given a physical examination and a dental examination. This process may take up to ninety days, and then the inmate will be transferred to another facility or will serve his sentence in Kilby Correctional Facility.

Charles had a series of medical problems prior to incarceration. He described developing problems with cataracts after eye surgery and having triple by-pass, open heart surgery. He shared details about the touch-and-go process of his recovery: *"From the 20<sup>th</sup> of December until the 4<sup>th</sup> of January I was unconscious, and when I came out, the nurses called me their miracle patient!"* On the health continuum he would be considered the moderate level care patient. He did not report any mental health concerns and did not list any psychotropic medications.

He provided detailed information about the healthcare process from the perspective of an older adult who had access to consistent healthcare before he entered prison. He said that most of his problems from the 'outside' world had been

exacerbated by the 'inside' world. While at Easterling, he reported "The doctors had messed around with my Coumadin level, and I had to be transferred here (Hamilton A & I) as a chronically-ill patient." Additionally, Charles was hard of hearing, had limited physical mobility, had dental problems, and had suffered three bouts with pneumonia. At the time of the interview, he was recovering from a physical injury that had prevented him from gardening as much as he would have liked. After his most recent bout with pneumonia, he recalled this experience changed his blood sugar levels.

*The nurse told me she would put me on steroids and it would run up my sugar. They checked it some time later and it was up in the 400 range, which is god-awful! Cause your sugar should be in the 100 range. It is still messed up to a point. I have to take the first insulin shot recently."*

I inquired if he was a newly diagnosed diabetic patient. He asserted that he was trying to prevent that from happening,

*Well, the nurse practitioner seems to think I am, but I am determined it's not gonna happen. I watch what I eat and when they serve cake or something, I scrape off the icing. Then I don't eat those hard candies or anything. I watch carefully and try to think of what has high sugar content.* Charles did not have any children, but instead, considered

his nephew's sons (his sister's grandchildren) to be as close as children to him. He reported a close relationship with his nephew and the nephew's wife. He depended on them for regular contact with the 'free world,' and he noted that they maintained his home for him.

### *The Network of Care*

Cantor's (2000) model of social care describes the various social actors that influence and play roles in an elder person's life in terms of their care, social interactions, and well-being. This model describes the network of care as operating in a series of concentric circles with the older adult in the center of the model. For this study, the model included the following groups of people who interacted with the elder prisoners at Hamilton A & I: healthcare providers, correctional officers and staff, community volunteers, family members, and church pastors. To best understand the social care network model of an elder prisoner, specifically, one also must consider the correctional facility as part of the network. This section will include an overview of the prison and each group of social actors who are involved in an inmate's health and healthcare. (A diagram of the conceptual model is included in Appendix C of this document.)

#### *Correctional Facility and Healthcare Setting*

Hamilton A & I is the smallest prison camp in the Alabama correctional system. All correctional facilities in the state house nearly double the number of inmates they were originally designed to hold. The ADOC noted in FY2007 that the rate was 196.5% for the combined ADOC facilities, with most facilities well over 200% capacity. Hamilton A & I, a medium security

facility, was originally designed to house 123 individuals and in FY2007, the total occupancy was 291 or overcrowded at 236.6% (ADOC, 2007).

Hamilton A & I was built in 1981. The ADOC noted the average age of the prison facilities in Alabama was 25 years. The ADOC Prison Task Force Action Plan report also reported that "almost none of the facilities" meet the federal guidelines of the Americans with Disabilities Act, which was mandated under federal court litigation (ADOC, 2006).

The basic medical needs of the prisoners at Hamilton A & I were provided in the medical services office. There was a small infirmary for emergency and terminally ill patients. The ADOC acknowledged in the Prison Task Force Action Plan report, "the physical plant limitations of the institutional healthcare units do not allow for onsite long-term or advanced-care services" (pg. 3). At Hamilton, the infirmary area was able to serve up to ten bed-bound patients. The small clinic area was utilized for routine medical care and for nursing administrative work. Longtime healthcare provider Tonya noted,

*We have been able to utilize small space and small staff numbers to cover our inmates. We are, well, I consider us 'the nursing home' of the DOC". Hannah stated, "I think we get the sickest of the sick here, barring HIV or dialysis patients, they go to different facilities. But we get the paraplegic, bed-confined, and chronically ill patient.*

The prisoners' perception of the healthcare facilities echoed the issues of overcrowding and limited space. Hubie

noted, *"This here's what you'd call a small hospital for sick folk and older folk. You know that infirmary it's for those that's bedfast."* He hesitated to talk about the infirmary, as it was clear he associated the experience with suffering.

*"Well, some of 'em that's in the infirmary now got the cancer. One man, he's in there and he got where he couldn't talk, so they put one of them things right there (points to his throat, indicating trach tube was placed) and, you know he's just pitiful. It's just so pitiful to see them in there."*

Hank noted that having a camp with primarily aged and infirm inmates was a constant reminder that friends could die.

*I had a good friend that died about a month ago. We have been working together for a good while, and he got where he couldn't eat. Foods that he was eating, like toast, I was taking that to him from the kitchen. He got the diagnosis of cancer in his testicles, and after they operated on him, well...he just didn't recover.*

Bracketing: To better understand the care needs of the prisoners at Hamilton, I asked the medical care staff for a breakdown of the current care issues at the time of the study. There were 30 prisoners in the infirmary and the 'overflow' room (they required 24/7 skilled nursing care). Fifty-eight men required bedside meals, five were blind, ten had hearing aids, one prisoner was deaf, 80% of the population was described as HOH (hard of hearing). There was one quadriplegic inmate and ten paraplegic men. There were 25 men who were listed as partial CVA (had previous strokes), one cancer patient and forty-eight men in wheelchairs. The healthcare staff saw most of the men for

healthcare needs on a daily basis - either for scheduled pill calls, or routine care provision for hypertension and diabetes. According to my conversations with the medical care staff, the most common conditions in the facility was hypertension, followed closely by diabetes.

#### *Healthcare Providers*

Healthcare providers, primarily physicians and nurses, play a prominent role at Hamilton A & I. Aday (2003) notes that aging inmates have an increased need for primary medical care, and the treatment needs may be extensive. Medical services in state prisons are generally provided by contract services; in this case, a large correctional medical company had the healthcare contract for all of the prisons in the state of Alabama. The day-to-day healthcare is directed and supervised by a healthcare administrator who is a registered nurse, and nursing staff consisting of registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs). Physicians and dentists provide services on a rotating basis; there is not a full-time physician on duty at Hamilton. A full staff of RNs, LPNs, and CNAs, however, provide nursing care, around the clock. There are nurses who are on-call and work PRN or 'as needed' to fill gaps in the schedule when the full-time staff are on vacation or are sick. At the time of the study, a long-time RN employee had recently begun to serve as

the healthcare administrator for the facility. In our interview, she noted that she might normally work under a director of nursing, but that position was currently vacant. She and one of the other nurses I interviewed had been employed at Hamilton A & I for the majority of their professional careers.

Tonya: " *I have been here 20 plus years, well, soon to be twenty-one!*"

Alexa: "*I have worked my way up in the system here and this is my ninth year.*"

A nurse practitioner visited the prison four days per week, seeing from twenty-five to thirty patients per day. As noted in the definitions, a nurse practitioner functions in a collaborative role with the physicians and can diagnose and treat a wide range of medical needs. A physician arrived on Thursday and Friday, and he saw as many as forty patients each day. An eye doctor and dentist made visits each month.

There were medical procedures for the elder prisoner that could not be addressed in the correctional facility setting, for example, more complex tests or surgical procedures or more involved dental work. Inmates were sent out for scheduled visits to 'free world' physicians and dentists who provided contract services to the prison. This medical care process was consistent with other correctional facilities across the state. This was largely due to lack of in-house space to provide long-term or

advanced medical care as noted above.

Professional work in corrections healthcare is a challenging, yet rewarding, job. All the medical personnel described their positions with a great degree of pride. *"It seemed like a challenge, because institutional nursing was something I had never done before."* Tonya talked at length about the healthcare quality and how they were fortunate at Hamilton A & I to have high quality nursing staff.

Tonya: *"I feel that we deliver **good** healthcare - really hands-on healthcare because of our population. Because that is what is required here - this is what **our** type of inmates/patients require."*

Nursing care at Hamilton A & I is provided on a full-time, seven-day-per-week basis. The nurses are the primary caregivers, and they coordinate and manage all of the healthcare processes. When asked for a description of the day in the life of a corrections nurse, Tonya responded:

*Packed! We have between five and twenty sick calls we have to address each morning. We have 2-10 infirmiry assessments - which this is the patients that are really sick - and we go over them from head to toe every day. We monitor medications, vital signs, intakes. We have patients with trachs (tracheotomy tubes), IV's, and PEG tubes (percutaneous endoscopic gastrostomy tube) - and you know, these are the people we look really closely at.*

She took a breath and then went further in her explanation:

*You have maybe 10-15 chronic care patients - which this means high blood pressure, diabetes - that are seen. And we have to find out - are they taking their meds? What is their glucose level? What is their blood pressure? We do this **daily**...all of this.*

She gave this description some more thought and then stated that this was the typical weekday - and as there was no physician on Saturdays or Sundays (except for emergencies), the routine on the weekends would be slightly different. A full description of the nursing activities for a 'typical day' is provided in Appendix B of this document.

There is a distinct difference between corrections nursing and 'free world' nursing, and the nurses at Hamilton A & I highlighted the difference in their interviews. All nursing care takes place with a correctional officer present.

*Tonya: The hardest part of bringing a street nurse or 'free world' nurse and bringing her into this setting is security. Because you are used to (a patient saying) 'my head hurts' and that means you **do** something, or 'I have a fever' and you **do** something. Here you are monitored, you have to have security with you.*

Corrections nurses must change the focus of how they 'see' their patients in the prison setting. As Tonya spoke about working with the 'prisoner as patient,' she described how the nursing role changes in the institutional setting,

*But, in the prison system, they (prisoner) can't go somewhere else, you are their only link to the doctor. You are the only one that's going to see them today. So you (the nurse) have to learn to make these judgments about **why** they are seeing you today, and that's one of the hard parts of being a corrections nurse.*

An additional support to the medical team was a full-time, master's level psychologist who functioned not only in a professional counseling role, but also as a discharge planner

and as a connection to families of inmates and to the 'free world.' She coordinated early release plans for inmates who were terminally ill or in need of medical release due to complex medical problems. She designed and implemented the drug treatment groups and educational groups. She was instrumental in bringing a Vipassana Buddhist meditation retreat to the facility. She also conducted anger management groups to address mental health needs of the prisoners. When asked about how he would describe the psychologist's role in the camp, Hank responded, *"Everyone has to go through her to get the information. She does the social work, the counseling, the management and the drug treatment and ... (pauses and begins to laugh) ..You know, she really does a lot! She has a lot of paperwork to keep too."*

During my visit to Hamilton A & I the psychologist was working diligently trying to establish a GED program for the inmates. This, however, was no small task. While I was there, she had received word that it might be very difficult to set up as *"there doesn't seem to be anyone at a higher level that sees a value in this type of program for the men here (specifically addressing the older male cohort)."*

Bracketing: This comment in particular, really illustrated the complex nature of her work with the older prisoner population. The 'free world' does not recognize the value of care and

rehabilitation for older inmates. Much like the younger prison population, the older inmate may serve a portion of his sentence and then return to the outside community. The more supports that can be put in place for him while he is incarcerated, the more likely he will have a successful reintegration back into the larger society.

#### *Social Work*

There are no social workers employed at Hamilton A & I. During the interviews, the other healthcare providers acknowledged that a social worker would be an important member of the medical care team in the prison. A further discussion of this is included in Chapter Five.

#### *Correctional Officers*

Security is the primary objective in any prison, therefore, the largest number of employees at Hamilton A & I are the correctional officers. The hierarchy of correctional officers in the ADOC includes the following ranks: correctional officer trainee, correctional officer, correctional sergeant, correctional lieutenant and correctional captain (Alabama Department of Corrections, 2007). Once a correctional officer trainee achieves permanent status he or she becomes a correctional officer. After one year as a permanent correctional officer, the employee can be promoted to sergeant status. After three years of experience, an officer may be promoted to the

level of lieutenant, and the highest level of promotion is captain. At the time of the study, there were forty-two officers working in the facility, although there was official authorization to employ forty-six. The warden specifically hired one female correctional officer for the camp to be available for working with the women who came to the facility for visitation. All visitors must be searched prior to attending visitation, and she was assigned to work with female visitors to the facility in accordance with ADOC Visitation policy. The policy specifically states, 'There shall be no cross-gender searches' (p.11, AR303, 2006).

Hank noted his experience in other institutions made him more aware of the differences in his interactions with the correctional officers in this prison. *"When the Captain (the head correctional officer in the facility, beneath the Warden) came here, ooh boy he did some things and it all got straightened out! Things have gotten so much better. He's fixin' to go on the hill (to work at the state office level)...and I told him, 'I wish you'd stay a couple more years!'"* He described how inmates and correctional officers alike had difficulty with change, but how the change was managed was important. *"We had a hard time (when the captain came to work here), you know, it's hard doing something different than what you always do. They (correctional officers) get settled in what they do to run*

*things."*

Bracketing: I was able to observe officers, staff, and inmates interacting in the front area of the prison. It was apparent that although these correctional officers were authority figures, they were well-liked and respected by everyone. The general atmosphere, at least in this area of the prison, was congenial.

#### *Community Organizations and Volunteers*

The volunteer sector that serves the prison community falls under one of two types of work: representatives of non-profit organizations and church/religious organizations.

Several non-profit organizations in the state serve the needs of Alabama's prisoners and their families. The ADOC has a page on their website that provides current links to all available resources for inmates and families. I was unable to determine if this information was available in print form for individuals who did not have access or could not use a computer. Dedicated volunteers who are vocal advocates for prisoners do much of this work. Most of the services in these organizations are geared towards younger inmates who have families and children in the 'free world.' The Alabama organizations mirror those offered in other states. There is not a specific organization in Alabama that works only with elder inmates and families. However, there are several organizations statewide

that work with inmates and families: Aid to Inmate Mothers Program (Montgomery), SKIP, Inc. Community Resource Services (Montgomery), Alabama-CURE (Birmingham), The Center for Extended Families (Centre), and the Governors Task Force to strengthen Alabama Families (Montgomery).

One volunteer I interviewed for this project was a self-described inmate and family volunteer consultant. When asked to describe her current work, Lucia noted,

*I develop mitigating circumstances for capital cases and work with families who have members who were charged with murder. You know there is such a financial and emotional cost. There is a lack of resources for families and the phone call situation is very expensive.*

She acknowledged the stress of a family member's incarceration had multiple long-term costs.

*The current system is one in which the people are unwanted and this is the least effective approach to working with prisoners. This is a behavioral model that is destructive for incarcerated individuals and those who work with them. How intelligent is that?*

She noted the correctional system model encourages long-term financial connections (phone and medical expenses) to the system, "They employ a "company store" approach and the prisoner and ultimately the family are always indebted to the system."

The second type of organization, and often the most visible 'free world' organization that interfaces with the prison, is the religious organization. Faith-based organizations in Alabama include: The Ordinary People Society (Dothan) and The Alabama

Justice Ministries Network (Birmingham). The five religious organizations I contacted for this study had similar missions for their work in the prison setting: caring for an underserved and often neglected segment of society.

The church plays an active role in most prisons in the United States. It is likely that one of the primary sources of counseling and comfort for inmates is the prison chaplain. At the time of the interviews, the position of prison chaplain for Hamilton A & I was vacant. A much-admired, very dedicated chaplain had recently left the position, and there were no current plans to replace him. Given the population of aged and infirm men, this position was a vital one, and both the warden and the inmates were disappointed to see it remain vacant.

I was able to speak with clergy from four churches in the surrounding community who provided services to the prison. Of the churches that had websites, most had a link to their prison ministry services. The ministry services included faith-based educational programs, weekly church services, and weekend faith conversion retreats. The prison ministry coordinator from the Madison Church noted,

*Yes, our church provides weekly services and support to the prison. We see this as a call from God. ... You can see in the Bible where it clearly states what our responsibility is towards the prisoner, you need to see the verse in Matthew.*

The pastor with the University Church of Christ in

Tuscaloosa asserted that prison ministry programs were active in Alabama. *"Well, our church has twenty plus years in the Kairos ministry. This is a separate ministry in the church. It is composed of groups, comprehensive retreats and personal service."*

Bracketing: I was not familiar with the Kairos Prison Ministry and was able to obtain materials for the national organization that further explained what the group's purpose was. The mission statement noted *"The people of Kairos are called by God to share the love of Christ with those impacted by incarceration"* (Kairos Ministry, 2005, p.1). Specifically related to healthcare issues, volunteers provide support and prayer for inmates or family members that have experienced difficulties. The mission statement related this social support to their belief, *"The love of Jesus Christ motivates His followers to provide food for the hungry, drink to the thirsty, welcome to the stranger, clothes for the naked, and visits to the sick and those in prison"* (p.2).

Several denominations provided weekly religious services and a bible study. The services were similar to what might be available in the 'free world.' Hamilton A & I had a small chapel on the prison grounds that was utilized for religious services. Most church organizations shared a common goal of *"spreading the word"* or *"sharing the teachings of God."* The religious

organizations did put responsibility on the prisoners to create a shared community experience from these weekly or monthly services, *"We like to see these men take on the task of building their faith by having their own study groups."* The idea behind this was to create an infrastructure that might reach more men interested in religious teachings on a more frequent basis than the church volunteers could provide.

Just who is the volunteer in the community or religious organization? He or she may choose to volunteer their time due to a personal connection. One church volunteer noted, *"I have a family member in prison, and I know how rough that is. ... I have seen what prison can do to a person's family and they need the support of someone who has time and energy to give."* The volunteer may also serve due to a religious or spiritual calling, *"I believe it is my biblical duty to go (to the prison)."* and *"If you read the scripture, you see that we have a purpose we are fulfilling."* The mission to volunteer was described as an important one, in addition to the reason behind the participant's personal reason to engage in this activity. A volunteer in the Kairos prison ministry program said,

*It says in Matthew (Bible verse 25:35-37), 'For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me.'*

Churches and social support organizations provided support

to inmates and families. For the elder prisoner, the church was the primary outside presence that visited the prison. The religious organization and volunteers were supportive of the elder inmate in times of stress and healthcare challenges.

This support was connected to the 'mission' to 'bring brothers to God' and to provide a spiritual plan for the men in coming to terms with their mortality.

### *Family Members*

The family members of an elder prison inmate are the part of the network of social care who are the least well connected to the prisoner. They are restricted by distance, correctional policies, broken or strained relationships, financial burden, and physical health. Phone calls were the primary means of contact between family member and prisoner, because three of the four families of the inmates who were the center of this study lived a great distance from the prison facility. Several of the adult children or extended family members lived out of state and travel for personal visits was not a reasonable option.

Three family members of the five I approached agreed to be interviewed by telephone for this study. Broken or strained relationships had taken a toll on some. Family members who declined to participate in the study noted, "*This is a part of my life I don't want to discuss*" and "*We think it would bring up memories...too sad.*" The literature often describes the inmate's

family as 'the forgotten victims' of incarceration (Schwartz & Weintraub, 1974; Sharp & Marcus-Mendoza, 2001; Rikard & Rosenberg, 2004). For the elder inmate, the possibility of damaged interpersonal relationships is quite high. The social stigma of having a loved one in prison can contribute to fractured relationships. One family member noted, "*Who can you talk to about this (why a loved one was incarcerated and how a person on the outside feels)? You keep it to yourself.*" For others, the reasons behind the incarceration are painful and they have made choices not to be actively involved in the prisoner's life. In Hubie's case, for example, the reason for his incarceration appeared to have irreparably damaged his relationship with his spouse.

Financial burden or hardship was a concern for some family members. If a prisoner has a home or assets outside of prison, care of this property is the responsibility of family. Two of the men had developed arrangements with either an extended family member or an adult child to manage this. One family, however, had experienced a significant hardship with incarceration. Hubie's family had not previously had any connection with the prison system, and the stress of Hubie's imprisonment had created a financial burden for his spouse. He noted, "*Well, I told her (before he went to prison) that we got a little debt to pay and as far as I know she's trying to make*

*them payments. I told her not to send money here, but make sure she pays them debts, you know!"*

Hank's family situation appeared to have repeated a pattern from his early years. He talked about growing up in a home with no father, and about the challenges that presented for his mother. *"I grew up in a home where I didn't have a dad, and I always felt like something was missing."* Having spent most of his adult life in prison, he saw the pattern repeated with his own daughter, who is now in her thirties. When asked if he saw himself in her, he responded, *"Yes, I do! She can be real stubborn, but I can understand that. I can understand her anger - now, I don't like it, but I can understand it."* Phone calls and the occasional letter maintained his relationship with her. He was not comfortable with his family visiting him in prison. *"It's a hard deal to ask, really, to ask your kids to come in here to see you. It's rough in here."* He expressed optimism about his relationship with her in the future, *"I understand where she's coming from (being angry with him) but I'm hoping once I get out that I can gradually build a relationship with her."*

Hubie's family did not have the challenge of distance because they lived in a nearby community. However, the devastation to the family due to the reasons for his late-life incarceration prevented him from having much contact with his

spouse and adult children. He did maintain regular contact and visitation with one of his sisters and a brother-in-law.

However, their age and personal health problems interfered with visitation at times. *"I got one sister about my age, and she is retired. She's gotta husband in pretty bad shape, and she can't come (to visit) as much."* These personal healthcare needs often prevented them from being consistently involved in Hubie's life.

Charles had daily contact by telephone with extended family members. He freely acknowledged that this type of contact was a luxury, because prison phone calls are generally prohibitively expensive for most inmates and families. Charles noted he had personal savings and resources on the outside that allowed him to purchase phone calling cards.

Will also had a supportive family relationship with his adult children. He described them as successful and very involved in their own lives and families. His primary contact with them consisted of letters and monthly phone calls.

Three of the men were adamant that they preferred their families not visit them while they were in prison, even if the option were available. They talked about the environment and expressed that they did not think it was a good environment for families to visit. Hank stated *"It's a hard deal to ask your kids to come in here to see you. It's rough in here."* Charles was emphatic about family visits, from a safety standpoint, *"I*

*don't want any of them to come to visit. Because, if anything happened to them I would always feel the blame and I wouldn't have anyone to do anything for me (on the outside)."* Healthcare staff stated they believed family visits were a positive experience for those inmates who had family connections. Neither healthcare providers nor correctional officers noted a safety issue for family visitors. The ADOC has structured guidelines for visitors that minimize potential risks for staff or family members. For most of the families, travel expense and distance were the primary reasons they did not visit. For some family members, however, emotional distance was also expressed as reason visitation and contacts were limited or non-existent.

*Part Two: Weaving Stories into a Common Thread*

This study had four broad, general research aims:

1) To explore how prisoner health and health care was affected by changes in the prisoner's health and functional status; 2) To explore how family awareness and involvement affected prisoner health and healthcare; 3) To explore the influence of policy on prisoner health and healthcare; and 4) To explore the influence of the larger societal discourse on prisoner health and healthcare. In this section, I discuss each research aim as part of a cross-case analysis in an effort to present an in-depth picture of health and healthcare for older inmates. Participant responses and my personal bracketing notes are included in each

section to further illuminate the categories of interest.

### *Changes in Health and Functional Status*

The first research aim reflected upon the elder prisoner's changes in personal health and functional status. Specifically, I explored issues surrounding access to care as an inmate's level of need (ability and/or disability) changed; how healthcare needs were determined and what services and programs (food, exercise, social networks, spiritual support, and emotional support) contributed to better health.

Two conclusions were obvious when the participants discussed access to care issues: a) The prisoners stated the healthcare process on the 'inside' was difficult to navigate and understand; and b) The healthcare providers stated that 'care' was provided under very different circumstances than in the 'free world.'

When the prisoners were asked to discuss who helps them understand how to navigate the system when they have a health concern, most described the length of the process of getting things done. Hank understood his diagnoses, and knew what to expect of the medical care system. He explained the process for a diabetic patient, *"I'm a diabetic, so I am supposed to get checked - yearly, and they give you that. But I also get my blood taken every 90 days to check my cholesterol levels.*

Bracketing: To clarify, in the conversation with Hank about his

diabetic care and medical check-ups, he was discussing the scheduled, yearly exam that was provided to him. He described this examination as being 'specific' for a diabetic patient. This may have actually been his yearly physical, which the ADOC is required to give all prisoners. As a diabetic patient in Hamilton A & I, he would have daily blood sugar 'finger-sticks' to monitor his glucose levels.

The men concurred that getting regular and emergency dental care was one of their biggest concerns. Researchers have noted that appropriate dental care in the prison system nationwide has been difficult to access (Lindquist & Lindquist, 1999; McGrath, 2002). Eight of every ten inmates (state and federal combined) had sought dental treatment (Bureau of Justice Statistics, 20078). Hank laughed and stressed an obvious point that was echoed by all the men, *"I mean, you know, it's hard to live with dental problems! I am sure you know that. It's not a good situation really."* Will had been waiting for a follow up dental appointment,

*Well, they ah, usually send you out to a dentist, but it's not very, I'll be honest, it's not very good here. Ah, I've been trying to get a partial now for, I'll say since October last year and I'm still waiting. They did um, one impression two months ago, and I haven't heard anything since."*

Hank stated he preferred going outside to the 'free world' dentist, *"I can relate to that dentist. I know when I go downtown that those people will explain everything they done and*

*their attitude is pretty good. And they don't act up."* It was clear from the interviews that the prison system did not put a high priority on dental care for the prisoners. This was due, in part, to the limited availability of a dentist to treat patients in the facility. When an inmate needed to be treated off site for his dental needs, the prison system had to coordinate with a 'free world' provider, and arrange transportation and security for the trip. This, as the ADOC acknowledged in its annual report, was quite expensive and used considerable time and manpower (ADOC, 2007).

Hank added that if a choice were available, he would prefer a 'free world' medical care service. After thinking about this statement for a few minutes, he further asserted, "*You know, we done had some really good doctors here, but for some reason they don't stay. Well, they stay awhile and then... then, they don't stay any longer for some reason.*"

Access to healthcare changes as an inmate's level of need (ability and/or disability) changes while incarcerated at Hamilton A & I. The healthcare providers also discussed the changes in groups of inmates as they were transferred in and out of the facility. According to Tonya:

*Each time, or each chain (a new group of inmates coming into the facility) is different. You get new inmates in and you don't know their needs right off. You screen their jacket, you follow them for things like 'are they compliant with pill calls? do they comply with their insulin regime?' or whatever it is. You learn as they stay here, but sometimes*

*the turnover is fast and you may not learn a patient's needs. Ones that have been here a long time, you know them pretty well, and you know what to expect. 'Frequent flyers' we call them!*

The healthcare providers stated that there was more than one way to consider the notion of a 'typical' elder prisoner in the facility. Alexa, the healthcare administrator and a registered nurse, described the physical characteristics and the familial experiences,

*Umm, well there is the tattoos, you know if they have lots and lots of tattoos you can tell they have had a hard life. You know it's not that they LOOK older than 'free world' people but it's just that they look like they have had a harder life. You know, not just on the outside, but really the inner - I'd say inner, they act a little differently. Some of em, you know it just depends on how they, well, you know, their family experiences, I think. Even before they get put in prison, I think family life shapes a lot of how they are now in prison, personality-wise.*

When asked to consider the elder prisoner specifically, she noted, "I don't know if you could have a typical older prisoner as they age, they all have different needs." Tonya agreed with this assessment and wanted to clarify this by relating the discussion to 'free world' elders, "They are not typical because each one of us represents how we took care of ourselves. What our family history is medically and what we are doing about it now." Alexa added that there were many similarities between the elder prisoner and older adults on the outside, "Yeah, you know, the aging process is really similar to 'free world' people. You know that's what we call them, 'free world' people. (laughs) I think it is probably really similar."

When the men were asked how they thought healthcare needs were assessed, Hank expressed that he thought needs and programs were determined based on an inmate's age, *"You know, a yearly exam is scheduled for all of us, but it depends on your age (what other types of services they provide). And, at my age they give me an EKG, urine tests, blood tests, check my proteins and do eye exams."* Charles and Will thought that needs were assessed during the yearly physical that was required for all inmates.

Hamilton A & I had many advantages being a smaller facility, and those prisoners who had spent time in other prisons were quick to point this out. The facility did provide fresh food, opportunities for exercise, social and spiritual support, anger management programs, and emotional support programs.

The prison had its own vegetable garden, which provided fresh, seasonal vegetables for the inmates year round. Charles' comment was similar to those of the other men on this issue: *"Well, I will say this, the food is better here than other places."* Being able to eat homegrown vegetables contributed to the men's health and sense of well-being. The healthcare providers noted that dietary guidelines were developed by the ADOC for the entire prison system. Addressing dietary needs for the elder prison population presented a challenge, as they might have contraindications with certain foods. For example, Charles

was taking Coumadin (an anti-coagulant), which has specific dietary guidelines to avoid green leafy vegetables. He had to avoid collard greens, which appeared regularly on the menu, to keep his medication regulated appropriately.

Both the correctional staff and the men noted that the more able-bodied prisoners took advantage of an outdoor walking track and workout area for physical exercise. Although Will described the walking in circles as somewhat monotonous, he noted that to stay healthy he took advantage of all he could participate in. *"And I mean working out and I really like to try to keep my mind active, so I mean it's, I really feel, I feel good. I don't think I'm aging that fast."* Hubie also walked daily and described the benefit of having a walking partner. Hank worked out when he could, and Charles used his gardening activities as his primary source of exercise. Tonya noted that if there were funds to improve the facility in this area, she would like to see more options for the disabled inmates. *"I would love to see a covered area outside, where the elder inmates could go out and get some fresh air or whatever. Currently, there's nowhere for them to sit in the shade."*

The correctional staff psychologist was an advocate for the elder prisoners in terms of social and emotional support. She had coordinated educational programs, anger management groups, psycho-educational support groups, and the yearly Buddhist

meditation retreat. She had little to no funding to support these services, and was constantly looking for ways to expand opportunities for the inmates that were inexpensive or free.

Finally, due to the specific care needs of a primarily aged and infirm population, Hamilton A & I was structured differently than other prisons in the state. In many respects it appeared to be more like a nursing home setting than a traditional prison. It was the only prison in the state to have air-conditioning throughout the facility.

Charles: *"Well, I think the most positive thing about this place has GOT to be the air-conditioning! No way to go without air with all the sick people. That's the biggest plus."*

Hubie: *"This prison here - this ain't like other prisons. Inmates tell me that other prisons is different. This here is what you'd call a regular hospital for sick folks and older folk."*

Will: *"This is only camp with air-conditioning. The living conditions are a lot better here."*

Bracketing: Each participant discussed the air-conditioning in the facility. The prison camp is required to be air-conditioned due to the aged and infirm population. In my documentary research, as I visited the ADOC website, I noticed under the 'frequently asked questions' section that "Are the state prisons air-conditioned?" was one of the top questions. The American Correctional Association suggests summertime temperatures in state prisons should range from 66 to 80 degrees. Nationwide, however, most prisons are not air-conditioned.

### *Family and Peer Relationships*

*Family relationships.* The second research aim considered the awareness and experience of the family member of an elder prisoner. Through the interviews I explored the level of

involvement an inmate's family had in the inmate's healthcare process. Additionally, I inquired about the healthcare decision process and how the family was involved, if at all.

Family is a complex topic to consider when working with older prisoners. Many of the inmates have been in the system for long periods of time, and interaction with family has dwindled or has stopped altogether

The families that are still involved have little, if any, input or knowledge about day-to-day healthcare needs of the prisoner. Charles had the personal resources to be able to contact his family members every day by telephone. He was by and large, the exception to the rule in terms of communication with family members.

Charles noted: " I talk to \_\_\_\_\_ (family members) almost every night of the week. They know what is going on with me (health concerns), but they mainly take care of my needs on the 'outside.'"

Hubie: "Well, I tell them how I'm doing when they come here. Every time I go to see the doctor, I tell them about it."

Family ties can be easily strained due to first-time incarceration as an older adult. Marriages are damaged and relationships with adult children are fractured. In many cases, an older spouse must take on the burden of the household, in addition to other duties. Hubie's family was devastated by his late-life incarceration:

Hubie: *We got a farm and she (my wife) takes care of that, and she takes care of her sister who's sick. And since I got in, she don't stay home much. I don't talk to her much. She don't have time to come here.*

The other end of the spectrum is the damage to the family relationships from long-term incarceration. Hank noted that he came from a small family and many of the extended family members had died since he had first been incarcerated. He did maintain phone contact with his younger sister, and some contact with his adult daughter.

Hank: *"I have a sister, but you know, most of my people have been deceased since I've been locked up. My sister's a couple of years younger than me."*

One area of inquiry I focused on during the interviews was the involvement of the inmate's family (prison family or outside family) in healthcare decisions. Three of the men stated that they did at least have conversations with their families about their health and healthcare decisions. This was largely informal:

Charles: *No, I don't have a living will or anything like that, but I try to let them (family members) know that I don't want to be put on any machines. But since they have power of attorney, they know that all my burial plans are in place. Everything is taken care of. In other words, I'm not going to cost a cent to a soul when I leave!*

Hubie: *"If there was something bad to happen, then they gonna see about it. They (siblings) say if they's anything we can do and they send me money."*

Hank's experience, however, was quite different, perhaps due to the length of time that he had been in prison.

He expressed regret about how his incarceration had impacted his ability to talk with family members' about his healthcare.

*Hank: That's one thing we really don't never talk about because I really..(long pause) I'm older than my sister and she always looked up and depended on me. But she had to go through her whole life without me being there. And just to think about that something might happen to me and she would have to do the same thing she did for my mom (provide caregiving and make medical decisions) and we just hope that one day I'll be out there. And there's the possibility it won't happen like that...We just stay away from that subject.*

Correctional staff and healthcare providers described the value of family involvement, if it could be arranged, for a terminally ill or dying inmate. They acknowledged that this was not always an option, especially for someone who had been incarcerated for most of his adult life, but that it could be a very positive support for the elder inmate.

*Tonya: "We could save the state money by doing that. Doesn't he get the same kind of care if that prisoner has family members that are ready, willing and able to take care of him?"*

Bracketing: During the interviews, there was discussion of the need for a formalized process and/or policy for compassionate release that specifically addressed the elder prisoner. The medical care staff and psychologist noted it was not an easy task to accomplish, yet there were clearly men in the facility who might have been best served by the compassionate release process. There had been attempts to create a policy to address this issue, and as of February 19, 2009, Administrative

Regulation 708 was formally established. According to the ADOC: "It is the policy of the ADOC to allow medical furloughs for certain geriatric, permanently incapacitated, and terminally ill inmates who meet the eligibility requirements as authorized by Alabama State Statute Act No. 2008-550 and approved by the Commissioner of the ADOC" (ADOC, 2009, p.1). Further, the policy has specific language that acknowledges the elder inmate:

"Geriatric Inmate: A person 55 years of age or older who suffers from a chronic life-threatening infirmity, life-threatening illness, or chronic debilitating disease related to aging, who poses a low risk to the community, and who does not constitute a danger to self or society" (p.1). I believe this development in corrections policy is a step in the right direction, and I am hopeful this policy will assist the appropriate release of the terminally ill inmate.

The healthcare providers and correctional staff acknowledged the institutional barriers to family involvement in the healthcare process. Correctional policy prohibits family members from accessing health information about the elder prisoner. Even in end-of-life circumstances, families have very little input or involvement in the prisoner's healthcare. This can be stressful for the healthcare staff, inmates and families.

Tonya: "We have very limited interactions with families, usually they are directed to the ADOC or to the facility healthcare administrator."

Alexa: "Well, here, I am the only one allowed to talk to the families, none of my nurses can. So..anytime a family call comes in I have to deal with it. On top of everything else, I have to stop what I am doing and talk to them. And, I want to be able to tell them what's going on and help them feel like they are getting what they need to feel like part of that family member's last days and to understand whatever is going on with them. But, in the chaos of the day...you never know what's, well, how it's going to play out.

Overall, families of the elder prisoner face significant challenges to maintain contact with their family member. Due to the correctional system, emotional and physical distance, families were not involved in the inmates' healthcare process.

*Peer and 'inside' relationships.* In many cases, if marital or biological family relationships are strained or nonexistent, supportive relationships are formed in the prison setting.

Overall, the men concurred that given the amount of time they had to think about their health, it was often a topic of their conversations with the other prisoners, correctional staff, or healthcare staff. Hank noted he could talk with others in a general sense about his health. "I got a couple of close friends back there and we will talk about it." He did make the distinction that this conversation was mostly informal, "We'll talk about going and seeing the doctor. And you know, you just don't tell a lot of people about your stuff in here."

Additionally, Hank would talk to the staff psychologist about

his health concerns; "She's real smart on a whole lot of things. So if I tell her something (that bothers him) she will give me two or three scenarios to look at, and I can kinda line this thing up against that."

The nursing staff in particular discussed how inmates relied on each other in a familial role.

*Alexa: Oh yeah, a lot of them do . You see a lot of the families won't have anything to do with them. And when they have been in prison 25-30 years and their family hasn't had anything to do with them - well, that other person (the inmate) becomes their family. That is even if they haven't known them but a year or two - that is because the inmates have transferred around from place to place. And sometimes, the younger guys will befriend the older ones and try to take care of them and help them. And I think this is a good thing.*

*Tonya: Lots of times, yes, they help each other out. At this camp it is unique, given the age population. For example, Joe has been there with them since they have been here (in prison) and they want **him** sitting by the bed if they were in a hospice situation. Not necessarily the person who might be working there. They would rather have the person that shares their interests and who they are used to being with.*

Prisoners' peers appeared to function more in a familial role than biological or extended family for the elder prisoner. Particularly for those men who no longer had contacts with family members due to death or distance, the peer relationship provided a source of companionship.

### *Influence of Policy*

This research aim provided an opportunity for me to examine the impact of policy on the prison healthcare process.

Specifically, I wanted to explore how policy affected the design

and implementation of prison healthcare for the elder prisoner. I wanted to examine how the participants perceived the healthcare policies, and how the policies have evolved in the Alabama prison system.

In order to gain some understanding of the current prison healthcare policies, I believe it is necessary to explore the historical context within which the prison system in the state of Alabama is located. In 1974, landmark case *Newman vs. Alabama*, was the first time the federal district court ruled that the healthcare delivery system in Alabama prisons was unconstitutional under the Eighth Amendment (Freeman, Gollub, Wolski, Gshwend, Hawthorne, Golden, Kelly, 1981). The court mandated changes to prison medical care and guaranteed the constitutional rights of prisoners to receive appropriate healthcare services. The state of Alabama was ordered to develop comprehensive policies and procedures for the improved delivery of medical services to the inmate population. The correctional system opened a segregated unit for HIV-positive inmates, and a facility for inmates who required dialysis services. The Hamilton Work Release Center was closed, and re-opened as Hamilton A & I. In May 1981, the aged and infirm inmates from Kilby Correctional Facility were moved to the new location as an effort to address the specific medical and care needs of the elder and infirm prisoner.

Institutionalized settings, such as prisons, are heavily dependent upon policy to guide the day-to-day processes of the facility. The ADOC has specific policies that address the format and content of inmate medical records, medical visit co-pay (at the time of the study this was \$3.00 per medical visit) and right to treatment, inmate mail, phone calls and mental health treatment plans.

The participants' perceptions of healthcare policies varied. Prisoners had a great concern that the prison policies concerning their health needs were designed to keep them from knowing exactly what was happening.

*Charles: There is one thing that needs to be looked at...they do not inform the patient about the tests and so forth. They made a blood test on me and then changed my medications. Well, then you don't have any idea what it is! And you don't know why..and that is what is wrong.*

*Will: If you don't they won't say anything and a lot of the time you have to go two or three times to really get any kind of satisfaction (about your problems). That's the only thing, one of the things that I really don't like about it, because they won't tell you anything. They act like it's a secret...And a lot of the time they prescribe to the, they don't try to correct the problem. If you got a pain, they just give you something to kill the pain, but they don't try to find out what's causing the thing.*

Bracketing: The issue of adequate, appropriate and timely medical information for the prisoners came up several times in the interviews. How and what information is communicated to the men appears to depend upon the circumstances of the medical service and the person providing the medical care. If the men

are in line for the pill call, for example, they are standing with large numbers of other inmates waiting for medications to be administered. In this situation, the amount of time a nurse would have to provide information would be extremely limited. Conversely, if the inmate has a scheduled appointment to meet with the physician or nurse practitioner, there may be more time allotted to educate him on the medical procedures and prescriptions.

Correctional healthcare staff follow specific policies in providing care. Security guides every part of correctional work. Tonya discussed the process of transitioning from a 'free world' nurse to a corrections nurse earlier in the social network of care discussion. She further commented on this issue: *"Well, the patients here , a lot of them do have a goal of going home because they are 'life without' (sentenced to life without parole). This changes your focus of providing care."*

Although the nurses and medical providers were giving 'care,' the institutional policies reminded them that they were working with prisoner *first* and patient *second*. The prison healthcare staff see their patients according to ADOC guidelines and the care is structured to fit the correctional system. Essentially, healthcare is supervised by a correctional officer at every point of the process, from the most routine medication administration to a more personal, physical examination.

The Alabama Department of Corrections (ADOC) has specific confidentiality policies, which dictate how and what healthcare information is shared with the prison inmate and his family. At the time of the study, a specific policy, 'Confidentiality in Mental Health Services and Mental Health Documentation (A.R. 604)' was under review and was not available for further exploration (ADOC, 2007). This issue illustrates how policies can potentially create a disconnection between institutional caregivers, prisoners, and families. The healthcare staff explained policy enforcement and interpretation of policy guidelines,

*Tonya: We have very limited interaction with families - usually they are directed to the DOC or to Mrs. \_\_\_\_\_ (the head nurse for the facility). We see them if it's a special circumstance and the patient is very, very low. And all we do is support care for the family. You can't really disclose information. You can give them 'He's been stable today' or 'he hasn't..' maybe he's had this problem or that problem, but you can't really go into the detail like you would in the 'free world.' 'Cause that information has to come from the ADOC.*

The men shared that the correctional policies that governed how and when they were able to communicate with family dictated much of what they felt comfortable sharing with family members about their health. In general, the time allotted to visit with or talk with someone from the outside was so limited that to discuss his or her personal health seemed counterproductive.

ADOC Inmate Phone Service policy noted, phone call privileges were scheduled as follows: Sunday through Thursday

the phones are available from 8:00 a.m. to 10:00 p.m.; Friday and Saturday the phones were available in the 8:00 a.m. to 12:00 p.m. timeframe. Further, the policy stated, "All phone calls are recorded and the duration of a call is fifteen minutes. The inmate is allowed to make a collect phone call from an approved list of call recipients." (ADOC, 2005).

According to the ADOC regulations for visitation (AR303), an inmate is allowed to have eight approved visitors on a visitation list. Visitation is typically scheduled in a four-hour block two times per month at the discretion of the warden. Family members are expected to spend a certain amount of time registering and having their person and belongings searched (ADOC, 2006).

Given the rules and regulations that govern the family contact process, conversations about their health were limited to less formal discussions, as Will explained,

*Interviewer: "So, when you talk to them, is that a question that comes up, 'How are you feeling?'"*

*Will: "Oh yeah. Yeah. I talk to my daughter regular. She writes. She always, she's always asking about how I'm doing, you know. She keeps her close check on me."*

Hank limited the information he shared with his adult daughter and his sister perhaps related to the burden placed on the family. He explained that he did not talk with his family about health issues because this placed a financial and emotional burden on them. Additionally, he noted phone contact

was required to be a collect call placed through a prison phone company provider, which was a deterrent. *"When I call my sister, it costs about \$8.00 or so (long distance and in-state) that can get expensive if I call regular, so I make a point not to."*

The correctional system in Alabama utilizes a medical co-pay system for prisoner-initiated non-emergency services. The policy (A.R. 601) was established to reduce overuse and abuse of medical services (nursing, physician, dentist, etc.) and to promote inmate responsibility for their own health (ADOC, 1996). The policy further states an inmate will not be refused services based on his ability to pay. The fee of \$3.00 is either deducted from the prisoner's account, or the account is charged for the fee and the money is withdrawn when funds are available.

As Tonya noted in her discussion of the 'frequent flyer,' the prisoners do not tend to see this policy as a deterrent to requesting medical services. In fact, it appeared that the policy had two consequences: prisoners continued to utilize the healthcare system at a high rate, and prisoner accounts had many charges for medical services. If a prisoner experienced a lack of satisfaction with a healthcare visit, he would sign up for the next available sick call slot. This might occur several times before the inmate received either satisfactory treatment or healthcare information. For an elder inmate such as Charles, with personal funds to cover needed expenses, this situation was

likely not a problem. For an inmate such as Hubie, however, the family could potentially be placed under financial strain, if he overused or abused the healthcare access process.

Correctional policies were both a help and barrier to the delivery of healthcare services to the elder prisoner. The primary policy is security and supervision. Healthcare providers and processes are supervised by a correctional officer at all times. This level of supervision creates a different dynamic between healthcare provider and patient. Policies that govern confidentiality and healthcare records were potentially interpreted in a way that prevented the elder prisoner from gaining information about his treatment and diagnoses. It was also likely that education and cognitive functioning levels could impede the level of understanding some prisoners had about their health and the health policies. Communication policies (phone, mail, visitation) were restrictive due to safety and security concerns. These policies were potentially detrimental to continued, supportive contact from family and friends regarding health issues.

#### *Influence of Larger Discourses (Society)*

The final research aim provided an opportunity for me to explore the impact of the larger social discourses or the 'free world' understanding of the elder prisoner and prison healthcare. I specifically wanted to consider the impact of the

public perception of this marginalized population in our society.

For some inmates, the outside community had little influence on their use of services. If the prisoner had strong 'outside' connections and had been self-sufficient, he had little personal need for interaction from the 'local' community.

Charles: *I don't (use community services). The only thing is, I've always been an independent sort of person. That (using services) never occurred to me, but it is always appreciated. Like when the people come up in here and bring a little Christmas package - you do appreciate that. It's something different and something you can't get from the prison store. Of course, for me, money is no object - but I do feel sorry for those guys who are here without any help - I guess the services are good for them.*

For other participants, however, a connection with the larger community was vital to their well-being. Hubie stated he looked forward to interacting with the church and volunteers, "Yes ma'am, they always ask how you getting along? And I always say I am doin' good for the circumstances. And I think it helps you stay in line with other groups (here he was specifically talking about various religious organizations)". Will was also actively involved in church activities. As he said in his vignette he attended weekly services and enjoyed teaching a Sunday school class.

The social construction of the prison inmate as a negative part of society has an influence on prison healthcare. For persons not living in or working in the prison setting, the

elder prisoner is the *other*, a part of society that is so marginalized he deserves little attention. The issue of prisoner healthcare does not register with some people as a reasonable use of time, money, or resources. I interviewed a community member who worked in a local business near the prison, "Well, I know the prison is there, and I figure they get what they need. Don't give their health much thought!" The media in the United States share some responsibility for this social construction. Charles discussed at length the influence of the media on the perception of the prisoner and prisoner health.

*Well, you know they said on the news that the prison system made several millions of dollars last year. And if that is so, they are not doing, as far as I'm concerned, what they could do for prison healthcare. I don't hear them talking about that.*

He stated the media twist the information to change how the general public thinks about a topic: "Oh my gosh, I sit out there (in the TV area) and watch ABC News and I just get, get..Well, my blood pressure goes up! It tears me up about the media, I have no use for the media!"

Hank stated he saw a need for education of the general public about prisoners and healthcare.

*You know, I think that could be a good thing, I'm sure it will be real interesting to a lot of people. You know, you are here (interviewer) and actually talking to the people, and not just hearing rumors from people on the outside. Maybe to educate people about this (kind of prison) will help some people understand some things they didn't before.*

Will made an interesting observation about how many of the

older prisoners he lived with had just "given up" and gave no thought to planning for life on the outside. He noted the many of the men saw themselves as prisoners, and their sense of self had deteriorated to the point where they were hopeless. He related this to the long-term stigma of being an inmate,

*Well, most of em in here is that way. (Not able to think of life as a free man) I can think of one where his son has, you know has plans when they get out. But, the problem is a lot of em, I think they just don't care no more.*

He further explained that some of the men had no sense of belonging on the outside, therefore they did not take any responsibility for themselves on the inside,

*And they're not, they don't, if they get out, I don't think it hurts them, if they don't, it...They don't have no plans for the outside. They're just going out there blank. And I'm quite sure medical facilities, or medical care is the last thing they got on their minds.*

Healthcare providers discussed the stigma surrounding their choice to work in the prison setting. Tonya noted it was common, early in her career for someone to question her choice of work, "You are a woman! And you are working in a prison?" She said that it influenced people to the point that she had trouble developing friendships, "Kinda, well, you know you realize it's not the job that, well you can tell they don't want to be your best friend!" Alexa agreed with this assessment, "Yah, people say, and 'you work in a prison?' I have had that from day one. Nine years ago they would say 'you work in a prison, what's wrong with you?' (laughs) 'Are you crazy too?' No, not crazy."

The larger discourse played a significant role in the social construction of the elder inmate. For persons in the community, the prison was there to take care of the prisoners, and community involvement was not needed. For the prisoner, the stigma of being labeled as prisoner had a long-term influence. Some inmates distanced themselves from family members, and gave no thought to what life on the 'outside' might bring. For those employed in the prison system, there was potential isolation associated with prison work.

Bracketing: I had anticipated that it might be easier to speak with collateral participants than it actually was. Those who were gracious to share their time with me were forthcoming in providing insights into prisoner healthcare. For me, it provided a sense of gaining new knowledge, but it also opened opportunities for more questions. The responses to the semi-structured interviews opened doors to new questions and areas of the elder inmate research that need to be explored. Finding a voice to share this information seemed to be important for each participant. For the healthcare providers participating in the study was a chance to share the complex tasks that they do daily and to talk about why they love the work they do. For the 'free world' participants the interviews were a chance to ask questions and to reflect on the enigma of the prison itself.

### *Emergent Themes from Cross-Case Analysis*

After the data were arranged and analyzed, five themes emerged from the narrative data that highlighted the most prominent issues about elder prisoner healthcare. The overarching themes were: a) demands: prisoners, healthcare providers, and facility; b) expectations: prisoners, healthcare providers and facility; c) barriers to care; d) making changes; and e) education and seeking support. All of the themes emerged under the conceptual notion of 'a free world model of healthcare forced into a restricted environment.' These themes evolved from the narrative data by consistent repetition within and across the four cases.

Particular circumstances for the elder prisoner interviewed were different. For example, each had been incarcerated for a different length of time and some had been in multiple institutions. Although there were differences in health status, age, relationship to family, connection with the 'free world,' socioeconomic status, and family of origin, their experiences of the healthcare process were similar. Their stories were singular, but each case resulted in the same experiential circumstance: receiving healthcare in prison is a major focus of their lives. They each expressed positive and negative experiences, questions, confusion, and frustration about their personal health, healthcare decisions, and healthcare system.

The following sections explore each of the emergent themes across the four cases and the social network of care. Examples are included in each section to help clarify the themes.

*Demands: Prisoners, Healthcare Providers, and Facility*

The theme of *demands* was present in the interviews in relation to several areas. Consistently across the four cases, the prisoners' concept of 'time' strongly influenced their personal healthcare demands.

Healthcare providers have constant demands on their time and limited resources with which to provide care. One of the nurses noted, however, that while the number of inmates has steadily increased in the prison, she believed it had not influenced quality of care,

*Alexa: Umm, I think the number of nurses we have is adequate for the care we give our prisoners. You know when I first started here we didn't have as many nurses, but we didn't have as many inmates. I think they have increased the number of nurses, as we have needed it. I don't think that has ever been an issue.*

Hank noted that he could understand some of the demands on the institutional caregiver.

*Hank: You know if you are gonna be an LPN or training here, on the job training - man, there's a lot that goes with it! I think that once they get here (new healthcare staff) and they see all that goes on with the job. Cause, it's like (they probably say) 'hey man, this guy done defecated on his self - and I got to clean it up'. And I can understand that but, hey - and you know they probably get angry about the hours they work. I mean they **work some hours!***

He reiterated that while he thought he understood this, he

expressed some dismay in the treatment of some prisoners.

The physical facility experiences demands on its capacity. For more than ten years, the correctional facilities in Alabama have been operating at nearly 200% capacity. A healthcare provider noted,

*Hannah: "well when I first started here the inmate count was 185 and that was the MAX we could have in this building. And now it is 300, so... That is the max now. So, the actual body count has increased AND the percentage of our sick out of the total has increased too."*

Interviewer: *"But the facility itself has not increased?"*

*Hannah: "Well, no. You know they brought that trailer in. They have that trailer and they house inmates in it. When I first started the nurses' station was in the back, then they built all this up here (front offices, lobby, and porch) and added on. So you could say it has changed some, but the biggest majority of the building has not changed."*

Bracketing: In my documentary research about the history of Hamilton A & I, I found evidence to support the information about the increase in the number of inmates. In 1999, an additional 42 beds were added to the facility, and the official capacity of prisoners was increased to three hundred. No new construction was completed to manage the increase in men; instead, a portable housing unit was added to the grounds.

*Expectations: Prisoners, Healthcare Providers, and Facility*

The theme of *expectations* was evident throughout the discussions with all participants. Again, this theme had different connotations depending on who was discussing expectations.

The prisoners have certain expectations about the quality and delivery of healthcare. They expected to be informed of test results and medical procedures, but they stated they only gained this information if they inquired. Hank stated,

*Well, you only get results if you go down there. Like when you go down for the diabetic screening you can ask then. Now, if I am with the nurse-practitioner, she will talk to you and explain the results pretty good.*

The men responded that they had witnessed treatment of the more frail, difficult to manage inmates that reminded them they did not want to be incapacitated or die in prison.

*There is situations where you know a guy will be on a liquid diet, cause they can't eat solids and there was just this lady that don't work here no more, who was feeding them. But...(waited to finish sentence) it was **how** she was feeding them, well - you just had to see it for yourselves.*

He further asserted that he knew working with the difficult, very ill inmates was stressful, but wondered why someone would take the job if they did not care. "Being here, you know I understand, and it's just hard to understand how people can be real abusive and act like it's the normal thing to do."

The healthcare providers have expectations of the prisoners to understand the care process and to conform to the care delivery system. Alexa responded that this was part of the job that was difficult to manage at times,

*I just don't think some of them understand our aspect of how our day just can't be consumed with one inmate. They*

*don't see the big picture because they are locked up back there, and they can just see their little world, and it is hard for them to understand it all. So I just think the patience, and them understanding we are here to help them - they just have to give us TIME to do what we need to do for them.*

The healthcare providers and correctional staff agreed that this was an area that was unique to working in the prison setting, but they stressed they could see the prisoners' point of view as well.

*Hannah: Probably there is not a whole lot we can do about that, just reiterate to them that we are doing the best that we can. We tell them, you just need to give us time for us to accomplish what we can accomplish for you and it takes time. You will get the care you need. But a lot of them they say something, or they write something (on the sick call sheet) and they expect it five minutes from then.*

The entity of the prison itself is subject to expectations. There are expected, budgeted state funds that are needed to cover operating expenses and increasing healthcare costs. When I discussed cost issues with correctional staff, they acknowledged the expenditures for the elder prisoner were an issue specific to their facility, *"Cost? Well, we're talking about taking care of the geriatric patient here. We need (adult) diapers and pads for our facility and that will outweigh the cost of any other facility's supply needs in that area."* There is an expectation that the facility will operate in the most cost-effective manner possible, within the constraints of their budget. Tonya noted the connection between cost-effectiveness and patient education,

*We try to be cost effective. Those pads, diapers and wipes*

*are used to keep those guys clean out there. That would probably be two-thirds of our budget, I'm sure. And we want to be organized and use what we need, and educate them about it.*

### *Barriers to Care*

The theme of 'barriers to care' highlighted many areas where there was a disconnection between the prisoner and the various persons in the social network of care.

Communication was a recurring barrier to care. From the healthcare providers' point of view, communication was an "area that we need to work on." Their concern about communication was how to effectively let the prisoner know why he is receiving a specific type of care. Tonya noted, "We try to say, you know we are giving you good care, it may not be what you want, but I want you to understand that your ideas about your care might not be to the best of your health."

Correctional staff, healthcare providers, and volunteers agreed that communicating with someone in prison meant they had to first acknowledge the stress of being institutionalized,

*Hannah: Well, probably true in here (that the inmates worry about their quality of care), because that is all they have to think about. They don't have the ability to grasp anything from the outside world -which is different from a nursing home, cause there is people coming in and out and visiting and I think they have it a little easier, cause they can they can actually SEE the outside world, they don't feel like they are just in that one little space.*

The men also stressed communication as a barrier to care. From their viewpoint, lack of communication from healthcare

providers about procedures, testing results, and preventive care measures was quite frustrating. Hank knew his medical history quite well and stated how frustrated he became if a care provider did not acknowledge his perception of his medical history and care,

*I had a similar problem when I was at \_\_\_\_\_ and they had prescribed me some pretty good medications. So I told her (healthcare provider) she could see this from reading my medical records and her response was, 'I'm finished with this - get up and get out!' I went to the lieutenant then, and he tried to help me.*

Effective communication is restricted in many ways. Policies, as noted before, guide the type of information that can be shared with an inmate or family member. In a search for information specifically related to prisoners and the HIPAA guidelines, I found that although a prisoner has a right to appropriate medical care, he may not have immediate access or the right to his medical records while incarcerated. Inmate medical records are also confidential and cannot be released to directly to active inmates or their family members. Medical records may be released to an inmate's attorney or physician, with the completion of a valid Authorization for Release form. Upon release from prison, inmates are provided with certain portions of their medical records they may need for continued care (Alabama Department of Corrections, 2006).

The size of the facility and the number of prisoners housed there presents a challenge to providing appropriate medical

care. Providing security and attending to medical care needs is a constant balancing act. Hank expressed thoughts about this,

*Well, I think it's a big problem in terms of healthcare. I don't know if it comes from the lack of resources, or the physical size of the place. It might also be due to the population size, but you know it does need to be improved on!*

Healthcare providers and staff agreed on this point as well. Alexa stated,

*I feel like eventually they will have to build a new one (prison). As the inmate population gets more elderly and sicker. I just don't see this small prison being about to house everyone years and years down the road. But, I don't think they will EVER build a new one here - maybe eventually a new one, but they would relocate it.*

These barriers to care presented issues that highlight a difference between 'free world' and prison healthcare: the patient and healthcare provider partnership. In the correctional setting, the prison-patient is not empowered to become an informed consumer or a partner in the healthcare relationship. Security is ever present, and is instrumental in preventing the exploitation of healthcare staff. This does create a situation which changes how medicine is practiced by the provider, and how care information is received by the recipient.

### *Making Changes*

For the long-term prisoner at Hamilton A & I and the staff who had worked there for many years, the primary reason the facility was able to make successful changes (improved work environment, increased options for activity programs, addition

of the garden) was the leadership of the warden. One staff member noted, "Our warden is **very** proactive to help us, he is very proactive!" A healthcare provider stressed, "We have made great strides from 1985 till today as far as much better medical care. I think the inmates here are very fortunate at this time."

The prisoners described leadership as necessary for change in the facility. Hank stated he thought good leadership from the physicians and the healthcare administrator made a difference in the care at Hamilton A & I. "When they have more staff here and a really good manager, that's leadership, the ones that actually do it. I've done met some good nurses here, some good doctors. You go down there (the infirmary) and they are gonna look out for you."

The participants agreed that there were still many changes that were needed in the prison and the prison system. The men talked about staff and environmental changes. The healthcare providers discussed facility issues.

Charles said changes in the environment for the healthcare staff might improve how they worked with patients. "It seems to me that if the workplace was better, that medical part of it, well, it could be far better. Hey, if they are getting paid enough, why don't they do it?" Hank thought if the process was streamlined, then "Well, then staff could take pride in what they do."

Healthcare providers and staff discussed changes that could be made to provide better care for the elder prisoners. Tonya and Alexa stated if funds were available, the first thing that was needed was a new, larger facility.

*Tonya: I would have a new building that is completely wheelchair accessible. Make more room in the infirmary, and improve the air-conditioning in the infirmary bay. These people we work with are so compromised, newer heating and cooling would make a difference.*

*Alexa: Oh, lord, I would just build a new prison! Build a new prison; I would build a bigger one and a build a bigger medical unit. I mean, we have an adequate one, but you can always make it better, always! You can always make things better even if you say things are great the way they are. There's always little tweaks and things that can make it run smoother. And provide room for more equipment or supplies.*

Building new prisons also a recommendation from the Prison Task Force report (2006). Specifically, the task force reported Hamilton A & I had been built in the 1980s, and like many of the prisons built during that time, there were areas of the facility that were in need of repair.

Hannah and Tonya discussed the need for space within the correctional facility that could be devoted to preventive healthcare. Tonya noted, *"Maybe to have activities that were more like what you would find in a nursing home or assisted living facility. The older population here needs to express themselves in some way."* Hannah agreed with this and talked about supportive services for stroke patients,

*We have those patients who have had CVA's (cardiovascular accident or stroke), and they can't move their limbs. I would like to see a place to do 'range of motion' and PT (physical therapy) exercises that are convenient for the nursing staff. Right now, we have no way for PT or OT (occupational therapy) to come in - we have to do this. They (prisoners) go out for a consult, the provider sends us a regime and we follow it.*

She stressed that the small space for healthcare and the amount of work that had to be done in the area, prevented them from giving the services in the most convenient and personalized way for the prisoner-patient.

#### *Education and Seeking Support*

Support for the prison can come from the community. The correctional staff noted that Hamilton A & I had been in the Hamilton community for well over twenty-five years and that the community understood the role of the prison. *"Our community as a whole, has realized - maybe not be accepting (of prisoners here) but to be more supportive of the finances the prison brings in."*

Garnering support from the 'free world' for the prisoner, and particularly the elder prisoner, continues to be a difficult challenge. Tonya noted, *"As far as people being open-minded and thinking about prisoners and rehabilitation...I don't think we are there yet."* All of the participants in the study recognized a need for public education about the need for support of prisoners as human beings. Church volunteers noted, *"Rehabilitation does work for some people. And we have got to give that 10% that it does work for a chance."* This notion was

in keeping with the idea that prison inmates can benefit from supportive religious programming while in prison that would continue to influence their lives upon release. Several participants stressed the need for the ADOC to be involved in the public education process. Hannah, a medical care provider, expressed,

*The ADOC as a functioning part of our government needs to be teaching that we do have people who can be rehabilitated. And our aging prison population, the public **really** needs to be educated on this.*

The healthcare providers were specific in their ideas about educating the public about elder prisoner issues. They expressed a need to help the general public understand the burden on the system when a chronically ill or dying prisoner cannot be released. Tonya discussed the implications for families, the inmates, and the community at large,

*Why should we continue to sentence someone who has complete, full-blown Alzheimer's? Isn't his life over anyways, that sentence - is much, much harsher. Or consider someone with terminal cancer who has less than three months to live. If they can get a medical parole - for one thing, this saves the state and taxpayers money, and this could be chance to further educate the public how this could be beneficial to everyone.*

This was a chance to involve family members who might still be actively involved in an elder prisoner's life. Tonya described a need for the shift in thinking about the elder prisoner, as elder first, prisoner second,

*Yes, this is a person who committed X crime, but he's been here twenty years and has family that can take him. He's*

*house-confined, and there's nothing he can do (to hurt anyone). If they have family available, ready and willing to take care of that inmate, we need to release them.*

### *Conclusions from the Cross-Case Analysis*

The five themes that emerged from the analysis of the narrative data were: a) demands, b) expectations, c) barriers to care, d) making changes, and d) education and seeking support. These themes evolved from the consistent repetition of similar categories within and across the cases. Although each case was unique in terms of the central elder inmate and his interactions with the network of social care, prisoners shared similar experiences of institutionalized healthcare. I will provide a further discussion of the resulting themes in Chapter Five.

### *Summary*

In this chapter, I presented the findings of the study. I began the chapter with the four case vignettes of each of the inmates. Next, I presented the 'network of social care' based on Cantor's (2000) model that surrounds and interacts with the prisoners: the healthcare providers, correctional personnel, family, community volunteers and church pastors. The second part of the chapter presented information from participants' experiences. I identified themes that emerged from a reflection on the interview data.

## Chapter Five: Significance, Discussion, Recommendations and Conclusions

### *Overview*

There are few prisons in the United States specifically designed to house and care for the elder inmate. Prior to this study, few had studied the experiences of elder healthcare from the point of view of the prisoner and the all the social actors involved in a network of social care. I employed a qualitative case study method to gain insight and understanding of the concept of elder prisoner healthcare - specifically in a small southern prison that provides care for the aged and infirm prisoner.

The four inmate cases represented singular, yet connected experiences of the health of the elder inmate. Each case included a vignette describing the individual whose health had been influenced by the incarceration experience in varying ways. The central themes of demands, expectations, barriers to care, education and seeking support, and making changes, emerged in a cross-case analysis. These themes portray the experience and multiple perspectives of elder healthcare in prison.

In addition to increasing the body of literature regarding the elder prisoner, the research has implications for research,

policy and social work practice. It has potential implications for the generation of prisoner/patient-sensitive interventions and programs.

In this Chapter, I discuss the findings from Chapter Four and the overarching themes that emerged across the four inmate cases. I present a discussion of the implications of the study for policy, social work practice and further research. Finally, I provide a closing vignette to complete the chapter.

### *Significance*

#### *Acknowledging the Standpoint of the Elder Prisoner*

The elder inmate participants and I discussed the benefits of sharing their stories. Discussion of their experiences is the starting point for an increased public understanding of the needs of older prisoners who use health services in the prison system and how the care process works in the prison setting.

Bringing their 'standpoint' to the front of the elder prisoner healthcare discussion is essential in creating a place for change in the process of care.

I suggest that the reader consider the elder inmate standpoint as a method for constructing effective knowledge about elder prisoner healthcare. The men provided stories and descriptions of their health stemming from personal experiences prior to incarceration and their involvement with prison healthcare. As Harding (2004) noted, we can achieve strong

objectivity by understanding the perspectives of marginalized individuals, and thus society can change how it views such groups.

### *The Elder Prisoner as a Social Construct*

What components define our concept of the elder prisoner is? Is there room for a shift in social thought or social consciousness to view the prisoner as 'elder'? In Chapter Two, I introduced the guiding theories for this study: standpoint theory and social constructionist approach. I now suggest that the reader consider that the notion of what we collectively identify as 'prisoner' can be reframed to address the elder population. As research regarding the older prisoner (Aday, 2003) indicates, the older prison population is significant due to their increased health and mental health needs. Therefore, I ask that we consider a re-framing of the elder prisoner as patient first and prisoner second.

More so than any other time in our society, we are experiencing a growth in the elder adult population (Aday, 2003). This aging trend in the 'free world' is mirrored in the prison population. There has been a subtle shift in the construct of the adult to include elder, as a recognized member of western society who has challenges, needs, and value as a human being. Western society has begun to create options for 'free world' adults to have increased access to healthcare

services and opportunities to be productive and engaged members. I suggest that by changing the social construction of the prisoner to address the elder prisoner, we can begin to change the correctional system.

Consistent with the concept of social constructions, the perception of human beings changes across societal contexts and cultural norms (Crotty & Crotty, 2004). It is possible to work with various understandings or truths about a member of society and begin to accept multiple perspectives of the world. This can allow for a change in the frame of reference to a more broadened perspective.

Is it possible to experience this level of change in a nation that imprisons a higher proportion of its people than any other country in the world? According to the Federal Bureau of Justice Statistics, in 2007, there were 2, 293, 157 persons incarcerated in the United States. From 2000 to 2007 the number of sentenced prisoners increased by fifteen percent, in other words, 1 in every 198 U.S. residents was incarcerated in a state or federal correctional facility (Bureau of Justice Statistics, 2007). Federal court decisions remind us that there are mandates for healthcare for prisoners. Regardless of the circumstances that led to a person's incarceration, he has a right to care that is appropriate for his medical needs.

### *Discussion of Research Aims and Themes*

The research aims for this study concerned four broad topic areas that were intended to stimulate discussion and thought about elder prisoner health and healthcare. These research areas provided an initial point of analysis for me as I began to work with the narrative data and documentary materials. The research aims were to explore, a) How changes in personal health and functional status influenced the healthcare process, b) How family awareness and involvement affected prisoner health and healthcare c) the influence of policy on prisoner health and healthcare and, and d) the influence of larger discourses (society) as these affected inmate health and healthcare.

The first research aim I explored was how changes in an inmate's personal health and functional status influenced the healthcare process. This research aim reflected upon the elder prisoner's changes in personal health and functional status. Specifically, I explored issues surrounding access to care as an inmate's level of need (ability and/or disability changed; how healthcare needs were determined and what services and programs (food, exercise, social networks, spiritual support and emotional support) contributed to better health. Participants discussed how physical changes limited their ability to participate in activities and to access medical services easily. This area revealed challenges from a personal perspective.

The second research aim explored the family as a part of the elder prisoner's health and healthcare process. Specifically, I considered the awareness and experience of the family member of an elder prisoner. Through the interviews I explored the level of involvement an inmate's family had in the inmate's healthcare process. Additionally, I inquired about the healthcare decision process and how the family was involved, if at all.

This particular area of discussion highlighted areas in the prison system that greatly impacts family functioning. My field notes and journal observations about this area led me to conclude that the family of the elder prisoner is less connected to the prisoner than the other members of the social network of care. As an alternative, the elder inmate may develop peer relationships within prison that provide emotional support.

The influence of correctional policy on health and healthcare was the third research aim I explored. This exploration provided an opportunity for me to examine the impact of policy on the prison healthcare process. Specifically, I wanted to explore how policy affected the design and implementation of prison healthcare for the elder prisoner. I wanted to examine how the participants perceived the healthcare policies, and how the policies have evolved in the Alabama prison system.

It became obvious in the discussion of policy issues that this is an area where there is a source of confusion and no The most significant finding was that there is no clear mechanism for helping the uninformed prisoner or person in the network of social care understand most current policies.

The fourth research aim considered the influence of the discourse of the larger society, or the 'free world' on the elder prisoner. This final research aim provided an opportunity for me to explore I specifically the impact of the public perception of this marginalized population in our society. The most important finding was that the larger society does not understand the older prisoner and the responsibilities the prison has in providing healthcare for him.

Five themes emerged from the narrative data and documentary research: a) demands: prisoners, healthcare providers, and facility, b) expectations: prisoners, healthcare providers and facility, c) barriers to care, d) making changes, and e) education and seeking support. All of the themes emerged under the conceptual notion of 'a free world model of healthcare forced into a restricted environment'. These themes evolved from the narrative and documentary data by consistent repetition within and across the four cases. The following section offers a brief synopsis of the dominant issues embedded within the five themes.

### *Demands: Prisoners, Healthcare Providers, and Facility*

The theme of *demands* emerged from the data as a result of the participants' discussion of how healthcare was provided and received. Demands were expressed as issues the participants related as most pressing at the time of the interview. Individual description of demands varied according to each inmate and collateral participants. The health circumstances of each of the men were particular, as was the place where the social network of care interfaced with each inmate. However, the way the demands stretched across their particular situations were unifying and thus, became a predominant theme in the data.

Time was an issue that was ever-present in the elder inmates' discussions. Their concept of time influenced their healthcare demands in several ways. The men were often frustrated with the amount of time that elapsed before a medical need was satisfactorily addressed. Time for the elder prisoner had no real fixed boundaries; therefore, the men spent much of their time thinking about how to obtain medical services as quickly as possible.

Time as a demand for the correctional staff and healthcare providers on the other hand, had a distinct set of boundaries. Time was determined by shifts that were worked, and a set number of activities that they needed to perform during each shift. Given that the population of Hamilton A & I was primarily the

aged and infirm prisoner, the time demands were greater for medical care staff than for staff in a general population prison. On a given day during the time of the study, for example, the nursing staff saw all of the patients for pill calls, multiple sick calls, and addressed chronic care needs. Two hundred fifty of the men were considered to be chronic care patients. To meet the demands of this schedule, patient care encounters were brief, and there was minimal time for healthcare provider-patient interaction.

Lastly, there were strong demands on the physical facility of the prison. This was a recurring topic under this theme. Overcrowding in the facility was an ever-present reality for the participants. The ADOC noted in its annual report for 2007 that Hamilton A & I was at 236.6% capacity (ADOC, 2007).

Prisoners, referred to the overcrowding when discussing the bunks and dorm-style rooms. One elder prisoner described living in the portable trailer that had been added to the campus for additional housing, *"well, I got 40 or so roommates in a double-wide and that's a different way to live."*

#### *Expectations: Prisoners, Healthcare Providers, and Facility*

The theme of expectations was present throughout the interviews as a source of misunderstanding and contention for the participants. Again, depending upon the perspective of the participant, expectations were expressed in various ways. A

unifying factor in each expression of expectations was a connection to the sub-theme of communication.

The elder prisoners had expectations that the quality and delivery of medical care would be at a certain level. For the men in the study who had experiences with 'free world' providers, this was especially frustrating. Charles and Will discussed their dissatisfaction in the amount of medical information they received. Both men indicated that it was often necessary to sign up for multiple sick call visits in order to have medical questions answered.

The medical care staff had expectations that the elder inmates would 'understand' their side of the healthcare process. At the time of the study, the ten nursing staff members worked rotating shifts to provide twenty-four hour care in the facility. The care providers noted that effectively communicating their perspectives to men with a wide variety of educational levels was a challenge. An additional challenge the care providers noted was the prisoners' attitude when receiving medical care. Alexa said,

*Well, one challenge is some of them think they need to get what they need to get when they need to get it. and they need to get it right then. Well, some of them just don't have a lot of patience, and that may just be an elderly thing in general, not specific to the prisoners. You know sometimes older people just don't have patience, and in this environment, you know...(pauses) they are not ALL demanding, but some can really be demanding.*

All participants discussed their expectations of the prison

system itself. At the facility level the warden and correctional administration expected that state budgeted funds would be available to cover regular operating expenses and the increased medical expenses due the aged and infirm population. Outside of the prison, the families and church volunteers had expectations about their level of involvement with the elder inmates. But these expectations were often frustrated by correctional policy. Families, in particular, described being frustrated and bewildered by the system. Finally, for the general public outside the prison, there was an expectation that prison could take care of the prisoners' needs and there was no need for the outside community to be involved.

#### *Barriers to Care*

The theme of 'barriers to care' highlighted many areas where there was a disconnection between the prisoner and the various persons in the social network of care. Many inmates have limited education and understanding about their healthcare conditions. Prisoners may avoid disclosing a healthcare condition due to their perception that "nothing gets done anyways". There is a lack of understanding about what services the full-time healthcare staff can provide compared with the physicians who practice on a contract basis. Healthcare staff in a prison setting face many challenges (personal and professional) providing 'care' and balancing their understanding

of what 'care' is in the prison setting. Security is always primary.

### *Making Changes*

Without exception, all participants in the study described changes needed in the structure and delivery of the healthcare system in the prison. Suggestions included adequate space and healthcare facilities for the older inmate, an increased budget for the specific health needs of the older prisoner, the addition of a full-time physician and dentist, and social workers for family and discharge needs. The staff psychologist worked to coordinate possible early or compassionate release options for the elder prisoners who were terminally ill. This task appeared to be quite time-consuming and the addition of a social worker could be a benefit. In Chapter Four, I noted the new Medical Furlough policy had just been finalized by the ADOC. This is a step in the right direction to make changes for the early or compassionate release of the aged and infirm prisoner who can no longer be adequately cared for in the correctional system.

For the long-term prisoner at Hamilton A & I and the staff who had worked there for many years, the primary reason the facility was able to make successful changes (improved work environment, increased options for activity programs, addition of the garden) was the leadership of the warden. Effective

leadership in the correctional setting for the elder prison population is balanced between security and care.

#### *Education and Seeking Support*

While the role of the prison may be understood in the community, support for the elder prisoner may still be difficult to acquire from the outside world. Hamilton A & I had been in the Hamilton community for well over twenty-five years and staff believed the community understood the role of the prison. As Tonya noted, *"Our community as a whole, has realized - maybe not be accepting (of prisoners here) but to be more supportive of the finances the prison brings in."*

This understanding, however, did not easily translate into support for the elder prisoner population. It was largely expected by the community that the prisoners' healthcare needs were taken care of by the prison and no intervention from the outside community was needed.

An interesting finding in the study concerns the support and relationships the prisoners have in their lives. Although the life of the incarcerated older adult is difficult in a setting such as Hamilton A & I, there are opportunities to develop relationships and supportive connections. For inmates such as Charles and Will, connection with family members by phone was a consistent means of support. They depended upon extended family members to manage their homes on the outside.

For inmates such as Hubie, fellow prisoners provided a source of support. These relationships were limited to just a few friends, suggesting that there are trust issues that need to be addressed. He stated he was close to his 'bunk-buddy' and had friends who walked and exercised with him daily. Hank and Hubie discussed having one or two close friends with whom they could share health concerns. Hank noted, *"I gotta couple of good friends here and we will talk about family or medical. We'll talk about going and seeing the doctor. But you just don't tell a lot of people about your stuff in here."*

Will and Hubie depended upon the support and relationships they had formed with church volunteers. Will actively volunteered to lead a Sunday School group and attended church meetings at the prison. Hubie said he looked forward to seeing the preachers from the various churches, *"I got one preacher that comes in from Haleyville and we got to be good friends! He comes and he's just thrilled to see me and I'm thrilled to see him!"* They were viewed as sources of support and friendship. Both men discussed their spiritual and religious activities in a positive manner. For these men, their connections with church volunteers demonstrated others expressed care and concern about their physical and mental health and well-being. This is consistent with previous research (Ellison, 1994; Allen, Phillips, Roff, Cavanaugh & Day, 2008) that having

daily spiritual experiences was associated with having less depression.

The participants agreed that educating the general public about elder prisoners and their health needs was an important issue to address. As the healthcare providers noted, it would be helpful to understand that prisoners generally return to their home communities and rehabilitation is a possibility for some of these men. Additionally, participants noted that for changes to be made in the prison system for elder inmates, there must be a distinction made about who the elder inmate is. It is vitally important that the public recognize there are inmates whose physical health is compromised to the point that incarceration is no longer effective or warranted. In other words, their physical condition has deteriorated to a point where their body is a 'prison'.

#### *Implications for Social Work*

Although social workers do practice in corrections, Alabama does not employ social workers in the prisons in traditional social work roles. During the study, I was informed that "social workers" - (I was unable to determine if they were actually trained and licensed as social workers)- are utilized statewide in more of a case accountability function and are not placed at any one facility. They travel to each of the twenty-nine prisons to do what was described as records management. It

was quite clear to me after speaking with all of the study participants that social workers could serve much-needed services not only at Hamilton A & I, but also in all of the prisons statewide.

Alexa: Yes, CNA's, LPN's and RN's are here. But no social worker. You know we could probably use one!

Interviewer: Ok. Speak to that. How do you think a social worker could benefit the prison here?

Tonya: Social workers could help with the sick and dying inmates, and we get a **lot** of them.

Hannah: You know if they are not gonna be where they can hurt anybody and honestly, most of the time when they are that bad off they are not gonna be able physically to do anything to anybody - so, umm she (the facility psychologist) takes a lot of that on. And I think a social worker could maybe take some of that role and really help her with that end of it as well as - any of the other duties that social workers normally do in the hospital setting. (pause) Or in the nursing home setting. It would sort of take some of the weight off of some of the other people here that have to do similar kinds of things that a social worker would do.

Tonya related the need for social work in the prison setting to continuity of care issues for elder prisoners.

*I could see where that could help. Especially with the older frail or the fragile health people that do get medically discharged or early parole. Because there is a regime (healthcare and medications) that has been established and we maintain this patient while they are here. And you will see them go out into the 'free world' and their health tumbles. Lack of education, continuance of care, something happens. There's a breakdown there.*

Finally, the healthcare providers discussed the supportive counseling role that a social worker might provide in the prison setting.

Tonya: I know they are behind bars for a reason, but there should be some way to help these people. (social workers

could) alleviate anxiety? That would help make our (nurses) jobs easier and I think it would make the patient more comfortable. It can help emotionally as well as physically. Alexa: We have several (dementia patients) right now. And you know, with them, when they start getting so sick and we let the families start having special visits and like they start calling and checking on them, that would be a great resource for the family to have and to feel like they are getting the information that they need. try to help them understand.

The prisoners, themselves were interested in discussing what a prison social worker might be able to do for the elder prisoner population. Hank said,

*I think a social worker is a real good idea. You know, cause everybody here has to go through one person (the facility psychologist) to get the information about their family and their home. A lot of these guys just don't have anyone to help them, and it's hard for her to do it all.*

#### *Recommendations: Where Do We Go From Here?*

#### *Questions for Future Study*

The findings of this case study call for additional study of the older prisoner population and, in particular, the process of providing healthcare to this group. There is no doubt the elder prison population in the United States will continue to grow (Aday, 2003). Some men will grow old in prison as a result of lengthy sentences, and others will enter prison for the first time as older adults. If the correctional system does not adapt, it will be ill prepared to cope with the physical and mental healthcare needs of its inmates.

The following questions emerged from the case study as a

result of my conversations with the participants a) how do we begin to move beyond the current view of the elder prisoner? b) How do we design and provide healthcare programs for the elder prisoner population that balances care and security? c) How do we use the limited resources and funding to accomplish these changes in state correctional facilities? and d) How do we incorporate social workers into the correctional system to work with inmates, families and bridge services with the outside communities?

The following sections do not specifically answer these questions, but rather highlight the challenges before us as researchers, social workers, healthcare providers, clinicians, and community members. I hope that this discussion will offer suggestions about how to promote a continuing dialogue and a further study regarding elder prisoners and their healthcare needs.

*Advocacy and Awareness.* Advocacy research is necessary to present information to the correctional system and to the social work community about how we can be more responsive and proactive in our work with the elder prisoner population. This can be accomplished through an increase in qualitative research that allows the reader to connect to a personal story and attempts to understand the elder in the context of the prison setting. In addition, quantitative research is necessary to inquire about

the level of awareness and preparedness of the correctional system to handle the growing elder prisoner population in the United States.

The next step after this current study might be to survey the state prisons to determine their current level of support and programming specifically for the elder prisoner.

Additionally, a cross-case analysis of the few correctional facilities specifically designed for the elder inmate could be conducted. These studies could help determine the level of a) training in the facilities and programs, and b) the manner in which elder healthcare issues are addressed (e.g. employee training, specific treatment models, types of programs, etc.).

Additionally, as gerontologists and the correctional community have started to address this issue on a larger scale, there is a need for social work to become involved in advocacy for older prisoners. Advocacy task forces in the states can work with the elder prisoner, families and communities. Social work collaborations with organizations such as NCHC and ACA can lead to larger scale inquiries into and on behalf of elder prisoners.

There is a public awareness and education issue as well. As Tonya noted, "*I think teaching and opening up to the public about what we do would go a long way. But that has to be balanced with the reasons that some of it (the information about the inmates) has to be private and protected.*" The men noted the

value of promoting greater public awareness of the elder prisoner and healthcare needs as well; Charles said, "*It might help for people to know what the conditions are like in here. I mean, we should have a more modern way to get water, these pipes (referring to the water fixtures in the dorms) are not good, and this kind of thing saves the public money.*"

There needs to be a shift in the social construct of the prisoner to one that encompasses the prisoner as both elder and human. This shift perhaps is needed in particular, where healthcare needs take precedence over punishment and security. Those of us in the 'free world' do not see this as an issue for change because we are in the position to marginalize the elder inmate. A shift in thinking can assist us in recognizing the healthcare needs of the elder prisoner as a human issue. By acknowledging a changed view of the older prisoner as a place to start, we will be better equipped to develop support programs and services for elder inmates and their families.

*A new model of health/social care for the elder prisoner.*

Does an elder prisoner lose access to more specialized care because he develops chronic or terminal healthcare issues in prison? How does the prison system adapt to meet the needs of elder prisoners? Should the elder prisoner be housed in the general prison population? Are we approaching a time in the United States where a new model of prison healthcare is needed?

Is there an alternative model of healthcare in the prison setting that can better address older prisoners' healthcare needs?

As discussed in Chapter Two, prison programming historically has been approached in the same manner as the design of the facilities: for the younger inmate. Aday (2003) highlights a gap in correctional policy - most facilities do not have any efficient plan for those inmates who will be serving long-term sentences (Aday, 1995, 2003). Correctional facilities are not designed to accommodate an elder person's limitations.

As a healthcare provider, Alexa noted nursing care is structured differently for a younger population,

*Really I have to go back to the percentage of our elderly and our sick, even though we are very small number-wise, like the big facilities, out of 1500 inmates most of their inmates are gonna be young with no health problems. They are just young whipper-snappers, 20-something years old, and the nurses don't have to do anything with them. I mean they have to do the yearly checkup, but they don't have to do the daily medical care like we do here.*

The ADOC acknowledged in its report (2006) that none of its facilities meet the Americans with Disability Act (ADA) standards, "All facilities are in need of repair; some need major renovations, some may not be economically repairable at all. Almost none of our facilities meet the federal Americans with Disabilities Act requirements, which recently became mandated under federal court litigation. (p.4)" Tonya agreed

with this by noting that in her 'wish list' for the prison, she would have wheelchair accessible areas throughout the facility.

Hamilton A & I provided me a unique opportunity to visit a prison that is primarily designated to care for the aged and infirm inmate. An exploration of this correctional facility from the point of view of the prisoners and the medical care staff provided me a glimpse into a potential model for elder prison healthcare. First, although it is close to 200% capacity, it is the smallest correctional facility in the state. Alexa noted,

*Oh, well, we are just tee-tiny. Most of the other prisons are 1500 to 2000 inmates. They are HUGE. Most of the other prisons like each one has specialties, like one prison - so all of our dialysis people will go there, and one will have all of our HIV people there. Our specialty is the aged and infirm prisoner.*

The proactive approach of the warden addresses the unique needs of the inmates at Hamilton A & I. He carefully budgets to account for the increased medical care expenses of an elderly population. He created an opportunity for the inmates to have a garden to increase the amount of fresh vegetables in their daily diet. He is supportive of specialized spiritual and mental health programming that can benefit the prisoners. The correctional and medical care staff employed in the facility have some training and educational support related to working with an aged and infirm population.

The fact remains, however, that Hamilton A & I is a state correctional facility in a state where only a small percentage

of the state budget is available for corrections. It is bound by the policies and procedures of the ADOC. Because this facility only represents a small portion of the total inmate population, budgets, guidelines, and staffing needs are determined using standards applicable to the general prison population.

Hank expressed concern about this issue as an inmate who had lived in various facilities in the state. *"This place is mostly sick people, unlike the other camps. You have some people (at other camps) who have some physical problems but nothing that compares to the camp here."* He specifically referenced the infirmary as an area that was heavily utilized by the prisoners,

*We just really need a larger area in there. That infirmary is just too crowded and it's really not a good situation. Then they (the correctional officers and medical care staff) could monitor it better, and probably keep it a lot cleaner.*

Medical care staff noted they provided the best care possible within the guidelines and budget constraints of the system.

Alexa said,

*I think the number of nurses we have is adequate for the care we give our prisoners. You know when I first started here we didn't have as many nurses, but we didn't have as many inmates. I think they have increased the number of nurses, as we have needed it. I don't think that has ever been an issue.*

Tonya agreed, noting that medical care in the system had improved since the 1980s; *"We have made great strides from 1985 till today, as far as better medical care. We've come a long way! Then again, there's always room to improve."*

Both prisoner participants and collateral participants advocated for change. They agreed that if there was a 'wish list' for the elder prison population, an expanded model of healthcare would better address the inmates' needs. Hannah noted,

*I feel like eventually they will have to build a new one. As the inmate population gets more elderly and sicker. I just don't see this small prison being about to house everyone years and years down the road. But, I don't think they will EVER build a new one here - maybe eventually a new one, but they would relocate it.*

Hubie thought that maybe other prisons should be similar to Hamilton A & I,

*I'd think they (other prisons) would like a better set up. That's what I'd bring in for everybody. Just make sure it's where they don't do nothing to try to hurt you. You know, they (correctional officers and medical care providers) don't try to down you or talk about you. I know this prison here ain't like other prisons though.*

Perhaps a blend of the incarceration model (security and correctional supervision) and an elder care model (nursing home or assisted living) that includes more involvement of communities, social support agencies and families could be developed. Tonya described the types of activities and supports needed for the aged and infirm prisoner. She acknowledged that the facility currently seemed more like a nursing home, and perhaps approaching the care of the prisoners in that manner could be a positive change. She noted, "*There really needs to be something for every type of inmate here to do, from the minimal*

*care to the bed bound patient. We really just don't have a place for all of that, but it is needed."*

### *Evaluation of the methodology*

#### *The Instrumental Case Study*

For this qualitative inquiry, I chose the case study method. I specifically chose the instrumental case study method because it allowed me to explore the concept of elder prisoner healthcare from multiple points of view. By using a case study approach, I could approach prison healthcare from both a personal level and a systems level. This method provided me the opportunity to explore the topic in a way that highlighted the strengths and needs of the prisoners, the healthcare providers, and the healthcare system at Hamilton A & I. The case study approach seeks to generate knowledge of the particular (Stake, 1995).

Qualitative research is specifically designed for immersion into the data to create an in-depth understanding of the experience and perspective of case participants (Creswell, 2002; Stake, 1995; Yin, 2000). The use of the case study method in this study had both strengths and limitations.

#### *Strengths*

One strength is to narrow the scope of a qualitative study. Creswell (2003) notes the use of delimitations in the early process of the research allows the researcher to narrow the

scope of the study. He suggests one method is to "focus on specific variables or a central phenomenon" (p.148). For this dissertation, the study was confined to interviewing the elder prisoner and various social actors connected with the healthcare process in a small southern prison.

Use of multiple sources of information is essential to the case study method. Creswell (1998) notes, "one aspect that characterizes good case study research is the use of many different sources of information to provide depth to the cases" (p.251). Yin (1989) recommends the use of up to six different types of information in a case study. For this particular study, I utilized in-depth interviews with elder prisoners and collateral sources, field notes, exploration of ADOC policies, and historical documents related to the establishment of Hamilton A & I and healthcare in the Alabama prison system.

Another strength of this study was the use of the in-depth interview process. By conducting in-depth interviews, I was able to hear the experiences of the participants in their own words. I was able to present each case as a portrait of the elder prisoner and his perspective of the prison healthcare system. The interviews also allowed me to utilize "rich, thick description" (Geertz, 1973) about a topic that has only recently come to the forefront of gerontological research.

It is important to note here that the reality for each

participant is socially constructed, and each participant has his or her own 'truth'. My role as a qualitative researcher was not to objectively verify the words of the participants, but rather weave to their stories into the multi-layered cloth that represents prison healthcare for the elder inmate. Stake (1995) notes that the "real business of case study is *particularization* not generalization." In other words, the study of the case is not to stretch its applicability to the larger world, but rather, to understand it in its entirety and complexity. Because this study used a specific strategy to select a representative sample across an age and health status continuum, it provided a multi-layered perspective of the health of the elder prisoner.

### *Limitations*

In qualitative research we do not discuss limitations in the way quantitative researchers do, rather we acknowledge those areas of the study that present areas of potential variability or weakness (Creswell, 2002).

The notion of standpoint epistemology is a feminist theory. I posit that the elder prisoner can be viewed through the lens of standpoint epistemology because he faces marginality in society on multiple levels. He experiences oppression as an elder person, as a prisoner, and as a person who has multiple medical needs. I suggest that the inclusion of the elder male

prisoner broadens the conceptualization of standpoint of the oppressed. I believe my research expands the application of this to a wider population by including the elder prisoner.

In this case study, another potential limitation is the findings could be subject to other interpretations. In an effort to provide consistency and reliability across the categories and themes, I utilized the consultation of a peer reviewer.

#### *Experiential Reflections*

As part of the reflective process in this study, I believe it is important to share some of my reflections. One thing I found noteworthy throughout this study was each elder inmate and collateral participant's sense of responsibility to share information about elder prison healthcare from his or her point of view. I appreciated participants' willingness to collaborate with me as an 'outsider' in this study.

I attempted to conduct this study with honesty, integrity and a genuine interest in elder prisoner health and healthcare. As a social worker, I respect the value of research to inform social work practice. As a qualitative researcher I was able to accept that although I was the primary investigator in this study, all of the participants contributed to my understanding.

## Conclusion

The experiences of the four elder prisoners, Charles, Hank, Will and Hubie, as described in this case study, all demonstrate the notion that *"there's really no typical elder prisoner, just like there's no typical older person"* (Tonya). Some of the men's experiences were consistent with the literature. For example, Hank, Will and Charles expressed feeling frustrated and impatient by the pace of the care delivery system. However, the resiliency, positive approaches to self-care, and the unique outlooks of these men present potential opportunities for changes.

Their stories along with the additional perspectives of the collateral participants had an influence on me as a social work clinician, social justice advocate, and social work researcher. I know that these men have a view of the world that others may not experience, and certainly that I as a woman will not experience.

Although the participants in the study may not have necessarily viewed their life circumstances as *"opportunities"* for learning, they each recognized the power of their unique perspectives. They certainly were willing to discuss their thoughts and were interested that others might want to understand their viewpoint. As Will and Charles noted in their

interviews, *"I have plenty of time to talk."*

Generalizing the findings was not an aim of this research; the commonalities among the men were parallel to the characteristics of the elder prisoner described in the literature (Aday, 2003). Each inmate experienced personal healthcare issues and was completely dependent upon the system for the care and management of these conditions. Each of the men found that his connections with correctional staff, medical providers, 'free world' entities, and families were both helpful and frustrating.

I believe the following closing vignette highlights the essence of this dissertation study. It provides specific information to social workers, correctional administrators, prison and prison healthcare staff alike about how we might begin to work more effectively with the elder male prisoner.

Will reflected upon his experience with the 'free world' and prison healthcare systems. He asserted there were issues to be addressed from every level of responsibility from the individual to the system as a whole.

*Yeah, I think, think it's a little, a little of all of that (issues at every level of the care process). Well, I think my health's more important than just sittin' back there worrying about it and I'll just go in and ask them something.*

*Cause if you get a good nurse who, (comes here) to help prisoners working with health care. If she really tries to do like she would do on the outside they don't last very*

long. Because they can't do what they know they should be doing because these people got a restriction on it. I think a lot of 'em feel like because you're a prisoner that you don't deserve no better than you getting, well I don't see things like that. But I don't think that's no reason to deny a person, you know, his benefit as far as getting treatment. Getting the proper treatment that he needs..... sometimes they get angry cause you trying to find out something about your own health. I think that's kinda a bad attitude. It, it stops a lot of people from going when they should go. Cause they don't wanna go up there (sick call or clinic) and, and you don't want them (the staff) to get angry because they gonna be the ones to treat you. But out in the free world, you know if you go to the doctor, I guess if you're paying you've got a choice. If he sees something wrong with you, he's going to tell you, he's not gonna sand bag it and just let you slide, until, you know, it gets worse and worse and worse. And as far as us (the prisoners), Yeah, well, that's what most of our day is, and the conversations are about health care (laughs). But, most of the time, well we just discuss it cause there's not much you can do. You can go up there and complain. The only problem is, it's more older, infirm people here than there has been in the other camps. We got a lot of people in wheelchairs, on crutches. Some you got to help 'em do whatever they have to do (ambulating, eating, etc). They try to help, the inmates themselves, just the medical people. The inmates is doing more work here to try and help the people. People (prisoners) get the impression that nobody cares about them so when they get up (each day) they don't care, they don't try to take care of themselves in here. And when they get out, they come right back. And a lot of it stems right from when they get treated when they're in here the first time. It could end up being a cycle for them.

#### Summary

In this chapter I provided a discussion of the significance of this study, including the acknowledgement of the standpoint of the elder prisoner and the social construction of the elder prisoner. I reviewed the four general research aims: 1) To explore how prisoner health and health care was influenced by

changes in the prisoner's health and functional status, 2) To explore how family awareness and involvement influenced prisoner health and healthcare, 3) To explore the influence of policy on prisoner health and healthcare and 4) To explore the influence of the larger societal discourse on prisoner health and healthcare.

I then presented a discussion of the five overarching themes: a) demands: prisoners, healthcare providers, and facility, b) expectations: prisoners, healthcare providers and facility, c) barriers to care, d) making changes, and e) education and seeking support. All of the themes emerged under the conceptual notion of 'a free world model of healthcare forced into a restricted environment'.

Next I provided a discussion of the implications for social work policy, research, and practice. I suggested some recommendations for further study of elder prisoner healthcare. I explored the needs of the correctional system and the 'free world' community. I discussed the possible evolution of a model of prisoner healthcare that merged the duties of the correctional system with the needs of the elder prisoner. Lastly, I provided an evaluation of the case study methodology and my experiential reflections on the qualitative study.

With the graying of America's prisons, now is the time to explore how the current model of elder healthcare in the prison

setting is presented. For this dissertation, I used the instrumental case study qualitative method to provide insight into the cases of four elder prisoners residing in a correctional facility for older male prisoners. I also explored the network of social care within which each inmate experiences the healthcare process. Case study methodology can be used as a creative alternative to traditional approaches to description, and in the case of prison healthcare issues, it emphasizes the patient's perspective as central to the process. Emerging from this exploration are overarching themes which represent the ways in which healthcare is provided and received.

## References

- Aday, R.H. (2003). Housing and programming for aging inmates. *Aging prisoners: Crisis in American corrections*. Westport, CT: Praeger Publishers.
- Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research, 9*, 407-413.
- Aiken, J.S., & Mushenko, M. (1994). Why have-nots win in the HIV litigation arena: Socio-legal dynamics of extreme cases. *Law and Policy, 16*(3), 235-247.
- Allen, R. S., Phillips, L.L., Roff, L.L., Cavanaugh, R., & Day, L. (2008). Religiousness/spirituality among older male inmates. *The Gerontologist, 48*(5), 692-697.
- American Correctional Health Services Association. (2006). Retrieved October 17, 2008, from <http://www.achsa.org/index.cfm>
- American Medical Association. (1973). *Medical Care in U.S. Jails: A 1972 Survey*. Chicago: Author.
- American Public Health Association. (2003). *Standards for health services in correctional institutions*. Washington,DC.: Author.
- Arditti, J. (2002). Doing family research at the jail: Reflections of a prison widow. *The Qualitative Report, 7*(4). Retrieved November 12, 2005, from <http://www.nova.edu/ssss/QR/QR7-4/arditti.html>
- Arditti, J., Lambert-Shute, J., & Joest, K. (2003). Saturday morning at the jail: Implications of incarceration for families and children. *Family Relations, 52*(3), 195-205.
- Baxter, P. & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report, 13*(4), 544-559,

Retrieved from: <http://www.nova.edu/ssss/QR/QR13-4/baxter.pdf>

Bosworth, M., Campbell, D., Demby, B., Ferranti, S., & Santos, M. (2005). Doing prison research: Views from the inside. *Qualitative Inquiry*, 11(2), 249-264.

Brodsky, S. L. (1975). *Families and friends of men in prison: The uncertain relationship*. Lexington, MA: Lexington Books.

Bureau of Justice Statistics. (2001b). *Corrections statistics*. Washington, DC: Government Printing Office.

Bureau of Justice Statistics (2007). Special Report: State prison expenditures. Retrieved November 11<sup>th</sup>, 2008 from: <http://www.ojp.usdoj.gov/bjs/pubalp2.htm#spe>

Bureau of Justice Statistics (2008). Special Report: Prisoners in 2007. Retrieved February 13<sup>th</sup>, 2009 from: <http://www.ojp.usdoj.gov/bjs/pub/pdf/p07.pdf>

Bureau of Justice Statistics. (2007). Prison and Jail Inmates at Mid Year 2006. Retrieved November 24, 2008, from: <http://ojp.usdoj.gov/bjs/pub/pdf/pjim06.pdf>

Cantor, M.H. (1989). Social care: Family and community support systems. *Annals of the American Academy of Political and Social Science*, 503, 99-112. *Strategies for intervention* (The quality of aging, pp. 99-112).

Cantor, M.H. (1991). Family and community: Changing roles in an aging society. *The Gerontologist*, 31, 337-346.

Cantor, M. H. & Brennan, M. (2000). *Social care of the elderly: The effects of ethnicity, class and culture*. New York: Springer Publishing.

Carlson, B., & Cervera, N. (1991). Incarceration, coping and support. *Social Work*, 36(4), 279-285.

- Caverly, S.J (2006). Older mentally ill inmates: A descriptive study. *Journal of correctional healthcare*, 12, 262-268.
- Charmaz, K. (2006). *Constructing grounded theory*. London: Sage Publishing.
- Cohn, Felicia. (1999). The ethics of end-of-life care for prison inmates. *Journal of Law, Medicine & Ethics*, 27(3), 252-259.
- Coutourier, L.C. (1995). Inmates benefit from family services programs. *Corrections Today*, 57(7), 100-106.
- Craig, E., & Ratcliff, M. (2005). Controversies in correctional end-of-life care. *Journal of Correctional Health Care*, 9(2), 54-62.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among the five traditions*. Thousand Oaks, CA: Sage Publications.
- Creswell, J.W.(2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Crotty, S. N. & Crotty, J. (2004). Social construction and policy implementation: Inmate health as a public health issue. *Social Science Quarterly*, 85(2), 240-256.
- Danner, M.J.E. (2000). Three strikes and it's women who are out: The hidden consequences for women of criminal justice policy reforms. *It's a crime: Women and justice*. Upper Saddle River, NJ: Prentice Hall.
- Denzin, N.K., Lincoln, Y.S. (2005). *Sage Handbook of Qualitative Research*. 3rd Edition. Sage publications: Thousand Oaks
- Devers, K.J., & Frankel, R.M. (2000). Study design in qualitative research-2: Sampling and data collection strategies. *Education for Health*, 13(2), 263-271.

- Ellison, C.G.(1994). Religion, the life stress paradigm, and the study of depression. In J.S. Levin (Ed.), *Religion in aging and health: Theoretical foundations and methodological frontiers*, (p.78-121), Thousand Oaks, CA: Sage.
- Faiver, K.L. (1998). *Health care management issues in corrections*. Lanham, MD: American Correctional Association.
- Fazel, S. (2001). Hidden psychiatric morbidity in elderly prisoners. *British Journal of Psychiatry*, 179, 535-539.
- Fazel S., Hope, T. , Odonnell, I., Jacoby, R. (2004). Unmet treatment needs of older prisoners: A primary care survey. *Age and Ageing*, 33, 396-398.
- Fazel, S., O'Donnell, I., Hope, T., Piper, M., & Jacoby, R. (2004). Health of elderly male prisoners: Worse than the general population, worse than younger prisoners. *Age and Ageing*, 30, 403-407.
- Federal Bureau of Prisons. (2002). Clinical guidelines for social work professionals. Retrieved December 05, 2008, from <http://www.bop.gov/news/medresources.jsp>
- Fishman, L.T. (1999). Treacherous trysts, tender trade: Prisoner's wives as contacts and contraband carriers. *Women and Criminal Justice*, 2(2), 45-70.
- Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative inquiry*, 2(12), 219-245.
- Fuller, L.G. (1993). Visitors to Women's Prisons in California: An exploratory study. *Federal Probation*, 57(4), 41-47.
- Gallagher, E. M. (1990). Emotional, social, and physical health characteristics of older men in prison. *International Journal of Aging and Human Development*, 31, 251-265.
- Genty, P.M. (2003). Damage to family relationships as a collateral consequence of parental incarceration. *Fordham Urban Law Journal*, 30(5), 1671-1685.

- Geertz, C. (1973). *The interpretation of cultures*. New York: Basic Books.
- Glaser, B. G. & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine DeGruyter.
- Glaser, J.B. & Greifinger, R. B. (1993). Correctional health care: A public health opportunity. *Annals of Internal Medicine, January*, 139-145.
- Goffman, E. (1961). *Asylum: Essays on the social situation of mental patients and other inmates*. New York: Anchor Books.
- Hammett T., Roberts C., Kennedy, S. (2001). Health-related issues in prisoner reentry. *Crime Delinquency, 47*, 390-409.
- Hairston, C.F. (1991). Family ties during imprisonment: Important to whom and for what? *Journal of Sociology and Social Welfare, 18(1)*, 87-104.
- Harding, S. (1995). "Strong objectivity": A response to the new objectivity question. *Synthese, 104(3)*, 331-349.
- Harding, S. (2004). Can men be subjects of feminist thought? (pp. 177-197). In S.N. Hesse-Biber, & M. Yaiser (Eds.), *Feminists perspectives on social research* New York: Oxford University Press.
- Harris, O., Miller, R. (2003). *Impacts of incarceration on the African-American family*. Transaction Publishers: New Jersey
- Hogan, N.L. (1997). Activism and marginalization in the AIDS crisis. *Journal of Homosexuality, 32(3/4)*, 77-114.
- Holt, N. & Miller, D. (1972). Explorations in inmate-family relationships. Retrieved on May 20<sup>th</sup>, 2006 from: <http://www.fcnetwork.org/reading/holt-miller/holt-millersum.html>

- Howard, J. (1994). Effects of incarceration on families of inmates. <http://members.aol.com/nuhearts/effects.htm>
- Ingram-Fogel, C. (1993). Hard time: The stressful nature of incarceration for women. *Issues in Mental Health Nursing, 14*, 367-377.
- Keonig, H.G., Johnson, S., Bellard, J., Denker, M., & Fenlon, R. (1995). Depression and anxiety disorder among older male inmates at a federal correctional facility. *Psychiatric Services, 46* (4), 399-401.
- Kratcoski, P.C., Babb, S. (1990). Adjustment of Older Inmates: An Analysis by Institutional Structure and Gender. *Journal of Contemporary Criminal Justice, 6*, 264, 281.
- Kupers, T. (2002). A review of the literature. *Effects of visiting and education on prison inmates and families*. Unpublished manuscript.
- Lemieux, C.M., Dyeson, T.B., & Castiglione, B. (2002). Revisiting the literature on prisoners who are older: Are we wiser? *The Prison Journal, 82*(4), 440-458.
- Leob, S.J., Steffensmeirer, D. (2006) Older male prisoners: Health status, self-efficacy beliefs and health-promoting behaviors. *Journal of Correctional Health, 12* (4), 269-278.
- Levy, H. & Miller, D. (1971). *Going to jail: The political prisoner*. New York: Grove Press.
- Lincoln, Y.S. & Guba, E.U. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage Publications.
- Lindquist, C.H. & Lindquist, C.A. (1999). Health behind bars: Utilization and evaluation of medical care among jail inmates. *J Community Health, 24*, 285-303.
- McDonald, D. C. (1995). *Managing prison health care and Costs* (NCJ-152768). Washington, DC: Department of Justice.

- McGrath, C. (2002). Oral health behind bars: A study of oral disease and its impact on the life quality of an older prison population. *Gerontology, 19*(2), 109-115.
- McShane, M.D., Williams, F. P., III. (1990). Old and ornery: The disciplinary experiences of elderly prisoners. *International Journal of Offender Therapy and Comparative Criminology, 34*(3), 197-212.
- Marquart, J. W., Merianos, D.E., & Doucet, G. (2000). The health-related concerns of older prisoners: A review of research and emerging areas of inquiry. *Prison Journal, 77*, 184-208.
- Marshall, C., & Rossman, G.B. (2006). *Designing qualitative research*. Thousand Oaks: Sage Publications.
- Mertens, D. M. (2005). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods*. Thousand Oaks, CA: Sage.
- Miles, M.B. & Huberman, D.L. (1994). *Qualitative Data Analysis*. Thousand Oaks, CA: Sage Publications., Inc.
- Moore, E. O. (1989). Prison environments and their impact on older citizens. *Journal of Offender Counseling, Services and Rehabilitation, 13*, 175-191.
- National Association of Social Work Code of Ethics, 1999.
- National Association of Social Work Policy Statements, 2003-2006. Retrieved April 14, 2005 from:  
<http://www.naswdc.org/resources/abstracts/default.asp>
- National Commission on Correctional Health Care (1996). *Standards for Health Services in Jails*. Chicago: Author.
- National Commission on Correctional Health Care (1996). *Standards for Health Services in Prisons*. Chicago: Author.

- National Institute of Corrections. (1997). *Prison medical care: Special needs populations and cost control*. Washington, DC: U.S. Department of Justice.
- Neeley, C.L., Addison, L., & Craig-Moreland, D. (1997). Addressing the needs of elderly offenders. *Corrections Today, 59*(5), 120-125.
- Padgett, D. (1998). *Qualitative Methods in Social Work Research*. Thousand Oaks, CA: Sage Publications, Inc.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods*. California: Sage Publishing.
- Pew Center on the States. (2008). *One in 100: Behind bars in America 2008*. Washington, DC: Pew Charitable Trust.
- Poster, M.J. (1992). "The Estelle Medical Professional Judgment Standard: The Right of Those in State Custody to Receive High-Cost Medical Treatments." *American Journal of Law and Medicine, 18*(4), 347-368.
- Restum, Z. G. (2000). Public health implications of substandard correctional health care. *American Journal of Public Health, 95*(10), 1689-1691.
- Reviere, R., & Young, V. D. (2004). Aging behind bars: Health care for older female inmates. *Journal of Women and Aging, 16*(1/2), 55-69.
- Rodgers, P. (1990). Conjugal visits: Preserving family bonds behind bars. Retrieved from Legalzoom.com, January 10, 2005.
- Rikard, R. V., & Rosenberg, E. (2007). Aging inmates: A convergence of trends in the American criminal justice system. *Journal of Correctional Health Care, 13*, 150-164.
- Rosenfield, H. A. (1993). Older inmates where do we go from here? *Journal of Prison and Jail Health, 12*, 51-58.

- Roth, E. B. (1992). Elders behind bars. *Perspectives on Aging*, 21, 25-30.
- Seymour, C. & Hairston, F. (Eds.). (2001). *Children with parents in prison: Child welfare policy, program and practice issues*. Somerset, NJ: Transaction Publications.
- Schafer, N.E. (1991). Prison visiting policies and practices. *International Journal of Offender Therapy and Comparative Criminology*, 35, 263-275.
- Schneller, D.P. (1976). *The prisoner's family: A study of the effects of imprisonment on the families of prisoners*. San Francisco: R and E Research Associates.
- Schwandt, T.A. (2001). *Dictionary of Qualitative Inquiry*. Thousand Oaks, CA: Sage Publications.
- Schwandt, T.A. (2007). *Dictionary of Qualitative Inquiry*. Thousand Oaks, CA: Sage Publications.
- Sharp, S. F. (2005). *Hidden victims: The effects of the death Penalty on families of the accused*. Piscataway, NJ: Rutgers University Press.
- Shippy, R.A., & Karpiak, S.E. (2005). Perceptions of support among older adults with HIV. *Research on Aging*, 27(3), 290-306.
- Smylka, J.O. (1987). The human impact of capital punishment: Interviews with families of persons on death row. *Journal of Criminal Justice* 15, 331-347.
- Stake, R. (1995). *The art of case study research*. Thousand Oaks, CA: Sage Publications.
- State of Alabama (1996). Alabama Department of Corrections, Administrative Regulation 601, *Inmate co-pay for healthcare, June 19*. Montgomery, AL: Author

State of Alabama (2001). Alabama Department of Corrections, Administrative Regulation 700, *Food service administration, April, 5*. Montgomery, AL: Author

State of Alabama (2004). Alabama Department of Corrections, Administrative Regulation 622, *Treatment planning, August 26*. Montgomery, AL: Author

State of Alabama (2004). Alabama Department of Corrections, Administrative Regulation 405, *Inmate emergency visit, pass and leave program, November 11*. Montgomery, AL: Author

State of Alabama (2005). Alabama Department of Corrections, Administrative Regulation 600, *Mental health services, March 29*. Montgomery, AL: Author

State of Alabama (2005). Alabama Department of Corrections, Administrative Regulation 431, *Inmate telephone system, October 31*. Montgomery, AL: Author

State of Alabama (2006). Alabama Department of Corrections, Administrative Regulation 601, *Mental health forms and disposition, March 1*. Montgomery, AL: Author

State of Alabama (2006). Alabama Department of Corrections, Administrative Regulation 628, *Inmate discharge planning, October 20*. Montgomery, AL: Author

State of Alabama (2006). Alabama Department of Corrections, Administrative Regulation 303, *Visitation, March 23*. Montgomery, AL: Author

State of Alabama (2007). Alabama Department of Corrections, Administrative Regulation 602, *Mental health definitions and acronyms, January 3*. Montgomery, AL: Author

State of Alabama (2008). Alabama Department of Corrections, Administrative Regulation 448, *Inmate mail, October 20*. Montgomery, AL: Author

State of Alabama (2006). Alabama Department of Corrections Action Plan. 24 pages. Montgomery, AL: Author

- State of Alabama (2009). Alabama Department of Corrections Administrative Regulation: medical furlough program. February 19, 2009 32 pages. Retrieved from: <http://www.doc.state.al.us/docs/AdminRegs/AR708.pdf> February 21, 2009. Montgomery, AL: Author
- State of Alabama (2008). Crazy in Alabama: Over crowding, our experience in the private prison market and our plan of salvation. Pp.1-32. Retrieved December 14, 2008 from: [http://sentencingcommission.alacourt.gov/Publications/Prison%20vercrowding\\_AL\\_National%20Perspective.pdf](http://sentencingcommission.alacourt.gov/Publications/Prison%20vercrowding_AL_National%20Perspective.pdf)
- State of Alabama. Department of Corrections. (2006, September). *Monthly facility operations report* (September, pp. 1-11). Montgomery,AL:Author.
- State of Alabama. Department of Corrections. (2007). *Annual report* (December, pp. 1-25). Montgomery,AL:Author.
- State of Alabama. Department of Corrections. (2008, November). *Monthly facility operations report* (November, pp. 1-15). Montgomery,AL:Author.
- State of Alabama Department of Corrections. (2006). Hamilton Aged and Infirm Correctional Facility. Retrieved November 10, 2006, from <http://www.doc.state.al.us/facility.asp?id=11>
- Stephens, J.J. Bureau of Justice Statistics (June, 2004). *State prison expenditures 2001* (NCJ 202949).: Washington, DC: United States Department of Justice.
- Stone, T. T., Kaiser, R. M., Mantese, A. (2006). Health care quality in prisons: A comprehensive matrix for evaluation. *Journal of Correctional Healthcare*, 12, 89-105.
- Strauss, A. & Corbin, J. (1998, 2 ed.). Basics of qualitative research: Techniques and procedures for developing grounded theory. Thousand Oaks, CA: Sage Publications, Inc.
- Tewskbury, R. & Collins, S. C. (1995). Prison chapel volunteers. *Federal Probation*, 69(1), 26-31.

- Tewksbury, R. & Dabney, D. (2004). Prison volunteers: Profiles, motivation and satisfaction. *Journal of Offender Rehabilitation*, 40(1/2), 173-183.
- Tewksbury, R., & DeMichele, M. (2005, September). Going to prison: A prison visitation program. *The Prison Journal*, 85(3), 292-310.
- U.S. Department of Corrections. National Institute of Corrections. (2002, February). *Services for families of prison inmates: Special issues in corrections*. Retrieved February 22, 2005, from <http://www/ncic.org/pubs/2002/0/7272.pdf>
- Van Wormer, K. (2003). Restorative justice: A model for social work practice with families. *Families in Society: The Journal of Contemporary Human Services*, 84(3), 441-450.
- Vega, M. & Silverman, M. (1988). Stress and the elderly convict. *International Journal of Offender Therapy and Comparative Criminology*, 32, 153-162.
- Weil, N.H. (2005). Dialing while incarcerated. *The Journal of Law and Policy*, 19(42), 427-250.
- Weiss, R.S. (1994). *Learning from strangers: The art and method of qualitative interview studies*. New York: The Free Press.
- Williams, G. C. (1989). *Elderly offenders: A comparison of chronic and new elderly offenders*. Unpublished master's thesis. Murfreesboro: Middle Tennessee State University.
- Wolcott, H. F. (2001). *Writing up qualitative research*. California: Sage.
- World Health Organization. (1980). In. Retrieved November 15, 2006, from <http://www.who.int/healthinfo/en/index/html>
- World Health Organization. (2003). In. Retrieved November 15, 2006, from <http://www.who.int/healthinfo/en/index/html>

- Yin, R.K. (2003). *Case study research: Design and method*. Thousand Oaks, CA: Sage Publications.
- Zigmond, J. (2007). Healthcare behind bars, part 2: Help from the outside. *Modern Healthcare, March*. Retrieved October 25, 2008, from <http://74.125.47.132/search?q=cache:n-y76dWnJbUJ:www.modernhealthcare.com/article/20070319/REG/70315015+jessica+zigmond+2007+prison&cd=1&hl=en&ct=clnk&gl=us>
- Zucker, D. M. (2001). Case study methodology in nursing research. *The Qualitative Report, Vol 6(2), June*. Retrieved October 18, 2008, from <http://www.nova.edu/ssss/QR/QR6-2/zucker.html>

## Appendix A.

### *Interview Protocol*

The following questions will be addressed and used as prompts in a series of semi-structured interviews with older inmates (age 50 years and beyond), correctional staff members, healthcare providers, social service workers in the community who work with inmates and families, and family members of inmates.

#### *Inmate Questions*

- How would you describe yourself?
- How is aging defined in the prison setting?
- What healthcare problems have developed/or have been exacerbated as a result of your incarceration?
- What access to healthcare do you have?
- Describe a recent interaction you have had with the healthcare staff/providers.
- What activities can/do you participate in?
- Are there unwritten restrictions placed on you due to your age or health status?
- What is your involvement/contact with your immediate/extended family?

- Participation in programs through social services, churches or community organizations?
- Describe how you see the healthcare routine of this facility. Do you receive regular checkups? How are health emergencies handled?
- Who do you talk to if you have questions about your health?
- What are positive aspects of the healthcare in this facility? What could be changed or added?
- How do you see yourself becoming more involved in the decisions about your care?

*Staff and Agency Questions*

- Who is the elder prisoner?
- Are measures being taken to lower the cost of caring for the aging inmate?
- What challenges does the facility and staff encounter when working with older inmates? How has your agency/facility addressed the needs of older inmates?
- Are there policies in place to address the chronically ill, terminally ill or end-of-life issues?
- What barriers inhibit the facility's ability to address the aging population? (Prompts might include discussion related to cost of care, overcrowding, lack of public support for specialized inmate services)

- Describe a recent interaction you have had with the inmate (in this case) as healthcare staff/providers.

*Family Questions*

- What involvement/contact do you have with your family member? (prompts might include phone calls, visits, letters, etc.)
- Describe a recent interaction you have had with the inmate related to his health and/or with healthcare staff/providers.
- How would you describe the challenges you face as the family member of an older inmate?
- What challenges do you see your family member facing as he ages?
- What programs/services (prison provided and agency provided) have been helpful to you as a family?

## Appendix B.

### *Description of typical daily nursing medical services*

Types of patients and care needs (at the time of the study):

- Fifty-eight required bedside meals
- Five are blind
- Ten are hearing impaired and require hearing aids
- One is deaf
- Eighty percent of the total population is hard of hearing
- One is quadriplegic
- Ten are paraplegic
- Twenty men have partial damage from CVA (stroke)
- One cancer patient
- Forty-eight men use wheelchairs
- 30+ men require 24/7 care in the infirmary and overflow room

Nursing services provided:

- Five to twenty sick calls are addressed every morning.
- Two to ten infirmity assessments which include:  
monitoring medications, vital signs, managing trach tubes and PEG tubes, and IV's.
- Ten to fifteen chronic care patients (Hypertension, Diabetes) are assessed: medication management, monitoring of blood pressure, monitoring of glucose levels.
- Blood sugar finger-sticks: thirty to fifty at 9a.m., 3p.m. and PRN (as needed)
- Twenty or more insulin injections twice a day.
- Twenty or more sliding scale insulin administration - depending upon a patient's blood sugar reading at a specific time.
- One to two ER (emergency room) visits - typical "My blood pressure is up" to "full-blown heart attacks".
- Two to three transfers to other healthcare facilities (hospital, physician's office for a follow-up appointment, or to Birmingham to visit a specialist).  
This requires paperwork and materials to be taken from a patient's jacket, and prepared for an outside visit.  
This procedure is repeated upon the patient's return to the prison.

- Nursing staff may receive 200-400 cards of medications (medications for each patient, specific to their treatment needs). These medications must be screened (do they match the prescription, patient, etc.) and put away (in a secure manner).
- Nursing staff may order between 200-400 cards of medications per day for specific patient needs. Each patient may be taking between one and ten different medications based on their diagnoses and treatment plan.
- Ten to twenty dressings (management of wounds) are completed two times per shift, two times per day.
- For all infirmatory patients and 'out of the ordinary' patients (unexpected medical call) - the nurses complete SOAP charting. SOAP charting is defined as:

"S" Subjective: important and relevant positives and negatives from a focused history'

"O" Objective: important and relevant positive and negative physical findings, test results.

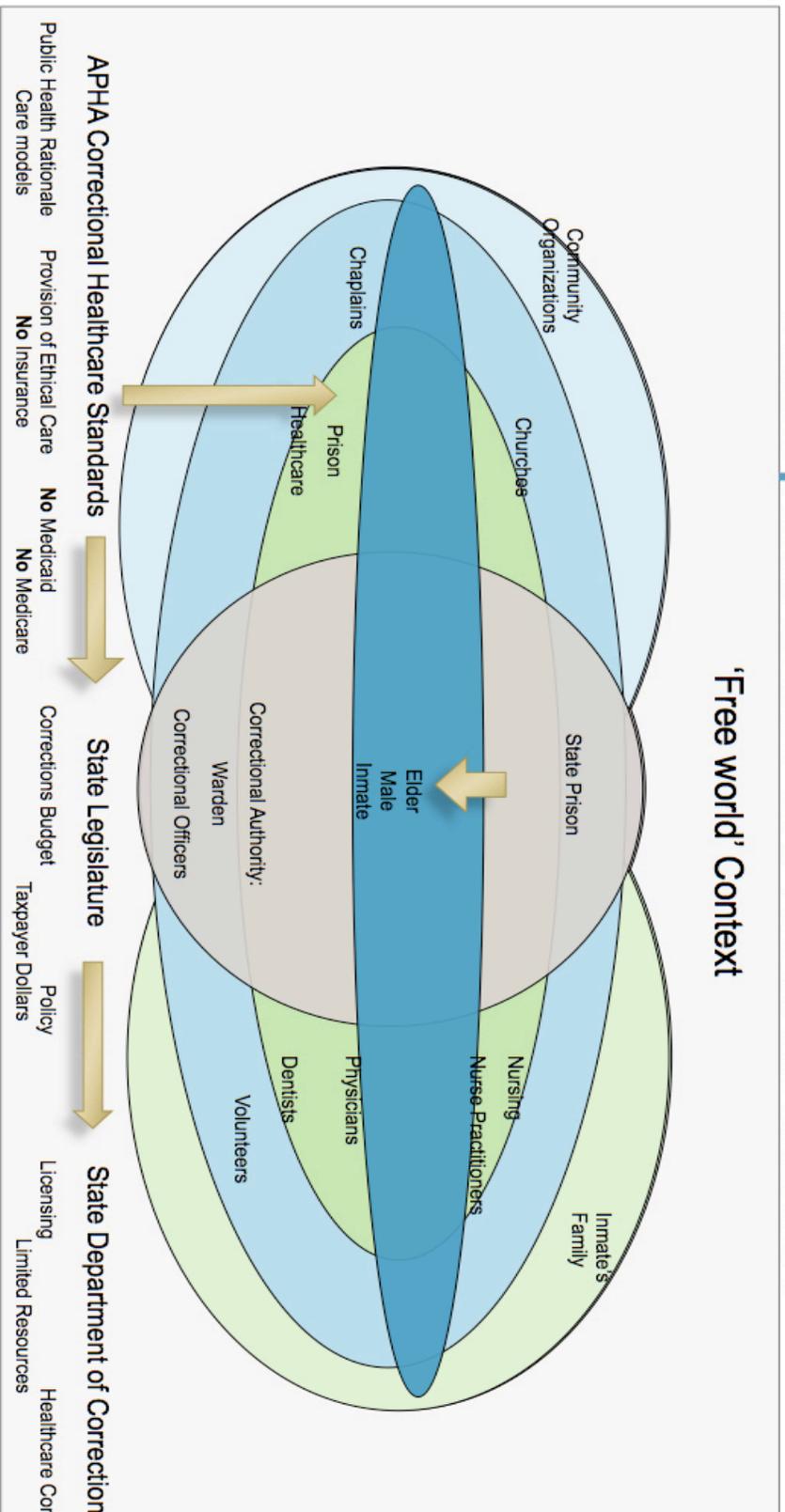
"A" Assessment: list of the differential diagnoses in priority of most likely or important as determined from S and O.

"P" Plan: list of tests or further diagnostic workup intended to narrow, confirm or evaluate differential diagnoses. Should include only tests or work up warranted by S and O, and should be cost effective.

- The nurse practitioner visits the prison four days per week. She may see as many as 25-30 patients each day.
- A physician visits on Thursdays and Fridays and he may see as many as forty patients per day.
- The eye doctor and dentist visit the prison monthly.

# Conceptual Model of Prison Healthcare

'Free world' Context



Appendix C.

This research is generously funded by: The John A. Hartford Doctoral Fellows Program