



“Silver Bullet”

Or confused greying fox?



Best Practice Support Model for Older Prisoners





Life in prison can challenge anyone, but it can be particularly hard for people whose bodies and minds are being whittled away by age. Prisons in the United States contain an ever growing number of aging men and women who cannot readily climb stairs, haul themselves to the top bunk, or walk long distances to meals or the pill line; whose old bones suffer from thin mattresses and winter's cold; who need wheelchairs, walkers, canes, portable oxygen, and hearing aids; who cannot get dressed, go to the bathroom, or bathe without help; and who are incontinent, forgetful, suffering chronic illnesses, extremely ill, and dying.

Old Behind Bars (Human Rights Watch) - 2012

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"Don't judge a man until you've walked two moons in his moccasins." Sharon Creech

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Background

The number of older prisoners in Australian prisons increased by 84 percent over the past decade 2000 - 2010 (ABS 2010b, 2000). This rising number and proportion of older prisoners has implications for planning, policy and service delivery across the correctional systems, with the most immediate and apparent issues facing older prisoners being related to ageing and associated declines in mental and physical health.

In Australia, the increasing levels of older and geriatric prisoners have been driven by factors which include the wider community's increasing longevity being reflected in the prison system, together with advances in forensic investigations leading to charges being laid many years after the actual offence. For whatever reason however, jails in Australia (and around the world) are now increasingly accommodating older people who have aged care needs that are currently beyond the capacity of a justice system to provide.

ABS 2011 data shows that older prisoners (over 60) have a much higher percentage of "serious" offence charge, than their younger aged cohorts. Sexual assault dominates the offences of older prisoners. Although a 'typical' older offender is not identified in the literature, the apparently increasing prevalence of sex offenders among older male prisoners is frequently noted throughout the literature (APCCA 2001; Bramhall 2006; Carlisle 2006; Crawley 2004; Crawley & Sparks 2006; Dobson 2004; Heckenberg 2006; Ove 2005; Papanikolas 2006; Prison Reform Trust 2003a, 2003b, 2006; Uzoaba 1998; Valios 2008). According to Heckenberg (2006), of all male sentenced prisoners over the age of 45 in Tasmania, South Australia, Victoria and New Zealand, 50 per cent were imprisoned for sexual assault and homicide.

In the UK, USA, Canada and Australia, this rise in older sex offenders in prison could be due to more aggressive policing practices and government legislative responses to public disquiet about sex offenders and so-called lenient sentencing (BBC 2003; Gaseau 2004; Heckenberg 2006). Contrary to other older offenders, sex offenders are a highly visible group and are frequently categorised by their offence, rather than their age (Bramhall 2006; Dobson 2004; Heckenberg 2006). Some writers argue therefore, older sex offenders are subjected to the highest level of discrimination of any offender group, by virtue of the combination of their age and offence category and the public attitudes that go along with these offenders (Crawley 2004; Crawley & Sparks 2006; Heckenberg 2006; Prison Reform Trust 2003a). If Wintringham is to provide best practice support for aged prisoners; there is no doubt, staff need to be supported to develop a deeper understanding of the issues faced by this cohort of prisoners.

Australian Guidelines for Correctional Centres indicate correctional services should provide proper health care to prisoners; yet there is evidence older prisoner's aged care needs are not met and further, they are more vulnerable to victimisations than their younger, generally stronger counterparts. This predicament for aged prisoners is paralleled by the aged homeless and has been well described by Bryan Lipmann ([Elderly Homeless Men and Women: Aged Care's Forgotten People](#)) Victoria's Justice system is clearly in need of expert advice and expertise from an organisation such as Wintringham to help provide for these older people.

Wintringham's specialist aged care focus leads it to be naturally involved with clients that have had some relationship with correctional services. Given this reality, Wintringham have commenced a more formal relationship with Corrections Victoria. Through this relationship Wintringham's knowledge of the issues surrounding housing, care and support of older prisoners has further developed.

As Wintringham has developed further understanding of the many of our client's correctional backgrounds, staff have become aware of the increasing number of elderly prisoners within Victorian jails. The growing numbers of elderly prisoners and the dilemma they provide to the Justice system with regards to how best provide appropriate care within a secure setting, resulted in an invitation from the then Secretary of the Justice Department, Ms Penny Armytage for senior Executives from Wintringham to accompany her on visits to a number of metropolitan and country jails to discuss the problem (2010). Whilst evidence indicates that Victorian prisons have a growing ageing prison population; there was little evidence of a coordinated approach to managing the aged related issues of prisoners in a contemporary manner. Strategies such as reliance on the prison hospital for care of the elderly have been employed. This is equivalent to the general "free-world" population being reliant on acute care hospitals for aged care services. Not only is this a costly approach to aged care; acute care hospitals do not have specialist aged care knowledge that the aged care industry has developed over many years.

Over the last three years Wintringham staff have identified a number of opportunities to improve the delivery of aged care needs within the Victorian justice system:

- Professional expertise in identifying aged related care needs of the older prisoner
- Specific linkages and exit planning to specialist aged care health services
- Specialist hospice care
- Building design that considers aged needs (i.e. Level flooring, specific facilities for care needs, wider doorways, lighter (easier to move) doors and proximal showers, grab rails etc)
- Consideration of the risks associated with older prisoners (the custodial / care risk framework should be different as compared to the younger general prison population)
- policy regarding sentencing options and early release ideas for the most frail elderly prisoners
- Coordination with aged care expertise to assist with all of the above
- Medical and psychological support for cognitively impaired individuals

The literature indicates that Australian policy makers and administrators are reliant on international experience to formulate strategies for the Australian experience for older prisoners. Several international examples exist of prisons designed to accommodate older prisoner's needs. In attempt to provide world's best practice advice and support Wintringham's desire to extend it service formally into the "Justice Space", the author visited a number of International prisons that had been previously identified as instructional to the care of the older prisoner (Old Behind Bars (Human Rights Watch)- 2012) to further develop Wintringham's knowledge of the issues facing ageing prisoner. Wintringham's aim: to advocate to Correctional Services, affordable human rights based model of care that considers the health, risk and justice imperatives of the older prisoners.

There are few other places in the world as instructional on the key care and custodial issues for older prisoners as the USA; In 1981, there were 8,853 prisoners aged 55 and older. Today, that number stands at 124,900. Unless something drastically changes, experts project that by 2030 this number will be over 400,000, amounting to over one-third of prisoners in the United States! In other words, the USA's elderly prison population is expected to increase by 4,400% over this fifty year time span. (AT AMERICA'S EXPENSE: The Mass Incarceration of the Elderly June 2012)

The key learning objectives identified prior to the USA study tour were:

- Care Models – how are care needs of older prisoners identified & assessed and how is care effectively delivered?

- Hospice Care within the prison – what models exist for care of the dying prisoner?
- What design issues need to be considered for aged prisoners? – How can care and justice imperatives be sympathetically moulded?
- Models for prisoner release – how are older prisoners released; who addresses the holistic needs of the aged prisoner in a planned release - “A discharge plan”.
- What are the best practice recreational opportunities for older prisoners
- What supports should be considered to ensure staff safety and well being with this cohort of the aged – are they very different to our current aged population?

What follows is a review of current literature and an analysis of the USA’s aged prison populations highlighting transferable learning’s for Wintringham and the Victorian Correctional system.

Executive Summary

Australia / Victoria's Aged Prisoners

Between 2000 and 2010 the population of prisoners aged 50 and over increased by approximately 1,500 across Australian prisons – an increase of 84 percent (ABS 2010b, 2000). In Victoria, whilst the prison population as a whole increased by 38 per cent between June 2002 and June 2012 the number of prisoners aged 50 years and over increased by 95 per cent. (Victorian Auditor-General's Report November 2012)

As of June 2012, the Victorian older prisoner population (over 50) was approximately 750 of which 154 were over the age of 65.

It is well documented that prisoners as a whole, not just the aged prison population, have far greater health needs than the general population, with high levels of mental illness, chronic health conditions, injury, communicable disease and disability (Hockings et al. 2002; Butler et al. 2004; Condon et al. 2007; AIHW 2010c). Further to this, it is known and recently well documented that older Australian prisoners are visiting prison clinics more often and for more health problems each time. (The Health of Australian Prisoners 2012 – 2012.) Further to this again, older prisoners with any form of cognitive impairment may not be able to follow prison rules and run the risk of receiving institutional punishment (for disobedience): increased sentences, confinement, transfer to higher security areas, or all of these which in turn may further compromise their physical and mental well-being (Haney, 2001) and burden the prison system with higher costs of housing an inmate.

The annual costs to house older adults in prison are estimated to be **3 times higher** than the estimated comparable costs for their younger counterparts (Falter, 1999 , 2006). The older prisoners healthcare costs are high because the prison environment is currently, by design, an extremely poor place to house and care for people as they age or become increasingly ill or disabled.

The current model of care for older prisoners in Victoria can best be described as follows: As an older prisoners aged care needs can no longer be "hidden", they are transferred to an acute care setting (St John's Hospital, Port Philip Prison) and because of hospital prison protocols, they are isolated for significant parts of the day. As of August 2013, it is understood that Corrections Victoria plans to extend St John's Hospital by an extra 20 beds to cope with the demand for acute health service – much of which will be from older prisoners.

The real net operating expenditure (which excludes capital costs and payroll tax) to house a prisoner per day was \$235 nationally (Victoria was slightly higher than the National Average). ([Productivity Commission Government Services Report 2013](#)) Hospital acute care models are known to cost well over \$1,100 per day ([Department of Health and Ageing 2010](#)) an amount almost 8 times more expensive that the equivalent average cost to care for a resident in a High Care Aged Care Facility in Australia which was priced at \$156 a day in 2011. (Grant Thornton, Australian Cost of Residential Aged Care Research, Service Costs in Modern Residential Aged Care Facilities, January 2012)

There is no doubt correctional staff do care about the older prisoner; they are simply not trained or experienced in observing the needs of the aged and whilst there is no doubt prisoners within Victoria have access to health care; there is little evidence that aged prisoners real aged care needs are being regularly addressed. Health care in Australian Prisons has again been reviewed within the last year. The overall

finding was, not surprisingly, prisoners have significant health issues, with high rates of mental health problems, communicable diseases, alcohol misuse, smoking and illicit drug use – than the general community.

Aged Prisoners Health is understandably worse than their younger counterparts.

Observations from the USA

From an aged care, and economic perspective the models of care observed in the USA prison system were of good quality but costly. Most prisons care models for “high care” older prisoners were founded on a hospital / acute care model as compared to using an Aged Care Model; which has lower cost care attendants (PCA) supported through nursing leadership. USA exceptions to the high cost care models, were found in prisons with advanced “prisoner care models” (Virginia, Missouri, Oklahoma, California) but even in these prisons, in most cases, when older prisoners became high care, they were transferred to an acute nursing care model within the prison system

Those prisons with prisoner carer models had a “softer” more humane feeling about them. A formalised prisoner care model is one for Victorian Correctional Authorities to further consider though it may have limited viability within the Australian context given: Australia’s smaller prison population, shorter sentencing and those prisoners with longer sentences tend to have committed crimes that would exclude them from providing care to older more vulnerable prisoners.

As mentioned, as all care options observed were influenced by an acute hospital care model of care; It was easy to see that an aged care model of care would be less costly, and ultimately provide more aged appropriate and age sensitive care. Rimutuka prison, New Zealand, was observed to be in the process of introducing such a model. It will be interesting to follow their progress.

In prison housing options for the older prisoner were found in both maximum and minimum security facilities. It appeared that minimum security facilities could more easily adapt their environments to age appropriate care and had a “softer” approach to authority allowing for flexibility to correctional rules for the cognitively impaired older prisoners behaviours.

In the USA, if you are an old prisoner and have no need for assistance with activities of daily living, transitional support into the community commence about 6 months prior to release. It was suggested by most transitional staff, that for this cohort of aged prisoner, prison probably provides a better quality of life. The same staff indicated that many older prisoners probably reoffend with minor offences, just to get back into the system, where their health and care needs are better supported.

Only some older prisoners who were VERY frail (HIGH CARE) have viable transitional option. Essentially, there are NO transitional care models for “low care” aged prisoners, and all prisons visited would have welcomed a viable transition option like Wintringham.

Some Aged Care “triage tools” were identified and used to screen older prisoners from a general prison to special “aged care areas” of a state’s prison system. Discussions with most health officials indicated there was low compliance with accurately completing the complex tools. Given low compliance with completion of the tool, many prisons used a basic referral to a central expert team who would complete a thorough aged care / cognitive assessment as part of the screening. If a prisoner did not qualify for aged care needs they were returned to the referring prison.

Given Australia has a system for assessing aged care needs (Aged Care Assessments Teams) it would seem to make sense to try and leverage their expertise for assessments of an aged prisoners care needs. Referrals to ACAS could be completed by prison nurses; once they were educated to the Aged Care Assessment Team Process.

From what was observed there is no doubt aged care provided into a prison environment has to be done differently. An aged care provider unfamiliar with prison would need to consider:

- Security / custodial interactions and issues affect the way in which care is delivered – it takes more time
- Because of security clearances, it takes staff longer to enter and exit the work place
- A heightened, even more intense approach to the medication management, security of medication needs to be considered
- The use of any sort of sharp object such as cutlery, scissors, wire etc needs a review of practice and consultation with correctional authorities on how risk to manage “sharps”
- Further consideration to how best support staff compliance with medication and sharps procedures is required
- Further consideration on the real need for segregation of specific prisoners for their own safety

Many of the information sharing with correctional authorities lead to the discussion about considerations for early release, based on medical grounds and health as an option for early transition. It was nearly impossible to get any authority to make a decision to grant this option as the risk of a serious re-offence is seen as too high. There is absolutely no rationality about the real risk a frail elderly prisoners poses to reoffending; just IMMENSE fear of an early release going wrong. The same sensitivity exists in Victoria.

As early release options for the older prisoner cohort are, in the short term, unlikely to be considered favourably by risk adverse bureaucracies, there is no doubt Wintringham should continue advocate and influence Corrections Victoria to develop an Aged Care appropriate facility within prison walls that can provide better support for aged prisoners than is currently experienced in the Victorian context. Advocacy for an Aged Care Model of care, instead of an acute care model of care, will help Corrections Victoria develop a more economically sustainable model of aged care.

Like many models seen in the USA and interestingly similar to the Wintringham model of care Aged prisoners are offered some segregation from their younger counter parts. Wintringham should continue to advocate for the evolution of an older persons prison (or area of a prison) where correctional staff can become more focused on aged prisoners needs (similar to what Helen Small observed in Singen Germany). To work well, quality and efficiency, the prison would need to have linkages to a local hospital AND have an aged care facility linked both within and outside the low security prison walls. Ongoing minimal custodial presence (24/7) supported by Corrections Victoria would probably provide the security risk framework that was acceptable to community concerns. In this context parties should remember that international criminologists and corrections experts universally agree that a person’s average likelihood of committing any type of crime declines sharply with advancing age. Having stated that, individual risk screening for appropriate placement into the aged care area of a prison should mitigate risks.

One can imagine that by now the author has developed some comfort in working within the prison environment, having been inside some 20 different prisons. On the other hand, The Aged Care System is naive and ill at ease with the older prisoners and the prison environment and most aged care professional will have a high level of anxiety about entering a correctional facility. As the prison system asks for more

assistance from the free world, consideration by the correctional authorities to support appropriate induction and mentoring to allay visitor's anxiety can only help a visitor function more normally which will lead to improved support for the aged care needs of older prisoners.

In moving forward with their involvement with older prisoners, at all times, Wintringham needs to consider the risks that providing carer to any of its potential client's poses. In reality Wintringham should be able to gain better information about released prisoners than many of its "non prisoner" marginalised clients. The correctional system usually has better client profiles, that can enhance care planning, than can be found with non correctional clients. However, Wintringham acknowledge there will be some clients, that should remain in the strict care of the justice system,

On a final note: the author extends sincere thanks to Bryan and Dot Lipmann for making this study tour and research paper possible.

Supporting Information / Literature.

Overall, older prisoners have poorer health and are less likely to reoffend than their younger prisoner peers. According to a BJS study, the percentage of all state prisoners (USA) who reported any type of medical condition in 1997 increased dramatically with age: approximately 48% of prisoners age 45 and older reported some kind of medical problem (excluding physical injury), compared to only 24% of prisoners aged 24 and younger. In fact, the official definition of the National Commission on Correctional Health provides premature ageing begins at age 50 as opposed to the traditional retirement age of 65 (Falter, 1999). This is consistent with the general population recommendation that “old age” be considered to start at age 50, especially for the more socially disadvantaged such as African Americans (Administration on Ageing, 2011). The rationale for aged 50 years may be because the average prisoner is often described having experienced premature aging in disease, disability, and overall health. Their health condition also may approximate the health condition of non incarcerated people who are 10 – 15 years older (Reimer, 2008). Wintringham research has demonstrated similar findings for the cohort of aged marginalised it provide housing and care.

Further, Wilson and Barboza (2010) estimate that the number of prisoners (USA) with some form of dementia in 2010 was about, 125,220, and suggested this would double by 2030 (n = 211,020). Given, individuals with medical conditions (both mental and physical) are more likely to require some form of assistance; it is reasonable to propose ageing prisoners require additional staffing because they need more help with day-to-day activities, have limited mobility, and are more vulnerable to mental or physical abuse by younger prisoners. (AT AMERICA’S EXPENSE: The Mass Incarceration of the Elderly June 2012)

Now consider that a range of national and international research has indicated that prisoners, as a whole – not just the aged prison population, have far greater health needs than the general population, with high levels of mental illness, chronic health conditions, injury, communicable disease and disability (Hockings et al. 2002; Butler et al. 2004; Condon et al. 2007; AIHW 2010c).

In general, the estimated costs annually to house older adults in prison are estimated to be **3 times higher** than the estimated comparable costs for their younger counterparts (Falter, 1999 , 2006). Although exact estimates are not available, given the nature of secure care environment, appropriate dementia treatment in prison is more than likely much more costly than in the community when the additional needs for security staff are factored in these costs (Wilson & Barboza, 2010).

One could assume that the higher costs of aging prisoners’ healthcare could equate to prisoners enjoying superior levels of care. Not so. Healthcare costs are high because the prison environment is, by design, an extremely poor place to house and care for people as they age or become increasingly ill or disabled. Prisons were designed with younger prisoners in mind and, as such, are usually not suitably well-equipped to accommodate the varied needs of ageing prisoners.

Further to this, international criminologists and corrections experts universally agree that a person’s average likelihood of committing any type of crime declines sharply with advancing age. Data suggests that by the time a person turns 50, his or her likelihood of committing another crime has already dropped precipitously. This holds true regardless of the crime for which the prisoner was originally convicted and sent to prison. (AT AMERICA’S EXPENSE: The Mass Incarceration of the Elderly June 2012).

With a very low probability that released prisoners, well on in years, will commit new crimes their continued incarceration in a super secure environment adds little to public safety. Risk of crime posed by individual prisoners is not determined solely by age. A review of a prisoner’s physical and mental condition as well as recent conduct behind bars should also be required. Nevertheless, an infirm or incapacitated prisoner provides little threat to public safety and justice experts rightly questions the merit in the continued incarceration of geriatric prisoners. (Old Behind Bars the Aging Prison Population in the United States 2012)

One of the most important and basic rules of survival in a highly structured environment like a prison is to follow directions to avoid disciplinary infractions. Therefore, being obedient is essential for survival and to avoid institutional charges that may result in secure confinement. Even the healthiest of individuals must be vigilant to rapidly respond to authority in the prison environment and responding “obediently” to prisoner leaders (Haney, 2001).

Consider an aged prisoner who may be cognitively impaired, or who is becoming increasingly forgetful because of early onset dementia. Many tasks of daily living, or structured prison life are too complex for those with dementia (loss of short - and long-term memory). Some older prisoners also may have cognitive impairment because of intellectual disability, which may see impairments with: reasoning, personality, language, visual processes, executive functions, behaviours, and relationships. Individuals with any form of cognitive impairment may not be able to follow prison rules and run the risk of receiving institutional punishment (for disobedience): increased sentences, confinement, transfer to higher security areas, or all of these which in turn may further compromise their physical and mental well-being (Haney, 2001).

The Older Prisoner - Australia

Between 2000 and 2010 the population of prisoners aged 50 and over increased by approximately 1,500 across Australian prisons – an increase of 84 percent (ABS 2010b, 2000).

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Total
Prisoners aged 50 and over in 2001 (n)	717	353	381	78	234	36	33	0	1,832
Prisoners aged 50 and over in 2010 (n)	1,185	657	618	272	422	66	81	25	3,326
Percentage increase in prisoners aged 50 and over (2001–10)	65.3	86.1	62.2	248.7	80.3	83.3	145.5	– ^a	81.6
Prisoners aged 65 and over in 2001 (n)	64	60	61	4	37	1	4	0	231
Prisoners aged 65 and over in 2010 (n)	161	118	109	51	59	14	12	3	527
Percentage increase in prisoners aged 65 and over (2001–10)	151.6	96.7	78.7	1,175.0	59.5	1,300.0	200.0	– ^a	128.1

a: Percentage increase could not be calculated due to zero base

Taken from: Older Prisoners, a Challenge for Australian Corrections (2011) Susan Baidawi, Shelley Turner, Christopher Trotter, Colette Browning, Paul Collier, Daniel O’Connor and Rosemary Sheehan

Of the prisoners aged over 50, the greatest growth has been observed among those aged over 65, whose numbers rose over **140 percent** in the decade from 2000 to 2010 (ABS 2000). This growth rate exceeds the increase in the national prison population, which was only 36 percent over the same time period (ABS 2010a, 2000). An increase that cannot be accounted for by the ageing of the general population (Baidawi et al. 2011)

Potter (2007) notes that higher proportions of older Australian prisoners are convicted of offences that attract long sentence periods (in particular, sex offences, homicide and drug-related offences) and this is a contributing factor to the rise in the older prisoner numbers nationwide (Grant 1999; Potter et al. 2007).

The following table from the Australian Bureau of Statistics analysis of Prisoner Populations clearly demonstrates that prisoners aged 55 years and over have a higher proportion of sexual assault offences than for any other age group.



Like their international counterparts, older Australian prisoners are less likely to reoffend than their younger prisoner counterparts. (Smith N & Jones C 2008). As well as this, sex offenders typically have lower rates of recidivism than do other kinds of offenders. Sex offenders (the predominant offense of the older prisoner) as a whole also have a lower comparable recidivism rate. (Note: there is a substantial body of evidence that demonstrates that substantially different recidivism rates and patterns and precursors of offending are found for different kinds of sex offenders and as such individual risk factors should always be considered). (Gelb K 2007, Recidivism of Sex Offenders, Sentencing Advisory Council 2007)

What about older the health of Australian prisoner health? Australian Aged Prisoners are more likely to have:

- A referral for further medical assessment on entry into prison
- A need to visit (and to actually visit) a prison medical clinic
- Need to visit the medical clinic more often
- multiple medical conditions such as arthritis, hypertension and diabetes
- mental health conditions and treatment
- test positive for hepatitis
- not increased weight whilst in prison
- report to a doctor or a nurse because of an accident whilst in prison
- prescribed medication
- report that their health had deteriorated whilst in prison
- worked in the prison industry (aged 45 and over)

Older Australian prisoners are visiting prison clinics more often and for more health problems each time. From The Health of Australian Prisoners 2012 – 2012.

Why would Wintringham be interested in Older Prisoners?

The profile of elderly clients at Wintringham is dramatically different to other aged care providers in Australia, and not unlike the clients described in aged literature describing aged prisoners. Wintringham

clients are invariably younger (than typical aged care clients), more socially isolated, have poorer education standards and lack most of the beneficial advantages of families. Often they have behavioural problems associated with addictions that are exacerbated when there is brain injury resulting from excessive alcohol consumption or trauma. Given these significant disadvantages, it is not surprising to learn that a substantial number of Wintringham's clients have at some stage been incarcerated.

Providing medical care to older prisoners has traditionally come with a steep price tag because, in general, older prisoners will have greater medical needs. Older prisoners are more likely, than younger ones, to develop mobility impairments, hearing and vision loss, and cognitive limitations including dementia. Older prisoners are also more likely to have chronic, disabling, and terminal illnesses. Prisoners who continue to age behind bars will eventually require assisted living and nursing home levels of care while incarcerated. Most prison officials look at the projected increase in aging prisoners in their systems and are realising, in the very near future, they will need to operate specialized geriatric facilities..... Some already do.

Given, Wintringham already work so closely with this cohort in a fiscally viable way; it makes absolute sense that Wintringham should explore options of housing and care for aged prisoners.

Wintringham – A Snapshot of the Older Prisoners.

Over the last few years Wintringham staff have visited many Victorian Prisons: Port Philip, Langi Cal Cal, Corella Place and Margoneet just to name a few. Wintringham have found correctional staff to be dedicated and caring for prisoner welfare. Yet the same correctional staff are also unfamiliar with the needs of aged and unfamiliar with the Aged Care System. A recent opportunity to review the care needs of an aged prisoner, prior to release, had staff commenting on a prison system that is not at all sympathetic to the needs of aged prisoners. During the visitation a Wintringham staff member saw a dozen other prisoners who, in their opinion, could well do with extra aged care assistance. When correctional staff were asked if there are any other prisoners who may have aged care needs the response was “no”. The same dedicated and caring correctional staff, could not see the care needs. This is not to say the correctional staff do not care about this group; they are simply not trained or experienced in observing the needs of the aged.

Many older prisoners have been observed to share a cell with a younger prisoner. Wintringham executive were told on one tour that younger prisoners had received some training to help the older prisoners, yet the author's experiences had correctional staff indicate younger prisoners, who have **definitely not** had training, may “help or guide” the older prisoner. The “official story” is the older prisoners are self caring. On follow up interview with the older prisoners, when pressed about their own ability to care for themselves, they have often indicated they receive some form of personal hygiene assistance with their care needs from the younger prisoners.

In general, if an aged prisoner needs more assistance than can be informally supported by a cell buddy, they are eventually transferred to St John's Hospital at Port Philip. So the model of care for older prisoners in Victoria seems to be, when an older prisoners aged care needs can no longer be hidden they are transferred to an acute care setting and because of hospital prison protocols, isolated for significant parts of the day. As of August 2013, it is understood that Corrections Victoria plans to extend St John's Hospital by an extra 20 beds to cope with the demand for acute health service – much of which will be from older prisoners. (Victorian Auditor-General's Report November 2012)

Cost Comparisons: Prison, Acute Care Aged Care

A review of current information on costs per person per day provide the following:

- The real net operating expenditure (which excludes capital costs and payroll tax) to house a prisoner per day was \$235 nationally (Victoria was slightly higher than the National Average) ([Productivity Commission Government Services Report 2013](#))
- Hospital acute care Models of Care are known to cost well over \$1,100 per day ([Department of Health and Ageing 2010](#))
- The average cost of care offered in a High Care Aged Care Facility in Australia was priced at \$156 a day in 2011! ([Grant Thornton, Australian Cost of Residential Aged Care Research, Service Costs in Modern Residential Aged Care Facilities, January 2012](#))

It is baffling to the writer that the Correctional system is not embracing an Aged Care partnership as most aged care providers have demonstrated over a long period of time they can provide equivalent (or better) quality of care compared with many public hospitals at a significantly lower cost than public hospitals can contemplate.

Release

Many older prisoners, on release from prison, are in a similar situation the many marginalised older Victorians who are referred to Wintringham on a daily basis; they either have no family (or friends) (or family or friends who do not want to keep in contact) and little or no opportunity for a stable home environment. Often, when they receive a scarce offer of accommodation, they need support to maintain the same accommodation. Some need the extra support that a low level aged care service can offer just to be able to maintain healthy decisions, as the following brief case study demonstrates:

Phil, an older person who was released from prison, was fortunate enough to secure supported housing with Wintringham. Initially support was offered through a housing support worker and focused on supporting Phil to attend his parole meetings as well as welfare visits and phone checks to see how he was settling into his new home. In a short period it became apparent that Phil had all the signs of a person who may have some cognition impairment that is evident in many Wintringham clients. Phil's life was becoming chaotic: his ex wife, daughter and son had moved in and were helping themselves to the little money Phil had. Drug use excess alcohol use became evident and regular disturbances were being reported by the neighbours. Police were called on a number of occasions, which of course created increased agitation for a person who had spent time on the inside..

It became obvious that Phil needed extra help to maintain his accommodation so an Aged Care Package was successfully applied for that provided Phil with some extra case management support. Even with the extra support of an aged care package, Phil found it difficult to say "no" to his families demands, particularly in the after hours periods when support from case managers was not available. Eventually Phil decided to move out with his son to other accommodation. Within a short period of time Phil's son was remanded in custody for an offence and Phil was again on his own, vulnerable to the next negative influence. Following another Wintringham request for an Aged Care Assessment, Phil was deemed eligible for low level hostel care. Phil has been living harmoniously in supported hostel accommodation for over 6 months.

One final comment about Wintringham prison experiences; most Wintringham staff have commented how different and “confronting” the initial “induction” into a prison can be. Prisons are highly structured and regimented and quite confronting for visitors who are not used to the environment. When questioned further about this experience, staff express some form of anxiety about the risk, or perceived risk of entering such an environment. “Am I safe to be left on my own?”, “they did not tell me I should not wear a skirt” The importance of this initial confrontation should not be underestimated. As the prison system asks for more assistance from the free world, appropriate induction and mentoring to allay visitor’s anxiety can only help a visitor function normally. An Aged Care System that is naive and ill at ease with the older prisoner and the prison environment cannot best support the aged care needs of older prisoners.

Legal Framework – Is there a Prisoner Right to Healthcare?

United States of America

USA correctional services appear to have a very consistent approach to the healthcare of their prisoner population. In part this is because there is a legal obligation of a prison service to provide the health care. The legal reasons for providing health care to prisoners were stipulated in a 1976 Supreme Court *Estelle v. Gamble* decision, in which the Court held that deprivation of health care constituted cruel and unusual punishment; a violation of the Eighth Amendment to the US Constitution. This interpretation created a de facto right to health care for all persons in custody. The decision also brought forth the concept of "deliberate indifference," a legal definition that prohibits ignoring the plight of prisoners who need care and translates into a mandate to provide all persons in custody with access to medical care and a professional medical opinion. US correctional authorities and health care professionals who infringe this right do so at their peril and may be prosecuted in federal or state courts (AMA (USA), Virtual Mentor WWW)

Within the USA there are also very active authorities / "watchdogs" that provide governance over care in custody:

The American Civil Liberties Union (ACLU) <http://www.aclu.org/prisoners-rights> - The ACLU National Prison Project is dedicated to ensuring USA prisons, jails, and other places of detention comply with the Constitution, domestic law, and international human rights principles. The ACLU aims to end policies that have given the United States the highest incarceration rate in the world.

The Southern Poverty Law Centre (SPLC) <http://www.splcenter.org/who-we-are> was founded to ensure that the promises of the civil rights movement became a reality for all. SPLC have won numerous landmark legal victories on behalf of the exploited, the powerless and the forgotten. SPLC claim to have toppled racism in the South, bankrupted some of the nation's most violent white supremacist groups and won justice for exploited workers, abused prison inmates, disabled children and other victims of discrimination.

Human Rights Watch <http://www.hrw.org/about> is dedicated to protecting the human rights of people around the world. We stand with victims and activists to prevent discrimination, to uphold political freedom, to protect people from inhumane conduct in wartime, and to bring offenders to justice. We investigate and expose human rights violations and hold abusers accountable. We challenge governments and those who hold power to end abusive practices and respect international human rights law. We enlist the public and the international community to support the cause of human rights for all.

A constant theme across all prisons visited in the USA was prisoners and correctional staff were well aware of the rights of prisoners. Any organisation acting as custodians of State detained prisoner are responsible for a high level of care and healthcare. Every prison visited during the study tour clearly articulated their knowledge of case law and the legal implications of not providing adequate care. Overall the medical / nursing care observed, of aged prisoners, was of a high standard. Consequently, many aged prisoners fully understand they receive higher levels of care within the USA prison system than they could ever possibly expect to receive in the "free world".

Australia

Within a Federal Legislative context, there are actually limited human rights protections for prisoners and former prisoners in Australia at present. While there are some prison monitoring systems in states and territories, there are currently no national standards for monitoring conditions in prisons and juvenile detention centres. The Australian government has announced its intention to ratify the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment (OPCAT). By ratifying OPCAT, Australia would commit itself to establishing a National Preventative Mechanism (a national system to monitor conditions in all places of detention in Australia) to prevent torture or other cruel, inhuman or degrading treatment in all places of detention.

If you are an Australian prisoner, you have some Federal options if you think your human rights have been breached. For example, you could:

- complain about discrimination to state and territory anti-discrimination bodies
- complain about inhuman treatment to state and territory ombudsmen
- If you are federal prisoner, complain to the Australian Human Rights Commission about human rights breaches.

However, if the Commission finds that a federal prisoner has suffered a human rights violation – for example, cruel, inhuman or degrading treatment or punishment – the Commission’s recommendations are not enforceable.

Prisoners can also face human rights difficulties once they are released from prison, despite the fact that they have served their time. For example, a former prisoner who is attempting to rebuild their life can face discrimination in employment on the basis of an irrelevant criminal record.

There are limited human rights protections for prisoners and former prisoners at the moment.

For former prisoners, there is only limited protection against discrimination in employment on the basis of criminal record. In the Northern Territory and Tasmania, discrimination on the basis of irrelevant criminal record is unlawful, but not in other states or territories. If you feel like you have been discriminated against in employment because of your criminal record, you can make a complaint to the Australian Human Rights Commission. Even if the Commission finds that you have been discriminated against on the basis of criminal record, there are limited options to resolve the situation. The Commission can only recommend a remedy. These recommendations are not enforceable, and you cannot apply to have your complaint heard in court.

It is important to recognise that most prisons are actually state or territory responsibilities. Depending on the final model adopted by the Australian Government, a federal Human Rights Act may have limited impact upon the states. To make a difference to human rights protection for all prisoners, Australia will need complementary state and territory human rights legislation.

Corrective Services Ministers' Conference

Federally, there is some governance through the Corrective Services Ministers' Conference - The role of the CSMC is to consider and deal with issues relating to both prison and community based corrections. These issues include: prison management, privatisation of prisons, competition and contestability, illegal use of drugs in custody; Infectious diseases in correctional institutions or their alternatives, or in those on parole; and the very high rate of imprisonment as a percentage of population in some States and strategies for

reducing this high rate, particularly in relation to Aboriginal offenders. In addition, issues relating to developing alternatives to imprisonment and problems with these schemes are of interest to the CSMC.

Guidelines for Corrections in Australia

The guidelines represent a statement of national intent, around which each Australian State and Territory jurisdiction must continue to develop its own range of relevant legislative, policy and performance standards that can be expected to be amended from time to time to reflect 'best practice' and community demands at the state and territory level.

The guidelines have evolved over several reviews and updates from the first edition of the 'Minimum Standard Guidelines for Australian Prisons' 1978. The guidelines are, as far as the author is aware, the most current "standard" of expectation for correctional authorities.

The guidelines contain little if any reference to aged care needs. They do not address - reasonable adaption's to account for an aged prisoners need; Clause 2.6 to 2.10 (Bedding), 2.51 Prisoners should keep themselves clean and should be provided with ablution facilities that are adequate to meet their health and cleanliness needs (what if a prisoner cannot keep themselves clean (see 2.32)

They do provide some minimal guidance for the following issues:

- Diet - 2.13 Special dietary foods should be provided where it is established such food is necessary for medical reasons, on account of a prisoner's religious beliefs, because the prisoner is a vegetarian, or where the prisoner has other reasonable, special needs. (older prisoner's dietary needs should be assessed and addressed)
- Accommodation - 2.4 Accommodation should be provided to respond effectively to the actual needs and risk status of a prisoner. In some cases, single cell accommodation may be provided, in other cases multiple or dormitory accommodation may be more appropriate. (This could also mean accommodation should address aged care needs)
- Health Care Needs - 2.26 Every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community. Notwithstanding the limitations of the local-community health service, prisoners are to have 24-hour access to health services. This service may be on an on-call or stand by basis.(aged care needs should be assessed and addressed under this guideline) also 2.31 All prisoners who have a medical complaint shall be seen by a health professional at intervals appropriate to the diagnosis and prognosis in each case, according to good medical practice.
- Different options for older prisoners? 2.32 Health professionals should advise the officer in charge of the prison whenever it is considered that a prisoner's physical or mental health has been, or will be, injuriously affected by continued imprisonment or by any condition of imprisonment, including where a prisoner is being held in separate confinement. The officer in charge of the prison should immediately make a written report of such advice available to the appropriate senior officer with a view to effecting an immediate decision upon the advice that has been given. A copy of the health professional's report should be placed on the prisoner's medical file.
- Release to an appropriate environment that will be able to support an aged offenders needs - 2.39 Where a prisoner enters or is released from prison is under medical or psychiatric treatment, where appropriate, the prison health service should make arrangements with an appropriate agency for the continuation of such treatment after release.

Victoria

The Corrections Act Victoria 1986 (and associated regulations) governs the operation of Victorian prisons. The Act outlines prisoners' rights in relation to access to reasonable medical and dental care (section 47(1)(f)(g) & (h)), and in the case of prisoners who are intellectually disabled or mentally ill, access to special care and treatment as considered necessary by medical officers. In Victorian prisons, every day, there are usually morning and afternoon clinic periods where prisoners can get medical attention from a nurse. A prisoner usually needs to book to see a doctor, dentist or specialist. Prisoners are also entitled to pay for and obtain a private medial practitioner, physiotherapist or chiropractor of their choice; but one can imagine the majority of prisoners do not have funds to support such requests.

The Corrections Act 1986 also outlines other rights for prisoners such as access to:

- Sunlight and the outside air
- Nutritional food
- Food that accommodates special dietary or religious needs
- Clothes appropriate to the climate
- Reasonable health care (mental, physical dental)
- Practice religion
- Make a complaint
- Correspond or communicate with authorities
- Education

Other Victorian legislation relevant to prisoner's rights includes:

- Drugs, Poisons and Controlled Substances Act 1981
- Health Act 1958
- Mental Health Act 1986
- Charter of Human Rights and Responsibilities Act 2006
- Information Privacy Act 2000
- Health Records Act 2001

There is no doubt prisoners within Victoria have access to health care. The healthcare and custodial staff working within the justice system are committed caring professionals providing the highest possible care within the system they operate. The Justice Health business unit, established in 2007, is responsible for the planning, coordination and delivery of contracted health services across police, courts, corrections and community corrections, to ensure an integrated and coordinated approach for health services within the Department of Justice.

Justice Health is overseen by a committee comprising senior representatives of the Department of Justice (Victoria Police, Courts, Corrections and Justice Health), the Department of Human Services and the Department of Health. It must be said, that during the time of writing this report, [the ultimate lines of responsibility for healthcare within Victorian prisons was confusing to the author](#)

Victoria is apparently in the process of transitioning to a single-lead service provider for all health services delivery across police, courts, corrections and community corrections. As previously mentioned Justice Health as the health business unit of the Department of Justice is responsible for the delivery of health services for persons in Victoria's public prisons. Across Victoria, there are 11 publicly-operated prisons, two privately-operated prisons (Fulham Correctional Centre and Port Phillip Prison) and one transition centre

(Judy Lazarus), which provide a range of correctional services from maximum security imprisonment to reparation and treatment programs. Primary, secondary and tertiary health and mental health services in Victoria's government-run prisons are delivered by third-party providers contracted by Justice Health. The operators of Victoria's two privately operated prisons also subcontract health services. If a prisoner, or family of a prisoner wanted to make a complaint about medical care received; it is difficult to envisage how this would actually occur; how could the individual escalate concerns about care?

Health care in Australian Prisons has again been reviewed in the last year. The overall finding, not surprisingly, was prisoners have significant health issues, with high rates of: mental health problems, communicable diseases, alcohol misuse, smoking and illicit drug use – than the general community.

Aged Australian Prisoners are more likely to have:

- A referral for further medical assessment on entry into prison
- A need to visit (and to actually visit) a prison medical clinic
- Need to visit the medical clinic more often
- multiple medical conditions such as arthritis, hypertension and diabetes
- mental health conditions and treatment
- test positive for hepatitis
- not increased weight whilst in prison
- report to a doctor or a nurse because of an accident whilst in prison
- prescribed medication
- report that their health had deteriorated whilst in prison
- worked in the prison industry (aged 45 and over)

Older Australian prisoners are visiting prison clinics more often and for more health problems each time.

[From The Health of Australian Prisoners 2012.](#)

The Australian Medical Association (AMA) released a position statement in September 2012 ([The justice system and public health](#)) which again highlights the significant extra health issues prisoners experience and politely articulates concerns with continuity of care for prisoners and resource allocation for health care in prisons as well as recommending the responsibility for the provision and management of health care in state-run prisons should be allocated to state health authorities rather than corrective services or their equivalent. Another recommendation made by the AMA is prisoners should have the right to use Medicare whilst in prison (this is currently not the case).

Aged Care Australia / Victoria

The Australian Government aims to ensure that affordable, accessible and quality aged care is available to all older Australians who need it. Most people prefer to stay in their own homes. Whenever possible, community care assists people to remain at home despite the effects of ageing. Where it is no longer possible to stay at home, aged care homes are available across the country offering quality care and services in a safe environment.

Most older Australians prefer to stay in their own homes, so there are a number of programs available to help out older Australians with daily living activities when it becomes harder for them to manage on their own. A Home Care Package is a coordinated package of services tailored to meet the consumer's specific care needs. The package is coordinated by a home care provider, with funding provided by the Australian Government. There are four levels of Home Care Packages:

- Home Care Level 1 – to support people with basic care needs.
- Home Care Level 2 – to support people with low level care needs.
- Home Care Level 3 – to support people with intermediate care needs.
- Home Care Level 4 – to support people with high care needs.

A range of services can be provided under a Home Care Package, including care services, support services, clinical services and other services to support a person living at home.

If you an older person can no longer live at home because of ageing, illness or disability, there are Australian Government funded places in aged care homes, Residential Aged Care, that can be accessed.

There are two main types of residential care in Australia; low level care and high level care:

- Low level care provides help with the activities of daily living such as dressing, eating and bathing, accommodation, support services such as cleaning, laundry and meals and some allied health services such as physiotherapy. Nursing care can be given when required.
- High level care provides people who need almost complete assistance with most activities of daily living with 24 hour care, either by registered nurses, or under the supervision of registered nurses. Nursing care is combined with accommodation, support services, personal care services such as help with dressing, eating, toileting, bathing and moving around and allied health services such as physiotherapy, occupational therapy, recreational therapy and podiatry.

Residential care can be on a permanent or respite basis. Residential respite provides short term care on a planned or emergency basis. To be eligible for community or residential care you need to be assessed by an Aged Care Assessment Team - ACAT.

During the life of the project, the author has found that federally funded Aged Care services are essentially not available for older prisoners. No written information has been able to be found on this specific topic but as most prisons are state or territory responsibilities, it is little wonder that there is reluctance for federal money to be spent on what is a State Issue. Having said that Wintringham have been successful in advocating for and supporting the assessment of older prisoners by aged care assessment teams over the last couple of years. This has enabled aged prisoners to be assessed for aged care services within prison walls so on release they can be supported by an Aged Care Provider.

Aged Care USA / States

Aged Care support in the USA is not as well regulated nor coordinated at a Federal Level, as in Australia.

Home care services are available in many communities. Meals and transportation are available to older people to help them retain some independence. Group or home-delivered meal programs help ensure an adequate diet. Meals-On-Wheels programs are available in most parts of the United States and a number of communities offer door-to-door transportation services to help older people get to and from medical facilities, community facilities, and other services.

There are several types of retirement communities. Large hotel corporations are in this field and other facilities are set up for members of a certain organization (retired military, Elks, etc.). Personal care homes (board and care) are licensed in many communities to provide shelter, supervision, meals, and personal care to a small number of residents.

Subsidized housing for the elderly is an option for the elderly poor in reasonably good health. Subsidized by Department of Housing and Urban Development, income limits apply. No round-the-clock care is provided but nurses come in to check blood pressure and assess a resident's functioning. Residents take meals in a dining room and may have use of a library, recreation area, or beauty shop.

Similar to Australia, Nursing homes offer two levels of care - skilled nursing and intermediate care - depending on the patient's needs. Most nursing homes offer both levels of care on a single site. Skilled nursing facilities provide 24-hour nursing services for people who have serious health care needs but do not require the intense level of care provided in a hospital. Intermediate care facilities provide less extensive health care than skilled nursing facilities. These facilities are for people who cannot live alone but need a minimum of medical assistance and help with personal and/or social care.

Medicaid the joint federal-state health care program for people with a low income is administered by each state and the type of services covered differs. There are strict income requirements and the application process is very complex and bureaucratic. Medicaid is the major payer of nursing home care.

Demographic Analysis Australia / Victoria / USA / NZ

Comparative Population analysis and related imprisonment data - Figures align to approximately data at June 2012

Prison Population for various ages								
	40+	50+	55+	60+	65+	Total Population	Rate 55+	Rate 50+
Aust		3162	1895	1076	548	21,507,717	0.009%	
Vic		751	437	255	134	5,354,042	0.008%	0.014%
NSW		1062	645	352	164	6,917,658	0.009%	0.015%
SA		275	165	94	57	1,645,000	0.010%	0.017%
New Zealand		852		259		4,405,200	0.000%	0.019%
New York			3925			19,378,102	0.020%	
Virginia			2505			8,096,604	0.031%	
Pensylvania	19,798		4084			12,742,886	0.032%	
Missouri			1996			6,010,688	0.033%	
Oklohoma			1875			3,791,508	0.049%	
Texas			12255			25,674,681	0.048%	
Mississippi		2801		612		2,978,512	0.000%	0.094%
California			12797			37,691,912	0.034%	

Comments on Data:

Exact comparisons are difficult as different age measures are collected across jurisdictions with the measure of 55 years and older being the most commonly collect comparator.

As a percentage rate of imprisonment, Victoria & Australia (0.008 – 0.009%) has about 2 to 4 times less 55 + year olds than USA States (0.020 – 0.048%)

Key Themes Identified During Study Tour & Whilst Completing this Project

A variety of different housing and care models were observed within the prison system visited on the tour. The differences observed appear to have been guided by the prison's history, the history of the relevant State's legal decisions and events that have occurred around those decisions.

Overall, the care of older prisoners was of a high standard, much higher than one expected from reading literature about older prisoners in the USA. All prisons visited have a well advanced working model to support older prisoners within the prison however formalised transitional options that provided supported care on release from prison were basically nonexistent.

From an aged care, and economic perspective the models of care observed were costly. Some literature indicate the high cost of care in a prison environment relate more to structural (building design); however from what was observed, the key driver of care cost would appear to be most prisons care models for "high care" older prisoners were founded on a hospital / acute care model as compared to using an Aged Care Model; which has lower cost patient care attendants (PCA) supported through nursing leadership. USA exceptions to the high cost care models, were found in prisons with advanced "prisoner care models" (Virginia, Missouri, Oklahoma, California) but even in these prisons, in most cases when older prisoners became high care, they were transferred to an acute nursing care model within the prison system.

As indicated earlier, prisoner carer models (younger prisoners providing care in prison) do exist. Younger prisoners are offered training and function as a PCA. Both Jefferson City and Joseph Harp Correctional Centres had excellent training programs. Further, those prisons with prisoner carer models, had a "softer" more humane feeling about them; As one prisoner carer expressed, "it is the first time that I can remember really caring about anyone else other than myself". The prisoner care model is one for Correctional Authorities to further consider; it may have limited viability within the Australian context given:

- Smaller group of prisoners that may qualify for prisoner carer model as the prisoner cohort is much smaller in Australia (compared to USA)
- Shorter sentencing provides limited long term carers and
- Those prisoners with longer sentences tend to have committed crimes that would exclude them from
- Limited options for use of acquired skills on release as Australian Aged Care Legislation may prevent most prisoners from being able to use gained training skills on release for employment within an Residential Aged Care Service.

As mentioned, as all care options observed were influenced by an acute hospital care model of care; It was easy to see that an aged care model of care would be less costly, and ultimately provide more aged appropriate and age sensitive care. Rimutuka prison, New Zealand, was in the process of introducing such a model. It will be interesting to follow their progress.

There is no doubt; Aged Care provided into a prison environment has to be done differently:

- Security / custodial interactions and issues do affect the way in which care is delivered.
- A heightened, even more intense approach to the medication management, security of medication needs to be considered

- Use of any sort of sharp object such as cutlery, scissors, wire etc needs a review of practice and consultation with correctional authorities on how risk to manage “sharps” should be considered
- Further consideration to how best support staff compliance with medication and sharps procedures is required as the risks of non compliance is potentially more catastrophic than with the current Wintringham client group.
- Further consideration on the real need for segregation of specific prisoners for their own safety as Australian custodial models seems to rely on segregation whereas models observed in the USA are not so reliant on segregation as a means of security - See Laurel Highlands

Prisons in the USA, similar to Australia, have a high percentage of mental health management support. The most impressive mental health support observed was at the California Men’s Colony. There was informal acknowledgement that the “deinstitutionalisation” of mental health was more like a “reinstitutionalisation” to the custodial system. (Cramer 2012) Current Australian Bureau of Statistic and AMA information indicate Australian prisoners also have a high percentage of mental health issues. However the same intensity of mental health care / support has not been observed within the Australian context. Forensicare (Victoria) is an exception to this, with its specialist Forensic Mental Health services; it has a strong mental health team, similar to that observed at California Men’s Correctional Colony. Wintringham should consider alignment with such a facility as transitional supports for older prisoners and professional collaboration between services could benefit both parties.

Older prisoner housing options were found in both maximum and minimum security facilities. It appeared that minimum security facilities could more easily adapt their environments to age appropriate care. From a building structure perspective, it appeared easier as there were less heavy structure to manipulate to make good for aged care alterations. From a staffing perspective, lower security prisons appeared to have a “softer” correctional approach which saw witness to greater empathy from correctional staff to a prisoner’s care needs.

Only some older prisoners who were VERY frail (HIGH CARE) have viable transitional option. Essentially, there are NO transitional care models for “low care” aged prisoners, and all prisons visited would have welcomed a viable transition option like Wintringham. Prisons were universally intrigued by Wintringham’s Mission. Most were particularly interested in how Wintringham was funded. There is overwhelming evidence of a broader issue of inadequate post-release planning and support for older prisoners in Australia as well (Ahmed 2008; Australian Institute of Criminology 2007; communitycare.co.uk 2003; Crawley 2004; Crawley & Sparks 2005, 2006; Department of Health 2007; Department of Justice 2009; Dobson 2004; Grant 1999; Her Majesty’s Inspectorate of Prisons 2004, 2008; Hobbs et al. 2006; Ove 2005; Prison Reform Trust 2003a, 2003b, 2004, 2008b; Rikard & Rosenberg 2007; Stojkovic 2007; Wahidin, & Aday 2006; Williams 2008). Writers point to a number of reasons for this inadequacy including, lack of coordination of funding, resources and service-provision between prisons, community-based correctional services and community agencies (Ahmed 2008; Prison Reform Trust 2008b), priority being provided to younger offenders, who are perceived to have greater chances for successful rehabilitation and re-integration (Borzycki 2005), and lack of state or federal strategies to address the needs of older prisoners, combined with restrictive criteria for the early medical release of terminally or chronically ill prisoners (communitycare.co.uk 2003; Her Majesty’s Inspectorate of Prisons 2004; McCaffrey 2007; Ove 2005; Prison Reform Trust 2003b; Rikard & Rosenberg 2007; Stojkovic 2007).

In the USA, if you are an old prisoner and have no need for assistance with activities of daily living, transitional arrangements for support into the community (rooming houses essentially) start about 6 months prior to release. For these prisoners, prison probably provides a better quality of life and it was

suggested on more than one occasion, that many older prisoners probably reoffend with minor offences, just to get back into the system, where their health needs are better supported.

Davies (UK 2011) indicates currently (in the UK) the needs of the elderly (prisoners) are being ignored at a national scale, which has meant an absence of a much needed comprehensive strategy that is able to manage these (aged care) problems. Davies goes on to say that in order to form such a plan, policy makers must consider expanding the individual initiatives that have developed across England and Wales;

Whilst early release, based on medical grounds and health is an option, it is near impossible to get an authority to make a decision to grant this option as the risk of a serious re-offence is seen as too high. There is absolutely no rationality about the real risk a frail elderly prisoners poses to reoffending; just IMMENSE fear of and early release going wrong. As an example, in Oklahoma, the Governor (Premier equivalent) has the final say! The same sensitivity seems to exist in Victoria, particularly as many of the older prisoners have a higher degree of public sensitivity than others.

As early release options for the older prisoner cohort are, in the short term, unlikely to be considered favourably by risk adverse bureaucracies, there is no doubt Wintringham should continue advocate and influence Corrections Victoria to develop a Aged Care appropriate facility within prison walls that can provide better support for aged prisoners than is currently experienced in the Victorian context. Advocacy for an Aged Care Model of care, instead of an acute care model of care, will help Corrections Victoria develop a more economically sustainable model of aged care.

In continuing to foster our relationship with Corrections Victoria we can also influence improved transitional care models for aged prisoners. By working closely with Corrections Victoria, Wintringham can continue to influence better care options within the prison system as well as assisting older released prisoners to be better supported in the community.

There would need to be a linkage to a local hospital (this probably exists) AND as the older prisoners care needs increase; Have an aged care facility linked closely (but on the outside of) the low security prison, with ongoing minimal custodial presence (24/7) supported by Justice Victoria.

At all times, Wintringham needs to consider the risks that providing carer to any of its potential client's poses. In reality Wintringham should be able to gain better information about released prisoners than many of its "non prisoner" marginalised clients as some form of formal history will be available about the prisoner.

Other themes that Wintringham will need to consider in working with older prisoners are:

- What are the real risks that an older offender poses to public, visitors and staff – the development of a risk screening tool is probably warranted?
- What is the risk that a public "outing" of a publicly despised criminal poses to Wintringham's public integrity?
- How do we gain better information about the risks a prisoner may pose and better information on their care needs?
- What training do we need to offer staff about the aforementioned risks?

It is highly probable that some older prisoners will have such a poor public persona; it may not be in Wintringham's best interest to consider care for them. As was found in Pennsylvania, Corrections Victoria could have the option of utilising Victorian Government (DHS) "controlled" aged care beds for the care of such prisoners.

Some Aged Care “triage tools” were identified and used to screen older prisoners into a special “aged care area” of a states prison system. In most cases they commenced as complex tools with the intention that a referring prison’s staff would be able to complete the tool for referral. Discussions with most health officials indicated there was low compliance with accurately completing the complex tools and ultimately resulted in reverting to a basic referral to a central expert team who would complete a thorough aged care / cognitive assessment as part of the screening. If a prisoner did not qualify for aged care needs they were returned to the referring prison. Given Australia has a system for assessing aged care needs (Aged Care Assessments Teams) it would seem to make sense to try and leverage their expertise for assessments of an aged prisoners care needs. Referrals to ACAS could be completed by prison nurses.

Transport from prison to hospital for acute health care needs has a significant cost impact for all prisons visited. Rostering logistics of ensuring extra correctional staff was available to accompany a prisoner were often presented as a major hurdle. Any aged care involvement within a correctional environment would need to consider the cost and logistics of inevitable hospital transfers.

Pennsylvania had retrofitted an old hospital for prison use. The use of such a building provides a solution for many aged related design issues (flat surfaces, wider corridors, lighter doors, larger bathroom and shower areas) as they had already been considered in the older hospital design.

Unlike the majority of prisons in the USA the focus at Singen (Germany) was on the older person – not necessarily the older FRAIL person. The majority of inmates at Singen had already successfully lived many years in the community and as a rule, this group has not aged earlier and are generally, in their care needs, representative of the larger aged care cohort.

The model at Singen will work for all comers provided they are happy to live community life and not threaten or terrorise other prisoners. Similar to Wintringham Wicking program, Singen relies on prisoners cooperating with the defined model of care. Staff are given advanced training to help them provide consistent care and behavior management of the prisoners.

Different to the USA and Australia, Singen staff find it relatively easy to place prisoners into residential aged care homes! The caveat here, however, is the total responsibility the corrections department take for ensuring that prisoners are appropriate for transfer. German law allows a prisoner to be held past their sentence if they are considered to be a risk if they are returned to the community. Conversely, prisoners should not die in jail. Those who are clearly approaching the end phase of life are transferred back to the community for palliative care and like treatment. The notion behind this being that the prisoner is too sick to be a risk of reoffending in the community if released and on this basis, their sentence can be shortened.

Most prisons provide some form of segregation where paedophiles, ex police, ex lawyers in particular are segregated from other prisoners for their protection. [Certainly, in NSW all child sex offenders are detained in strict protective custody.](#) The justification for placing child sex offenders (and child killers) in strict protection is that they are reportedly the most hated group of offenders in the correctional system, and therefore in need of the highest level of protection. [While there is some older literature to support this statement, there is also some evidence that suggests that it is the personality of the offender,](#) and not the offence itself, that makes an inmate vulnerable to attack by other inmates, and that some child sex offenders have successfully served their sentences in the general gaol population.

As an aside, the Puppies on parole programs (or similar), where prisoners are given the opportunity to train dogs for various community works, was a fantastic program. You could easily see and “feel” the benefit in each prison that supported such a program.

Reviews of Correctional Facilities

Fishkill Prison http://en.wikipedia.org/wiki/Fishkill_Correctional_Facility; have well documented expertise in Aged Prisoner Care.

The author thanks Superintendent William Connolly, Dr Carl Dr Carl Koensberg, Dr Joseph Avantzo, Paula Butler (Deputy Superintendent) & Lynn Cortella (RN1) for their time and support over the day. A presentation of the facility was provided which was followed by questions and answers and then a tour.

Fishkill Correctional Facility is a medium security prison in New York, USA and was constructed in 1896. It began as the Matteawan State Hospital for the Criminally Insane. For about 80 years, Matteawan State Hospital was one of the nation's most famous institutions for the "furiously mad." It began to change its custodial practises in the 1960's when the courts restricted the state's power to imprison the mentally ill. The whole Fishkill facility is now spread over 738 acres, 148 buildings most of which are over 100 years old) and is surrounded by about 7 miles of perimeter fencing.

Fishkill also now houses the Regional Medical Unit (RMU) for Southern New York's prisons. There are about 1700 prisoners in the facility housed in two general population housing complexes. The main building has 26 dormitory style medium security housing units. (This area was not reviewed)

This study's main interest was the newly built (2006) Regional Medical Unit, a free standing building devoted entirely to providing comprehensive medical care. There are five such RMU's in New York State which as a State has a prison population of 50,000; compared to Victoria with approximately 4,700 and Australia as a whole approximately 29,000. (New York State total population is approximated at 19.7 million compared to Victoria general population of 5.6 Million and Australia general population is estimated to be now 22.7 Million) From these figures, the incarceration rate per head of population appears to be about twice that of Australia.

The RMU is impressive. It opened in 2006 to provide a calm, comforting and safe environment for inmates. It specialises in the treatment of inmates with dementia-related conditions such as Alzheimer's disease. The average age of inmates housed in the unit is 62;25 years older than the average age system wide.

There is a Pre Entry Cognitive Assessment tool but staff indicated the tool is only partially used as it was found to be too time consuming and complex. Some referrals are now taken from other prisons based on information shared during the referral process and the unit, itself is being used as an assessment centre, in that staff may accept a referral on the condition that the prisoner will be returned to the referral source if Fishkill assess the prisoner as having no or minimal cognitive impairment.

The RMU has 80 beds in total, spread over 4 levels. The secure facility is more clinical than correctional in character, with the "white-walled" feel of a hospital rather than the steel and concrete finish of a prison. There are wide corridors and wide doorways. All doors are heavy and secure in nature which provides a challenge for an aged prisoner to open and yet they provide security for the vulnerable.

The whole facility is well ventilated and some of the single rooms have pressure controlled ante chambers for prisoners who may need to be isolated for infection control purposes. The design is essentially hospital / clinical like in nature. All floors are level and there are no bunks or obvious trip hazards. There is no easy access to the outside, so it is difficult for a prisoner to feel the sun or fresh air on their face. Whilst it was possible to access the outside – it was not easy for an older prisoner who needed assistance with ambulation.

There was evidence of high low beds with cot sides but there were no specialist type aged care high-low beds - The type of bed that goes all the way to the floor and minimises injury if one should fall from the bed. On discussion about the absence of this type of aged care bed, Fishkill staff indicated they could and would access such a bed if required.

There was obvious access to equipment and medical treatment for prisoners, walkers, wheelchairs and a full complement of medical treatments on offer within the RMU which by Australian standards is like a hospital with an aged care facility attached to it. The staff informed me both State and Federal laws mandate health support for prisoners and it certainly appears that the prisoners receive a high level of health support.

“Corrections Health” is fully funded by the Department of Corrections state of NY.

As mentioned the RMU complex runs like a regional hospital (Australia) or medical unit (US). It incorporates 60 “inpatient style beds.” 30 for Cognitively Impaired (CIU), 30 Long Term Care (LTX) (Aged Care) & 20 infirmary beds (sub acute care). It is staffed by Medical staff, Psychiatrist, Psychologist, Registered Nurses (Div 1 & 2 Oz translation) and carers. There is also a social worker, a funded recreational therapist (positioned not currently filled) and pastoral care linked to the unit. It is interesting to note that a Correctional Medical Position is seen as a good option for doctors as the employment offers a better work life balance than the high demands of private practice in the USA.

There is an obvious correctional officer overlay with the care that is provided but there appear to be less numbers of correctional staff in the LTC and the CIU than the infirmary. (This seemed appropriate) Staff are obviously dedicated to improving care and situation for older and ill prisoners with examples of humanity shared during discussion.

Some prisoners are trained in hospice care support but prisoners are not involved in direct care. Of interest to the author was discussion of a prisoner care model – a care model where prisoners could be trained to provide direct care to an older prisoner. Staff at Fishkill indicated their key issue of concern was the litigious risk associated with “carer error” as well as the industrial concerns of replacing staff with prison labour.

Onsite specialities supplied by the RMU include:

- Radiology
- Pharmacy with 4 staff providing 6000 prescriptions a month
- 5 dental care staff
- Emergency care
- Primary care
- Dialysis (chairs)
- Dietetics and
- other speciality care like phototherapy & telemedicine

– it appears all but surgery was performed in the DMU.

The CIU occupies the entire third floor of the prison’s four-story medical centre. The unit is akin to a maximum-security environment inside a medium-security prison, allowing it to accept cognitively impaired inmates of any security classification from any facility throughout the state system.

Among the programs operated at Fishkill is the Correctional Industries (Corcraft) program, providing some form of “recreation” for inmates who can manufacture beds, chairs and computer furniture for sale to state and local governments. They also fabricate, to order, heavy gauge steel specialty items, such as security doors and windows, for correctional and psychiatric institutions. For older, less able prisoners, a recreation staff member is usually available but the position was not filled at the time of the visit. There only real evidence of a formalised recreation program at the time of visit was the [puppies behind bars](#) which is well received by prisoners and staff alike.

Fishkill have a transition release program managed by Lynn Cortella, a Registered Nurse. Lyn indicated that there were about 16 older prisoners, who at the time of the visit, could be released but as they had no Aged Care Facility who would accept them, they remained in prison. The prison was trying to build a formal relationship with a service provider. Lyn further indicated, discharge / release, was not such a problem for an infirmed or wheelchair bound inmates. Older more active clients, who needed some care support presented placement problems. Exactly the sort of client Wintringham provide for, needless to say there was much interest in Wintringham.

Fishkill undertake a correctional accreditation process and I find out there is a well documented quality process for correctional facilities in the USA, similar to that of Aged Care Facilities in Australia with the [Aged Care Accreditation and Standards Agency](#).

[The Standards and Accreditation Department of the American Correctional Association \(ACA\)](#) serves a dual mission of providing services for ACA and the Commission on Accreditation for Corrections (CAC). These services include the development and promulgation of new standards, revision of existing standards, coordination of the accreditation process for all correctional components of the criminal justice system, semi-annual accreditation hearings, technical assistance to correctional agencies, and training for consultants who are involved in the accreditation process

Key issues discussed during the day tour were the discussion round risk:

- The risk prisoner presents of another offence or violence

- The risk perception of the corrections system which is understandably risk adverse (there is no tolerance for error from the public / media)

- The risk perception by public particularly if the crime committed (no matter how long ago) is of significant public interest) (and hence the real possibility that some prisoners are in a category that will never be released; thus requiring a commitment from the correctional system to provide for aged care needs within the correctional system itself.

The same risk perceptions and discussions have occurred within the Victorian context.

It was a privilege to tour the Fishkill facility and again I thank the staff for their support.

No photographs were able to be taken though I may access some from the power point if provided.

Photographs provided have been sourced from Google Images and are consistent with what was observed at tour.



Deerfield Correctional Centre

I was greeted warmly by:

Keith W Davis, Warden
Clyde Alderman, Assistant Warden
Susan Bolton, Business Manager
Teresa Porrovecchio, Operations Manager
Darleen Ellsworth, Programs Manager
Bonita Badget, Registered Nurse Coordinator
Beth Cabell, Programs (Farms, Reentry, Education) (compassionate release study)
Darlene Elsworth, Programs ID Awareness, VETS support, SOM, outcome measures
Kathy Walker, Unit Manager, Special Needs 57B
Meredith Wran Psychologist (Psych Associate)
John Beale, Recreational Therapist

At all times staff were open and forthcoming with discussions around the care of the older prisoners. It was evident that previous visitors may have misrepresented discussions surrounding the care of older prisoners (A “Current Affairs” phenomenon presented as “look what happens here – they lock them up and throw away the key”.) As such I feel obliged, early in this review to highlight, nothing could be further from the truth. It was very evident that Deerfield had a caring culture; one that was focused on support of the inmate’s physical and mental health as well a working towards supported re-entry.

The current Deerfield facility began receiving prisoners in 1999. It was specifically designed to house geriatric offenders, security level 2. [Prison security in the USA is generally rated from 1 to 5. 1= low security and 5 = high security.](#) Security levels are based on such features as the presence of external patrols, towers, security barriers, or detection devices; the type of housing within the institution; internal security features; and the staff-to-inmate ratio.

Even a low security prison, there was no doubt Deerfield is a prison. The dual cyclone fencing and razor wire make sure you are aware of that. Entry is through a secure system of checks and metal detection. My feet were x-rayed as I passed through the security area. (I saw the metal rods in the shoes I was wearing on the screen)

I am told the growth of ageing prisoners and their associated medical needs has been a challenge for Virginia as a State (and all states of the USA) and further expansion of the facility occurred in 2007.

The current facility holds approximately 1100 inmates and the 2012 population was 1067:

About 60% of these inmates being African American;
about 60% of inmates were single or no current relationship
about 20% had some measure of cognitive impairment
the Veteran population was unknown (or not provided)
The average age of inmates is 56 years:
46% = 51-60;
26% = 41-50;
18% = 61-70.

The oldest offender is 89 years of age.

Approximately 800 prisoners are on prescribed medication.

There is dedicated staffing for associated Health / Aged Care needs:

A full time medical specialist.

Best Practice Support Model for Older Prisoners

Well organised nursing staff with RN1, RN2, & PCA (Australian equivalent)

An inmate support model was also adopted where younger physically able inmates provide support for older prisoners (but apparently not direct personal care).

The key areas of interest were the 57 bed dormitory style assisted living unit and the 18 bed infirmary. On first reflection a dormitory may look and sound somewhat inhospitable when compared to a single or shared cell; but interestingly and quite paradoxically the dormitory environment offered warmth, comfort and support; that is not as evident in a structured cell environment.

Whilst there were other areas for prisoners, this study's main interest is the 57 bed dormitory style assisted living unit and the 18 bed infirmary.



Virginia has a State prison population of approximately 30,000; compared to Victoria with approximately 4,700 and Australia as a whole approximately 29,000. The Virginia State total population is approximated at 8 million compared to Victoria general population of 5.6 Million and Australia general population is estimated to be now 22.7 Million. There are also another 56,500 individuals who are on an active release programs. In short the incarceration rate per head of population appears to be about three times that of Australia.

Inmates and staff appear to exchange discussions freely, but one can sense a definite air of authority from guard to prisoner. Beds were mostly fixed metal beds of two heights (high or low); there were also some hospital type high low beds (about 7) on one wing of the dormitory. These were hospital style High Low Beds; not the aged care type that can lower all the way to the floor.

All grounds were noted to be level and on the ground floor. There were no stairs or trip hazards present and easy access to the "outside" for feeling the sun light on your face, breathing in fresh air, seeing the blue sky and clouds and seeing some green foliage (albeit through dual cyclone fences).



The 18 bed infirmary operated like a small hospital / emergency unit and was staffed 24/7 with registered nursing staff. There appeared to be a good triage system where inmates requiring more intense medical support were transferred to the local Southampton Memorial Hospital (about 20 miles away) where “13 secure beds” were provided; as well as having a number of outpatient clinics for prisoners.

Deerfield provides security staffing for the Hospital (at Deerfield’s expense) Of course this also means transport coordination for each prisoner. (Transport arrangements were not observed) Earlier that day an inmate with uncontrollable seizures had been transferred. Intravenous fluids and medications were provided in the unit but not respiratory (respirator) support. All seemed appropriate for the size, style and staffing for the unit. Pharmaceuticals were prepared off site through a provider and the Nurse in charge was very happy with the responsiveness of the service (similar to what Wintringham have with their Aged Care facilities).

At the time of the visit 801 inmates prescribed medications and about 4,500 prescriptions were being filled each month. The medical budget for the facility was projected to be approximately four million dollars annually. Other statistics of interest:

Of the total inmates (1066) 801 were receiving medications

50 inmates were wheelchair bound

Elective Medical Transportation trips during 2011 = 1614

Emergency medical trips during 2011 = 101

Deerfield has approximately 13 offenders with a dementia diagnosis. Eight are housed in the open dormitory and 4 are in the infirmary. Staff indicate there is an immediate need for a “celled” / secure dementia specific unit and Deerfield management has identified it as a priority; given dementia patients can be disruptive and can fall victim to other more able body prisoners. A need for additional Assisted Living Beds had also been identified; which will more than likely lead to the expansion of assisted living beds into another housing unit this reducing the amount of double bunks available. Staff indicate prisoners identified as requiring “assistance with living” are not (should not) be housed in a bunk area.



All housing units had a custodial staffing overlay. The presence of the custodial staff was subtle and interactions were noted to be respectful between both parties and not overlaid with power structures. These observations are difficult to measure; they are what one feels on observation. They were noteworthy to be written in this report. On commenting to the group about the custodial staff; discussions focused on the value of the custodial staff to the inmates as a comrade. It was also highlighted that the men still had time to serve for a crime that the courts had convicted them on.

The second in charge Clyde Alderman particularly represented the view that the prisoners had done wrong and until they had served their time, they were inside the prison system as punishment. When we discussed prison release he was adamant that all prisoners were sent home. This led to a discussion about what happens with most older prisoners in Australia where usually they may have outlived their family, have no family or their family no longer want anything to do with them. In fact few older Australian prisoners actually had a home

The Virginia Department of Corrections (VADOC) have a four year Virginia Adult Re-entry Initiative (VARI)– Strategic Plan (July 2010 to June 2014). There is a real focus on reviewing prison sentencing and re-entry practises whilst ensuring public safety in the State of Virginia. In fact, as I was writing this report I a new CNC documentary had been released - “Billions Behind Bars”- <http://www.cnn.com/id/44762286> . The VARI is a comprehensive plan to enhance public safety by aiming to ensure offenders successfully return to the community. The VARI has the strong support of the current Governor (Premier in Australian terms).

As mentioned in the VARI, “though there are risks associated with the new vision of offender re-entry, the greater risk is when offenders are released from prison unprepared to return the community and unprepared to become a contributing member of society”. The VARI acknowledges that the success of the initiative is dependent on the commitment and involvement of other key stake holders such as: State Agencies, the legislature (courts, magistrates etc., local governments, service providers and not for profit agencies (such as Wintringham – Victorian context).

Discharge Re-entry planning presents similar challenges to Deerfield as it has to all facilities I have thus far visited. Deerfield have a well developed process that starts six months prior to planned releases where “difficult to re-enter society cases” are presented on a monthly basis to a group which includes a number of disciplines: counsellor, medical, mental health, nursing, social work and security staff

Strategies employed include: trying to reengage family, visiting nursing homes, and engaging faith based groups for support. Despite best efforts, a number of aged offenders have no home like option to be released to. There was a fascination and interest from the staff at Deerfield, “why would an aged care provider be interested in working with older prisoner release. (This same fascination and “admiration” was expressed in Fishkill – “there is a need for a Wintringham in the USA!”).

Best Practice Support Model for Older Prisoners

Deerfield staff also shared end of life stories - inmates will die in prison. Inmates are supported through a palliative care process. Inmates are given as much opportunity as possible for visits and involvement from family when the end of life is near. Inmates are given the choice to move from the dormitory to the infirmary. There were stories shared that the end of life process is supported with prisoner choice: the value of having your prison mates around you in your last hours (the value for the dying but also for the living in knowing that the same may happen for them.)

A well structured recreation program was evident and supported by a recreational staff member. There was a fully functioning gym and basket ball court area. There was a medical overlay to this type of recreation. Older medically challenged prisoners needed medical clearance / permission for certain activities.

It is interesting to note that at both Fishkill and Deerfield, physicians were extremely positive about their work. The work life balance was quoted as a major benefit as there was not the management and administrative burden of a private practice; and overall the interaction from Doctor to patient was seen as a far more positive experience than one could achieve in private practice.



State Correctional Institution at Laurel Highlands; Pennsylvania's

Again I was made very welcome to another prison in the USA; the State Correctional Institution at Laurel Highlands; Pennsylvania's only prison that is specially tasked with handling sick and elderly prison inmates.



The prison is set outside the small town of Somerset (population of approximately 6,300) and is located about 70 miles southeast of Pittsburgh; just a twenty-minute sobering drive from the field where [Flight 93](#) plunged to the ground on 9/11.

Care of older prisoners (and prisoner in need of medical care) is provided around-the-clock at Laurel Highlands. There are approximately 1400 inmates at the correctional centre. Approximately 320 of this number are inmates that would be considered suitable for aged care within the Australian Aged Care system.

Many of the patients / inmate group have conditions such as Alzheimer's disease, physical disability, cancer and pulmonary disorders. There is also a very busy dialysis with 15 (+2) chairs treating about 74 prisoners with Haemodialysis. (I am curious to what appears to be a high rate of dialysis; it seems proportionally much higher than what I have heard of within the Victorian prison population – A study for another time!) Prisoners fill the chairs in three shifts on Mondays, Wednesdays and Fridays. Two more shifts come Tuesdays and Thursdays.

Laurel Highlands, as a prison opened in 1996 in buildings that once were the Somerset State Hospital; it is now a minimum security facility (Level 2 of 5). The prison has two "skilled care units" housing a total of about 100 inmates, many of whom are transferred from other prisons within the state. The building went through another update / upgrade about 7 years ago (2005) The average inmate age is 44, the highest in the state system; which you would expect as it is the key referral centre for older prisoners in need of extra support. There is an assessment tool, used for referral. Not every old or sick inmate makes it to Laurel Highlands.

The prison's medical team also provides such advanced services as tuberculosis treatment and ventilator support. Laurel Highlands' annual per-inmate cost is nearly 30 percent higher than the state-wide average; something you would expect as there is a higher cost to care for prisoners who need extra assistance with care.

There are about 320 inmates who live in the prison's medical unit, which offers both "skilled" and personal care. Not all of the 320 are elderly; many are younger with disabilities and or medical needs that require daily medical support. Many need assistance with activities of daily living: they may need to be reminded to take showers, or require help cutting their food or dressing and undressing.

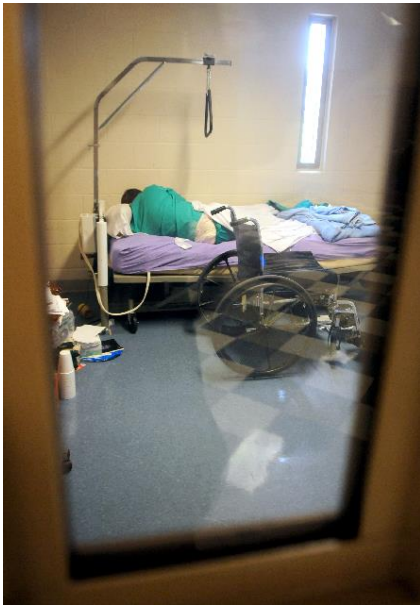
Best Practice Support Model for Older Prisoners

The prison medical staff includes approximately 26 registered nurses, 42 licensed practical nurses and 30 certified nursing assistants. There is one employed Director of Medicine and other contracted physicians. There is an onsite dental service, physiotherapist, social worker, counsellors. There is also a prisoner helper system, similar to what was observed at Deerfield prison where prisoners assist with “non direct/personal care”: cleaning, assistance with ambulating, assistance with different support programs like recreation and hospice support.

There is also a well defined recreation program arranged by one dedicated recreational therapist, who engages a team of prisoner volunteers to coordinate recreational programs. The enthusiasm of recreational therapist, to help prisoners with failing health to enjoy some amount of recreation was inspiring. You could see prisoners competitive eagerness as they completed activities arranged into an “A League” of a variety of activities. The more “abled” prisoners were enlisted as helpers to help arrange a variety of activities.



One of the benefits of retrofitting an old hospital for prison use is that many aged related design issues (flat surfaces, wider corridors, lighter doors, larger bathroom and shower areas) have been already addressed in the design. There are no bars on the windows (some medical treatment areas do have bars for security). One observes: grab rails, all floor areas are level and no obvious trip hazards. Showers are equipped with seats. There are even shower tables for inmates who can't sit up. For inmates with mobility problems, staff bring meals, rehabilitation and religious services to the unit. Many wheelchairs and walking frames are observed around the facility. Day and lunch rooms were of a “grand” size and much of the building was light and “airy”. It was not that easy for older prisoners to access the outside; but the outside views and areas were the best I have seen: Large grasses areas with large cyclone fences and razor wire. Laurel Highlands is in an undulating rural area so the autumnal views were quite spectacular and comforting (the interior felt less prison like)



Correction officers are on guard in the units 24 hours a day; like Deerfield, the guards presence was subtle (most of the time) and mostly respectful. It is important to remember it is a prison and there are also younger more agile prisoners in the mix, that no doubt from time to time need reminding of acceptable behaviours. As it is a low security prison and many inmates are frail, doors to inmates' rooms are not locked, but prison staff can activate automatic doors to quickly contain any problems. There is also a nearby restricted housing unit (RHU) where "problem" inmates can continue to receive care.(this is more like a high security unit).

During this particular prison review I find out that Laurel Highlands do not segregate prisoners because of certain offences they had committed. To date, I have witnessed in most prisons, some form of segregation where paedophiles, ex police, ex lawyers in particular are segregated from other prisoners for their protection. This was questioned, and I was told offences were a private matter. This position seemed remarkable to me as I was of the impression that it was a common practice to place sex offenders in protective custody. [Certainly, in NSW all child sex offenders are detained in strict protective custody.](#)

The justification for placing child sex offenders (and child killers) in strict protection is that they are reportedly the most hated group of offenders in the correctional system, and therefore in need of the highest level of protection. [While there is some older literature to support this statement, there is also some evidence that suggests that it is the personality of the offender,](#) and not the offence itself, that makes an inmate vulnerable to attack by other inmates, and that some child sex offenders have successfully served their sentences in the general gaol population.

Inmates who are terminally ill and still have time left on their sentences have two choices: die in prison or hope they qualify for Pennsylvania's compassionate release program. Typical of what has been seen so far during this study, there are stringent guidelines for medical release. Corrections officials or a prisoner may petition a temporary suspension of sentence for release to a treatment facility or hospice only if it can be shown that the inmate will receive more appropriate care and they pose no threat to the community, and they are seriously ill and likely to die within a year. If any of those circumstances change, authorities can petition to have the inmate sent back to prison. In short, a terminally ill inmate with time remaining will almost certainly die in prison.

More than 400 men have died at Laurel Highlands since it opened in 1996. As has been discussed in New York and Virginia, requests for medical / compassionate release are rarely granted. Apparently three Laurel Highland's inmates have applied. One was denied, and the others died before a decision could be made.

The prison releases inmates' remains to their families. Unclaimed remains are cremated and buried in marked, numbered graves. Inmates who enter the "skilled-care" unit sign advance directives and terminally ill inmates may have more privacy and longer visits. The prison's hospice program provides specialized nutrition, chaplain visits and other comfort measures. As previously mentioned, inmate volunteers are trained and will sit with those who are dying.

It was refreshing to spend time directly with nursing and other care staff. Discussions really assisted to understand some of the complexities (differences) that need to be considered for establishing an aged care program within a prison system:

The importance of providing a secure and accountable medication system. All medications were in extra / extra secure areas and many more medications were crushed than you would normally expect in your average aged care facility (this is about ensuring ingestion and preventing "resale" of medication)

All sharps, instruments, needles, syringes, razors, podiatry equipment etc were accounted for (as you would for medications) by a count system; supported by several routines such as bundling in packs of fives, tens, twenties or fifty; the use of "shadow boards for equipment like scissors, nail trimmers scalpels etc.- to make counts easier.

The use of canvas pouch bags for carrying items like syringes to prisoners for insulin and or other injectables. Each bag had a "count in" and "count out" procedure

The use of in house sterilising to more easily account for movement of instruments in and out of the prison system

Many cupboard and or medical packs (like a resuscitation bag) had plastic lock systems. If the plastic lock had been broken a full count of all equipment in the bag / locker was required.

Routines for medication seem linked to custodial processes like prison count times and or different movement of prisoners

There was a far greater accountability for every item of stock; a more thorough "stock in" a "stock out" process

Initially these processes seem quite daunting and time consuming but staff assured me that it was just something that you became used to and ensured greater safety and security for all (staff and inmates alike).

Staff demonstrated a great knowledge of the prison population's health issues. As an example, the infection surveillance nurse could confidently quote:

280 inmates had Hepatitis C,

8 inmates had Hepatitis B. As a side interest, this seemingly low number was explained; in 1992 there was a "compulsory" Hep B immunisation program in high schools in Pennsylvania.

9 inmates with HIV;

there was an active TB surveillance program (BCG vaccines were not mandated in USA like Australia)



Transition for older prisoners is coordinated by a full time social worker. The complexities experienced were similar to other prisons thus far visited. Prisoners for release were identified about 6 months in advance and supported with applications for any form of assistance they may be entitled to (Medicaid, disability pensions etc). Processes for application are at least as bureaucratic as Australian systems so any prisoner who has cognitive impairment needs assistance (I tried to navigate myself through the on line system one evening and became “dizzy” with the questions, forms etc.)

Most prisoners who were old and **very frail** were usually able to be accommodated in nursing homes as there is a State and Federal reimbursement system that made the care of this group viable for aged care providers. More notorious (public interest prisoners) in this **frail** aged category were more difficult to place but if really required there were State “owned” / run aged care facilities that would usually house this sort of prisoner. (Something that could be further considered by Victoria who has State managed aged care facilities)

The social worker indicated that a more difficult prisoner to find housing on release was the younger more able bodied disabled prisoner (55 – 65). Rooming houses / homeless shelters were often the only option. But this sort of transition was not usually successful as health care needs, and the minimal personal care needs were usually not able to be met, resulting in some sort of failure of accommodation and often the same prisoner would be reunited with the custodial system.

Again there was much interest, curiosity and praise of Wintringham, when it was explained that these were the sort of guys that we often provided care for. Wintringham services are needed in the USA!

The Jefferson City Correctional Center (JCCC) is a maximum security prison in Jefferson City, Missouri operated by the Missouri Department of Corrections. A High Security prison, (Category 5 of 5) it houses about 2000 inmates, with a staff of 660. The current JCCC was opened on September 15, 2004, replacing the Missouri State Penitentiary - Jefferson City which first opened in 1836.

JCCC has a well established prison industry – “Missouri Vocational Enterprises (MVE) is a program of the Division of Offender Rehabilitative Services within the Missouri Department of Corrections. Established by State Statute (RSMo 217.550) to create meaningful job training for incarcerated offenders, MVE utilizes offender labor, along with supervisors and administrative staff, to provide quality products and services to state agencies and other not-for-profit entities.” - <http://doc.mo.gov/mve/html/about.html> - MVE is a unique business that operates on a capital revolving fund and does not receive any tax dollars from the general revenue. The program provides excellent opportunity for inmate recreation and up skilling for future employment.

As the facility is a maximum security prison, all correctional procedures and support structures are influenced by the same security level. This is a very similar situation to Long Bay Gaol (Sydney) and Port Phillip Prison (Melbourne); as such movement around and through the prison is geared more highly around accountability for prisoners, their safety, staff safety and ultimately the safety of the public. These same structures and procedures govern the whole prison, and hence influence the surround, housing and support structures for the older cohort within the same prison walls.

State laws and sentencing influence (control) the placement of prisoners related to their crime. That is, certain crimes have legislated sentences that mandate maximum security for the entire period of the sentence; as such, the older prisoners will serve their sentence in the maximum security environment. It is not hard to envisage that the maximum security environment presents more challenges to meet (adapt to) the aged care needs of older inmates:

- More regular “counts” – up to six a day – establish periods of time where inmates are usually confined to their cell or a particular area to assist count procedures:

 - All doors to cells are large solid and heavy

 - All doors are regularly locked thus confining the inmate to the cell environment

 - Cells, whilst of a good size for two inmates provide limited space for walking frames and high low beds. Walking frames and or wheelchairs are stored in internal court yard proximal to the inmates cell

 - Greater cultural adjustment to aged care is required by correctional staff and health staff who have been used to working in a hardened maximum security environment

Like many other State Correctional Authorities over the past several years, the Missouri Department of Corrections has seen an increase in the aging offender population. The departments’ first “Enhanced Care Unit” (ECU) opened at the Jefferson City Correctional Centre in January 2011, to help manage the financial and logistical operations that come with the ageing prisoner population. The 36 bed ECU houses aging and disabled offenders in wheelchairs who may require oxygen or who have early signs of dementia, or other age related illness that diminishes the capacity of the aged inmate. Each offender assigned to the ECU has access to all services, such as canteen items, library, meals, educational, vocational and re-entry programs. In addition, they receive assistance, as necessary, with grooming, socialization and daily activities.

The standard of the maximum security prison designs sees the ECU in a pod of 36 cells linked together over 2 stories. Inmates with ambulatory deficits were kept to the ground floor with more able bodied prisoners and / or “Daily Living Assistants” (DLA’s) housed in the upstairs cells. (There were also examples where DLA’s were housed in the same cell as the older inmate because the older inmate had greater care needs.) This design is not so different to that seen at Port Phillip Prison, Victoria.



DLA’s provide complete care to assist an older prisoner with their activities of daily living. They function as a personal care attendant would in the Australian Aged Care Environment, providing assistance with activities of daily living (not skilled nursing care). DLA’s are trained by an external agency and from what was observed and discussed provide very supportive care to the older inmate. This DLA model was the first prison carer model observed where complete care is provided by a trained inmate (not shared with other professional care staff); and was developed as correctional authorities identified a need for the support of the older prisoner and sort to provide assistance in a fiscally constrained environment; an environment where there is great scrutiny on the cost of correctional expenditure to the citizens of the State of Missouri.

Whilst there has no doubt been a fiscal benefit for the DLA model, behavioural benefits for the younger prisoners providing care are obvious: the DLA role gives an inmate purpose, a sense of responsibility as well as a sense of restorative justice and if you exclude all of the aforementioned benefits it gives DLAs something constructive to do whilst in the correctional system. The DLA model also seemed to soften a harsh environment, redirecting inmates focus on self to the needs and care of another. JCCC were able to demonstrate tangible improvements within the first year of introduction of the ECU: improved care received by the EC inmates, reduced security concerns, less victimisation and decreased disciplinary actions for the same population (A great success!) (Also see the video on http://www.nytimes.com/2012/02/26/health/dealing-with-dementia-among-aging-criminals.html?pagewanted=all&_r=0)

Many examples were quoted by correctional staff of the DLA’s advocating for their older inmates needs and or speaking up for an older prisoner’s if their behaviour was considered purposeful and hence older inmate may be liable for punishment... *“he doesn’t really know what he is doing, all I know is he doesn’t like*
25/09/2018

anyone going near his water fountain, he gets angry when someone goes near his water fountain, and he just can't control himself". One prisoner indicated, he liked helping out with the program now and he certainly hoped it was still running when he got old and needed some help. (Ricky)

The DLA role is seen as an option for a vocation whilst younger inmates are serving sentence and fits into the previously mentioned Jefferson City Correctional industry culture. There are a certain number of paid DLA positions and many DLA volunteers. DLA volunteers have a better chance of receiving a paid DLA position when one becomes available. DLA's are rotated between older inmates with care needs; this shares the load of more burdensome older inmates and ensures more than one DLA has awareness about any particular inmates care needs.

DLA's are also employed in the Secure Social Rehabilitation Unit (SSRU) – another 36 cellular pod for mentally ill and or cognitively impaired inmates. Within the SSRU, each inmate has a very basic "care plan" that provides information for correctional staff and DLA's on each inmates care and behavioural needs. Each inmate in the SSRU is also colour rated in terms of their behaviour risk (yellow, orange, red, green, blue) to easily identify behaviour and treatment compliance (or success) This significant cohort of mental health inmates is not unusual within the American (or Australian) correctional system, just another challenge that the correctional system faces every day.

"Deinstitutionalization played a substantial role in the dramatic increase in violent crime rates in America in the 1970s and 1980s. People who might have been hospitalized in 1950 or 1960 when they first exhibited evidence of serious mental illness today remain at large until they commit a serious felony. The criminal justice system then usually sends these mentally ill offenders to prison, not a mental hospital." - <http://www.fed-soc.org/publications/detail/madness-deinstitutionalization-murder>

Whilst one immediately considers the DLA model would be worth considering within the Victorian context; lighter sentencing methods, resulting in fewer suitable prisoners for DLA type roles might make a formalised DLA option problematic.

There is a strong mental health model within the JCCC with multi-skilled mental health physicians who meet regularly with case managers (most of whom have previously been correctional staff), correctional staff and other health professionals as necessary. Case meetings review an inmate's behaviour from either a behavioural or mental health context, with the aim of providing some governance around how to provide appropriate correctional - behavioural strategies with a focus on an inmate's cognition. There were examples of the system working well and other examples where the system could be improved. The most encouraging aspect was the team were focused on continuous improvement around strategies that would enhance an inmate's ability to conform to acceptable and dignified behaviours that considered others rights.

Given JCCC is only 7 years old many design concerns for older prisoners have been addressed:

- walking pathways are wide,
- doorways are wide

- rooming (cells) are generally roomier than others previously seen, with good ventilation and adequate lighting.

- Bathrooms and toilets were found to be accessible with minimal trip hazards. (General Showers had a lip to the flooring area,

- there was at least one fully accessible shower and toilet area (completely level with no trip hazards) making it easier to manage the care of a more disabled aged inmate.

As an elderly inmates care needs increase to the point that they need specialist nursing care (skilled care) they are transferred to the Prison Infirmary. The Infirmary is a 29 bed hospital like facility. The design of the infirmary is influenced by the maximum security overlay, with single secure rooms, as well as 2 padded secure rooms for acute mental health / uncontrolled inmates requiring seclusion and safety from self harm during an acute mental health episode. The infirmary also provides; post acute care, medical care for younger inmates, a very active outpatient clinic for various clinical activities as well as an XRAY and dental service. Staffing and health service is facilitated through an external provider. Custodial staff and provider staff work collegiality together for inmate welfare.

Hospice care is provided in the infirmary and prisoners who are nearing end of life have more flexible visiting arrangements. Children are not allowed to visit within the prison, children are only allowed to visit in the specified visiting area.

A key difference found with medication management at JCCC was many non addictive and non mood altering medications are essentially self managed by inmates. (Inmates are given a month supply of medications and expected to manage these medications themselves. This strategy prepares an inmate for release as most likely they will need to self manage their own medications on release. Owing to the concern of "onsale" and medication abuse, narcotic (addictive) medications and mood altering medications are dispensed as required in single dose by the infirmary. There are approximately 650 to 700 prisoners on medications and they are prepared by an offsite pharmacy and managed through the infirmary.

JCC also have an active Puppies on Parole program; the program is a partnership between the Missouri Department of Corrections and animal shelters/advocate groups. There are 18 DOC facilities across Missouri that have adopted dog programs. The program matches shelter dogs with selected offender handlers. Handlers help the dogs through socialization training to make them more readily adoptable. Having seen a similar program at the Fishkill service and the response of inmates and staff alike to the dogs in the system, I have no doubt of the benefit such a program provides for the morale of the system and would be worth considering in Victoria.

Once again I was overwhelmed by the generosity of correctional staff. The JCCC staff demonstrated commitment to the inmate population, showing empathy and care in their interactions. There is no doubt that the custodial environments can be very challenging for all staff involved, yet the JCCC staff's disposition was one of continuously trying to find new ways to manage behavioural challenges.

Joseph Harp Correctional Centre (JHCC), named in honor and memory of Warden Joseph Harp who served as warden at the Oklahoma State Reformatory from 1949 to 1969. A medical unit was established in 2007 to provide housing for those offenders meeting one of the following criteria: Dementia/Alzheimer patient; vision impaired/blind; wheelchair bound; uses walker/crutches; 65 or older. Trained medical orderlies are offenders assigned to assist the offender residents of this specialized unit, providing basic skills to assist those who are physically disabled.

Again I was most warmly welcomed by Ms Pat Sorrel and Warden Mike Addison. All staff were open and sharing in information and ideas. The day begun with a "Shakedown" - a surprise raid by prison authorities on prison cells to search for weapons and other contraband. (see <http://www.youtube.com/watch?v=bainJTJgPmE> as an example; what I observed was a little less confronting than is depicted in the youtube video) Apparently water output escalates dramatically at the announcement and Lockdown of a Shakedown; toilet flushing!) Apparently ducks living near the sewerage plant are known to exhibit strange behaviours for days after the shakedown! External correctional staff and specialist dogs are involved. I find out it is a method of quality control in regards to ridding the prison of contraband. Shakedowns occur at least annually but may occur more often. They may be unannounced or planned.

The Joseph Harp Correctional Center is a 1370 bed (up to 1405) medium security institution located near the town of Lexington, in central Oklahoma. The site of the facility had been used by the Navy as a firing range during World War II. After the war, the land was turned over to the Mental Health Department, which in turn transferred it to the Oklahoma Department of Corrections in 1971. About 37% of prisoners are over the age of 45 and 235 prisoners are 56 or older. Over 48% (666) prisoners were sentenced for some form of assault (including sexual assault) and had sentences averaging 20+ years. About 70 % of offenders are on some sort of mental health medication. Similar to Jefferson City Correctional Centre; opiate and mood altering medications are dispensed by nursing staff and non opiate and non mood altering medications are essentially self managed; unless and older prisoner needs assistance with medication management. Medication rounds are dispensed twice a day.

There is a Medical Unit has four isolation cells for those with infectious/contagious diseases such as tuberculosis. The unit has been adapted for aged care needs with wider doors, lower drinking fountains, age adjusted toilet and shower stalls, and no obvious trip hazards. The unit and prison itself is well supported by a strong Mental Health Service including medication management, suicide prevention, individual psychotherapy, group psychotherapy, and psycho-educational groups.



<http://joshpushing.tumblr.com/post/10689301942/dying-inside-inmates-in-the-joseph-harp#note-container>

The facility is also supported by a range of skilled health professionals:

Mental Health: Coordinator, psychologist x 3, psych clinicians x 4, social workers x 2

Nursing: Manager, 20 RN's and 5 PCA's

Interestingly there is no after hours nursing coverage in the medical unit. Able bodied, fit young prisoners are trained as medical orderlies and are employed to assist the offender residents of the medical unit, providing basic care to the more disabled older offender. The unit is dormitory style with chest high walls separating each sleep area. There are also corridors of 4 bed cells. No bunks are used in this area. All beds are fixed. There are no high low beds.

I was fortunate enough to spend some time with one of the offender orderlies "Kirby". Kirby described his training as being over 8 weeks with homework. He was well briefed in vital signs, hygiene care, pressure care, infection control principles (gloves, hand washing and use of personal protective equipment), minor dressings, ADLS, catheter care. Kirby was as briefed as one of Wintringham carers; and Australian Equivalent of his role. Kirby indicated he received a basic a wage for his work, about \$27.00 a month (I think). This wage was slightly less than some of the other paid roles (Prison Industry) but Kirby saw other benefits in the role: teaching him great skills for his release, he lived in the medical unit and was away from the general harshness of the prison environment, the Medical Unit was the only Unit that had air-conditioning and he really liked the air-conditioning. There was a warmth and caring nature to Kirby's interaction. He was a good example of why an offender / carer model is worth some consideration.

Staff highlighted that not every offender was suitable for the role, nor was the role suitable to every offender. Offenders had to demonstrate good behaviour. Offenders convicted of serious assaults were precluded and there were examples discussed where offenders had not completed the training.

The key learning from the discussions at Joseph Harp is: with appropriate selection and appropriate training an offender / carer model can provide high quality, low cost care to older prisoners.

JHCC is supported by an outpatient style facility providing medical support with a full time physician and two full time physician assistants (similar to Nurse practitioners - Australia). There is an onsite dental

service, visiting radiological service and other visiting specialist clinics available. Whilst there is no infirmary on site at JHCC, there is a strong linkage to the nearby Lindsay Municipal Hospital. JHCC is the host facility for the DOC clinic located at the Lindsay Municipal Hospital (LMH), providing corrections officer assignment to the clinic. The correction officers main role is to complete regular prisoner counts, cell/ward searches, and in brief maintain supervision, discipline, control and order in the clinic. The LMH DOC Clinic provides surgery, recovery, emergency room and non-emergency appointments for offenders.

Hospice care is not provided on site; essentially older prisoners whose failing health requires more skilled care are transferred to the LMH, or may be eligible for Medical Parole / early release. Again, as has been discussed with other facilities visited, early release processes are governed by external reviews and owing to the sensitivities associated with early release; the process is long and tightly managed; ultimately the State Governor (Premier equivalent Victoria) makes a final decision after a recommendation has been made by the correctional authorities. Needless to say, whilst early release and parole are applied for; it is seldom approved before an offender dies in custody.

There are few, if any options for transition of older prisoners in need of aged care who are eligible for release. Again there was great interest in Wintringham service and how the Australian Aged Care System made it possible for Wintringham services to be possible.

Huntsville Texas, Estelle Unit

The Estelle Unit is about 20 Miles from the town of Huntsville, surrounded by woods with the longest entry of all prisons visited so far. Prisoners, dressed in white are seen working, clearing trees, with mounted guards providing supervision.



You know you are in a different world when you park your car at the Estelle Unit.



There is no doubting there is a different approach to security at Estelle than other facilities I have visited. (The [Estelle WWW](#) indicates that prisoners are classified from 1 to 4 (rating to 5) which is a similar of classification to other units visited)..... Guard towers are manned, and you may not enter the secure prison grounds unless you are accompanied by an official staff member. After the first two barred gates; one undergoes X-ray scanning, shoes off, metal detector scanning, all pockets emptied, belt off and back through metal detector gate and a final body frisk. Then you pass through another barred gate where you Exchange ID for a visitor pass (DO NOT LOSE THAT PASS); you then you lose count of the barred gates you pass through before you get to the medical treatment area. (There are barred gates every 30 yards or so that must be remotely opened by a guard.) The corridor you pass along is very wide, about 5 yards or so, with yellow lines running about a yard out from each wall along the corridor. Inmates must keep to the wall side of the yellow lines. Movement is very restricted. Running perpendicular to the corridor are outcrops of cells. (This is the main prison area) Eventually, after walking about 400 yards, you reach the medical unit area.

I was warmly welcomed by Shelly Hanson, Nursing Unit Manager who gave up her morning to show me around the medical unit.

The Estelle Unit opened in 1984. The Estelle High Security Unit was designed in response to an increase in prison violence in the Texas prison system. Around 1991 Texas Department of Custodial Justice (TDCJ) planned to build a separate facility for elderly inmates. In 1995 the unit received its current name.

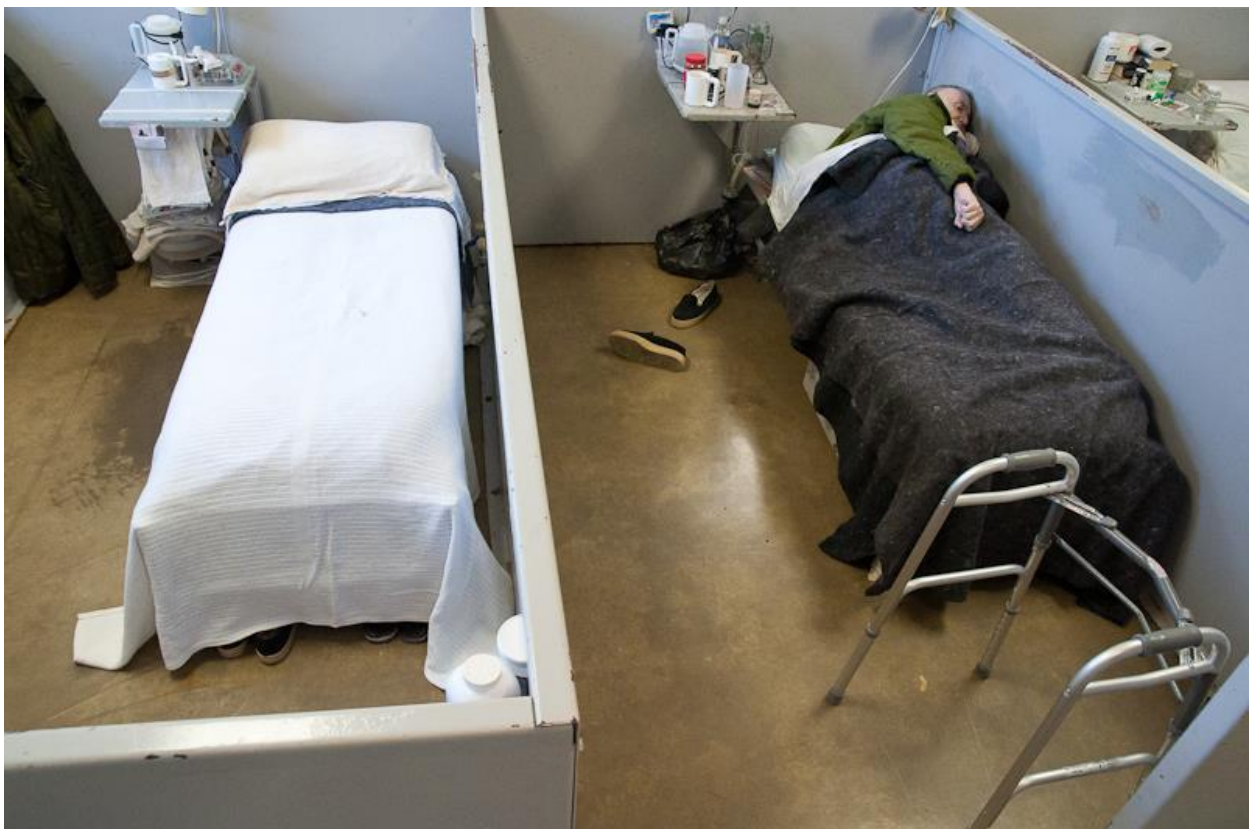
Best Practice Support Model for Older Prisoners

The Estelle Unit is a part of a large compound, sharing space with the Ellis Unit, which is 3 miles (4.8 km) away from Estelle. As mentioned, the area housing the Ellis and Estelle units is wooded. The Estelle High Security Unit is a self-contained facility north of the main Estelle prison facility. Of interest, but not part of this study, the high security unit is one of the Texas Department of Criminal Justice's "super seg" units, which have many administrative segregation cells. The security unit houses many of the most violent male prisoners in the State of Texas.

Given the high security arrangement at the Estelle and Ellis units; the interactions observed between guards and inmates were noted to be very formalised.

The management of the medical unit at Estelle is contracted to the University of Texas Medical Branch <http://www.cmhcc.state.tx.us/>. (A similar arrangement to Port Phillip and St Vincent's Health Care)

A 66 bed dormitory (half walls separate inmates) Geriatric Centre, houses older prisoner who can essentially self care. The shower and toilet area has been adapted to enable wheelchair and walker access. Flooring is flat with minimal trip hazards. All bed are fixed. There are a few "double size" spaces for inmates that have extra equipment to maintain their independence. Cleaning of the Geriatric centre is performed by younger inmates but there is no carer / orderly inmate model at Estelle. If an inmate requires supported care, they are assessed and transferred to the medical area, Geriatric Area.



The medical area is staffed by a range of Nursing, nursing assistant, medical, mental health and allied health staff and offers a large range of health supports for prisoners of all ages (including older prisoners):

- 24/7 emergency care and triage
- Comprehensive outpatient service
- Complete medication management
- Comprehensive therapy support for rehabilitation
- Hospice care
- Significant renal dialysis program (29 chairs, 165 treatments / week)
- Radiological service
- Mental Health Service
- Electronic Health record

Three main “housing Units” provide health support. Units comprising 50 beds, 33 beds and 37 beds, with a varying arrangement of single bed, single bed secure, single bed isolation and two, three and four bed rooms. Given the Unit provides health support for a range of custody level inmates; there are clear guidelines for how inmates will be housed depending on their classification, ranging from GP 5 & “Administrative Segregation” (including Death Row) who will be housed in single cell with door locked at all times. GP Level (1-4) may be housed anywhere. Some rooms are extra secure with no power outlets to prevent incidents of self harm.

Full dietary management of inmate’s needs is overseen by a dietician, providing various supported diets for renal impairment, diabetic and other specialised diets.

The medical unit will transfer acutely unwell inmates to a Corrections Approved Hospital – accompanied by 2 corrections officers.

There is no formalised recreation program. Inmates have access to televisions and books.

Transition arrangements for hospice inmates may include transfer to an aged care provider, if one can be found, only if the inmates receive clearance through the corrections process. Most older prisoners do not receive such clearance. Other transitional arrangements are arranged through the parole division and were not observed or fully discussed during this visit. Options for transition into the community were not obvious. There were no known aged care providers who would accept ex prisoners and a review of the parole divisions webs site

http://www.tdcj.state.tx.us/divisions/parole/parole_huntsville_placement_release_unit.html indicates transition may be into contracted Residential Re-entry Centres (halfway houses). A review of these facilities for Texas http://www.bop.gov/business/RRC_directory.pdf suggests they offer transitional housing options, and or minimal supported housing (see below)

http://www.uss.salvationarmy.org/uss/www_uss_waco.nsf/vw-sublinks/5B270A9C9B76D5D3852574260065F248?openDocument
http://www.voa.org/Get-Help/National-Network-of-Services/Housing/Affordable_Housing_Initiatives/Affordable_Housing_Helps_Rebuild_Lives.html

Following the review, one was left with the feeling, that there were really minimal care supports for older prisoners on release, if released, from prison in Texas.

Again, many thanks to Ms Shelley Hanson for her time in showing me the Estelle Unit.

The Mississippi State Penitentiary

is also referred to as "Parchman Farm".

There is not really much else in Parchman and it is many miles from anywhere.

There a strong link between Blues music and the prison system in Mississippi. Parchman is the title of a number of songs about Mississippi State Penitentiary (MSP); historically a hard time prison because of the Trusty system (now outlawed). Under this system, designated prisoners were used by staff to control and administer physical punishment to other inmates. There have been a number of blues songs written about Parchman Farm and several Blues musicians were imprisoned there, including:

- Bukka White (who wrote "Parchman Farm Blues" (<http://www.youtube.com/watch?v=jM23S12LXaE>) and Son House
- Mose Allison wrote a song called "Parchman Farm", distinct from the earlier blues songs. http://www.youtube.com/watch?v=v5hw9T9Ozv4&playnext=1&list=PL47424B3AACC6B286&feature=results_main It has been covered by Blue Cheer (as "Parchment Farm"), Cactus, Rick Derringer, Georgie Fame, The Kingston Trio, Dead Moon, John Mayall & The Bluesbreakers, Hot Tuna, and others.
- Over the years there have been a variety of bands and music provided by Parchman – see - <http://www.youtube.com/watch?v=y111nmkscoQ> for one of the earlier songs recorded by the inmates of Parchman Farm.

Confirmation of my visit to Parchman had been difficult to obtain in the lead up to my travels. This contributed to me forming the belief there was some reluctance on behalf of authorities to my visit. Final formal approval was only granted on the night before the visit was to take place after a personal call to the Superintendent, Mr Earnest Lee, who was very helpful and personally arranged final approval. I had earlier made the decision to just go to Parchman and try my luck if I was unsuccessful in gaining approval; for one thing, being in the home of the "Blues" was enough incentive to just be there!

There have been a variety of different housing and care models observed within the prison system visited on this tour. The differences have been guided by the prison's history, the history of a State's legal decisions and events that have occurred around those decisions. MSP was a very different prison to any others I had visited; its boundaries are not immediately obvious and it initially presents as rural community. Apparently, if MSP Parchman Farm was not where it was, there would be no town called Parchman; Parchman is all about the prison and given its geographical isolation, I learn that many staff have accommodation on the actual prison grounds!





I was greeted at the front gate, where I was asked to leave my car at the car park opposite the front gate. Escorted transport was then arranged to the administrative building where I was warmly greeted by Superintendent Lee and other corrections and health care staff.



Mr Lee provided an over view of MSP service:

Mississippi State Penitentiary (MSP), also known as Parchman Farm, is the oldest prison and the only prison with a maximum security section for men in the state of Mississippi, USA. MSP commenced operation 1901, and was constructed largely by prisoners; It is located on about 28 square miles in the Mississippi Delta region.

There is accommodation for 4,840 inmates. Inmates work on the prison farm and in manufacturing workshops. It holds male offenders classified at all custody levels. It also houses the male death row; all male offenders sentenced to death in Mississippi are held in MSP's Unit 29. The death sentence is enacted by lethal injection in a specific unit at the MSP. Other lethal techniques have been used over the years.

In 1961, "Freedom Rider"s (civil rights activists) had been convicted in Jackson (MS) and many were jailed in Parchman.. The first group sent to the farm were 45 male Freedom Riders, 29 blacks and 16 whites. Although most of the Freedom Riders were bailed out after a month; their experience of the harshness of Parchman gave the Freedom Riders credibility in the Civil Rights Movement.

Most of Mississippi Department of Correction's (MDOC) agricultural enterprise farming activity occurs at MSP.

The road from the front entrance to the back entrance stretches 5.4 miles

The perimeter of the overall Parchman property has no fencing. The prison property is located on flat cleared (by the offenders over the years) farmland of the Mississippi Delta.

MSP has been referred to as "a prison without walls" due to the dispersed camps within its property. MSP consists of several prison camps spread out over a large area, called "units." Each unit serves a specific segment of the prison population, and each unit is surrounded by walls with barbed wire. The more secure units have "lethal" electric fencing as well.

The theory behind the disperse geographical design is to prevent large cohorts of offenders thus minimising the potential for mass rioting – it also provides for a tighter, more supportive and less hostile community arrangement amongst the offenders.

There are about 50 different buildings across the MSP; It is actually quite difficult to comprehend the size of the MSP

There are approximately 4,500 inmates & 1,100 staff .

The units of particular interest to the tour:

Unit 31 – currently 90 beds which serves as the unit for inmates with disabilities – these may be aged related, physical or cognitive – but offenders must be able to attend to their own ADL's[& Unit 42, the prison hospital, which has 54 beds and also serves female inmates throughout the MDOC system. The hospital also has a Palliative Care Unit for dying prisoners, in the hospital

The prison has a Visitation Centre which serves as a point of entry and as a security checkpoint for visitors to MSP. After security screening, visitors depart the visitation centre in buses bound for the specific units

Mississippi State Penitentiary permits imprisoned men to engage in conjugal visits with wives; The practice began on an unofficial level around 1918. Originally only African-American men were allowed to participate, as society believed that the sexual drives of black men were stronger than those of white men. Prison authorities believed that if black men were allowed to have sexual intercourse, they would be more productive in the farming industries in the prison. By the 1930s, the authorities had permitted white men to receive conjugal visits. The Parchman conjugal visit program was designed so that all members of the family may interact with a particular prisoner. Mr Lee informed me that conjugal visitation programs, also known as the Extended Family Visit, survive in six states: California, Connecticut, Mississippi, New Mexico, and Washington (state).

Mr Lee's presentation was candid and revealing, presenting some of the difficulties of the past, (these are easily found by doing a basic search on Mississippi Prisons). The open exchange experienced during the presentation and on the tour was at odds with the opinion, I had previously formed regarding the difficulties finalising this tour. Like other Wardens or Superintendants I have met, Mr Lee is very proud of

his staff and facility and interested to know what other facilities I have visited are doing in the area of custodial care of older inmates. It appears the difficulties in establishing the tour are more about communication gaps and external bureaucracy risk assessment; than a real reluctance to share. From my quick visit I form the belief, there has been genuine reform in corrections in MSP; The lengthy article “Mississippi's Corrections Reform” <http://www.governing.com/topics/public-justice-safety/courts-corrections/mississippi-correction-reform.html> - gives a great overview of the significant changes that have occurred at Parchman over the last 8 years or so.



Following the presentation I am transported to Unit 31 and then Unit 42. They are about half a mile from each other. The drive to the units begins to give you an idea of the scale and geographical dislocation of the MSP. Offenders in green striped pants and white tops are seen, walking around the MSP unattended. There are different coloured uniforms for differently classified offenders; there are different restrictions and different correctional controls for differently classified offenders. Green Stripes are low risk offenders who can be seen working in the community. (I actually engaged three offenders the previous day at Greenville who were gardening around the tourist bureau. The discussions I had with them were so similar to discussions you could have with Wintringham clients!) Other uniform colors are: black and white horizontal stripes, all orange, all yellow and all red. The distinction is obvious and helpful for staff to know what custodial risk each offender poses.

On the way to Unit 31 we drive by a cemetery. Discussions turned to end of life care for older offenders. As with other correctional facilities; many older offenders either have no family, or family are unwilling to incur the cost of burial etc. As such, deceased offenders are buried, with a simple service / ceremony in a marked grave on site at Parchman.

Unit 31, the 90 bed disability unit staffed 16 hours a day by: a registered nurse, a custodial care manager, corrections staff and a LPN (Div 2 Equivalent). After hours, only custodial staff are present. If an offender in unit 31 has care needs that require after hours care, they are transferred to unit 42 (the hospital). Some offenders were known to disguise their needs so they could delay (prevent) the transfer to unit 42. This is not a statement about the care or service in Unit 42, it is more about the older offenders considering a move to unit 42 as a “final transfer” and a reluctance to leaving the “family” they have bonded with in Unit 31. In this regard there are obvious parallels to behaviour seen within Wintringham hostels where

residents delay transfer to our high care facility – if at all possible. Again, this is not a comment of care, but more one on the final journey.

Unit 42 is fenced by cyclone fencing and barbed, not razor, wire; the gate is controlled by a corrections staff member who sits at a main viewing desk within the unit. The call of “gate” can be heard, which is followed by a look for a familiar face. The gate is open and a check of ID on entry was the process for entry this unit. Apart from the brief identification check and confirmation that I was meant to be visiting, this was the first real security check that I have encountered on the unfenced prison grounds. (Very different to the Estelle Unit in Texas!) Offenders are seen to move relatively freely around the fenced unit. A litter of cats and kittens is observed outside the unit and I am told they are the offender’s / the unit’s pets.

Inside, Unit 31 presented as an aged, single story, well kept, airy, well lit and clean unit, built of better style brick. All floor surfaces were level with no obvious trip hazards and the doors are all wide. Offenders observed seemed to have care needs consistent with what you would see within a Wintringham low care facility. The facility had very good access to the outside fenced and grassed area; an aged offender could easily feel the sun and a fresh breeze on their face if they so desired. The unit had air conditioning and heating. The showers and toilets were noticed to be accessible, for any older prisoner with mobility issues. Televisions were observed and for offenders without a television there was a communal television. Many beds were height adjustable, some beds were fixed. There was a range of multi bed “wards” and some single bed rooms.

There was no recreation program or support.

Of interest, there was a suite of Conjugal rooms in unit 31 as well.

If a higher security offender is transferred to unit 31 the custodial conditions are adjusted for that offender.

Unit 31 also had an outpatient’s type area, where offender’s health is reviewed. Any offender who is in the unit for rehabilitation is also assessed here for return to their usual unit. Apparently some offenders try to feign incapacity to stay longer in Unit 31.

Prisoner meals were delivered to the unit from another unit (a sort of cook chill arrangement) and were served in communal dining areas with fixed tables and chairs similar to the style I had seen in other correctional facilities. I was told a dietician reviews all meals and special diets were available for offenders who require them.

As had been witnessed in other correctional facilities; offenders who were capable could manage their own “non mood altering and non opiate medications. The latter, more addictive medications, were managed by the nursing staff, who had a disciplined count system for these medications as well as all sharps, including scissors etc.

Unit 31 also had housing for about 6 younger inmates “Camp Supports”. Their key role was one of “fire officers” for the whole MSP. They are conveniently housed in Unit 31 as the Parchman fire station is close by. The “Camp Supports” also provided “non direct care” to the Unit: Cleaning, meal services and laundry duties were observed. The skilled staff indicated the “camp supports” do not do direct personal care. When questioned about what occurs after hours if one of the offenders needs assistance.... I was led me to believe there may be “informal” direct care provided. During my discussions with staff about their care model at Unit 31 and in Unit 42 they indicated they had been to Angola Prison in Louisiana to gain some improvement ideas. They were very positive about the experience. They informed me that Angola have a prisoner carer model (like others I have observed) A quick review of the internet provided: *The Louisiana*

State Penitentiary (LSP, also known as Angola) is a prison farm in Louisiana. It is the largest maximum security prison in the United States with 5,000 offenders and 1,800 staff. It is similar to MSP in that it is located on an 18,000 acre (73 km²) property. Angola is bordered on three sides by the Mississippi River. As of 2012 Burl Cain is the warden. The State of Louisiana's death row for men and the state execution chamber are there. See also: http://en.wikipedia.org/wiki/Louisiana_State_Penitentiary & <http://angolamuseum.org/?q=node/58>

Staff indicate there are some options for transition for older prisoners into the community. Staff reported there were several nursing homes in the country areas that will take some of the “high care” offenders. On further discussion it becomes apparent that offenders, who have previous histories of assault, have few options and further to this offenders who have “low care” needs do not have many options and some just stay in prison.

Unit 42 is a registered hospital. The security arrangements to access the hospital are similar to other facilities I have visited: ID, sign in, metal detector and frisk search. It is more formal and more structured as the hospital security has to account for all security levels of prisoners all of the time. Having said that, there is a difference to the approach, staff are warm courteous and friendly during the security intervention.

I am told that Unit 42 provides 24 / 7 nursing support to the inpatient offenders as well as providing a triage service to the other units. Offenders who become acutely unwell may be transferred to regional hospital. Offenders requiring surgery will also be transferred to a regional hospital.

A comprehensive array of allied health support is provided from the hospital: Therapies, mental health, medical, dental service, radiology and an in house pharmacist for the Unit. Offenders requiring dialysis are transferred to another regional unit. Female offenders are treated in the hospital and are isolated from male offenders.

Palliative care is provided for offenders in need of this service. Families, including children, are invited into the unit towards end of life care.

Unit 42 is divided into three wings. One wing is for high security offenders who are isolated in cells. The single cells range from a standard single cell room to rooms that are completely bare – for protective isolation. All cells have video surveillance to provide observation of isolated offenders. All offenders who are isolated receive ongoing mental health support and evaluation.

I am extremely grateful to Mr Lee and all his staff who were all so welcoming and forthcoming with information during my tour of Parchman.

California Men's Colony; San Luis Obispo, California

There is something brilliant about having your assumptions / hypothesis destroyed. Ideas that that you have developed from seeing other systems turned on their head because the next system you see, does it so differently that you realise the reasons for behaviours may not be about a structural design issue (they may have something to do with behaviour – but they are not the key issue)

At the CMC, the main “East Facility” visited; housed medium security (level 111) inmates, with individual cells, housing two prisoners in each cell. The facility has a fenced perimeter with armed guard coverage from watch towers. Housing blocks were divided into four quadrangles. Each quadrangle had its own dining room, work rooms, recreational area and two three-story housing units on the external perimeter of the quadrangle. There was also a fully licensed hospital located centrally to the four quadrants that provides comprehensive medical services; those services not provided on site are provided either at other correctional institutions (Haemodialysis) or the general hospital system (specialist surgery). CMC has a comprehensive Mental Health Delivery System in the form of an Enhanced Outpatient Program and Outpatient treatment for inmates. Offenders may also be assigned to the Correctional Clinical Case Management System, as well as a Mental Health Crisis Bed Unit.

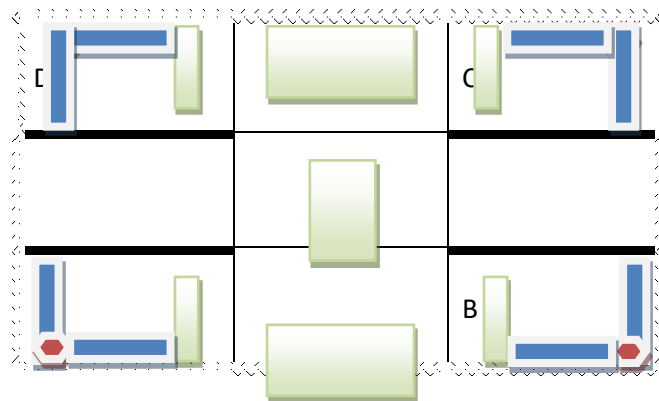


Diagram of design of the CMC as described above

A West facility that houses minimum security inmates in dormitory settings was not reviewed.

As of March 2012, the CMC's total population (East & West) was 5,524, which is 143.9 percent of its design capacity of 3,838. The West Facility opened in 1954, and the East Facility opened in 1961; whilst the facility was old and overcrowded, it was essentially well maintained and an air of harmony within the prison walls was sensed.

The security arrangements were again different at the CMC East area. I was checked in at the first / front entrance and my passport was cross referenced to an approval form. Shoes off, belt off and walk through scan. A prison visitor ID is provided and one is only allowed to proceed through locked doors, and lethal high voltage fencing with a contact host. During the process, other correction staff are noticed to walk in with bags etc. after showing their identity cards. Some were carrying pizza boxes and other sorts of food containers. It appeared that long term staff appear to be considered less risky and do not have to undergo a daily complete screen. Whilst, no doubt, some correctional authorities would not tolerate this approach to risk screening; there is something refreshing and trusting about this approach and one wonders what they will see ahead.

Once inside the prison, another check occurs at the central area. A quick tour of the hospital is offered which is similar to other hospitals visited. My host and I agree, there is more learning to be gained by

reviewing the housing units for the cognitively impaired and seeing the Gold Coats working; than reviewing another prison hospital. (The Gold Coats are prisoner support roles)

As mentioned, the east facility was designed as a set of four quadrants (A,B,C,D) each separately secure and each radiating from a central court yard. There were two three story buildings (housing units) that ran the two external walls of each quadrant. Each housing unit / building housed approximately 300 offenders – approximately 600 offenders per quadrant. Each quadrant had a wide open yard about 100 metres x 100 metres square. One side of the quadrangle had a high solid wall (used for racket and hand ball) and the other side of the quadrangle was buildings for staffing / support areas.



Guards were visible on the route to each quadrant, but less visible in the quadrant; you had to look hard to see guards. Armed guard towers were observed on most external quadrant corners. Again, the whole security overlay was different to what had been observed. There were at least 100 to 200 offenders intermingling in the court yard. Some played ball, some sat and talked some did exercises, some just paced. I was reminded of the high school yard I spent many years at (it was a quadrangle too – run by the Christian Brothers)

You cannot help but be “confronted” by the large amounts of offenders grouped, in harmony, in one relatively small area. Offenders were dressed in blue trousers, white tee shirts and intermingled amongst the blue and white are gold (faded yellow) coats. These were the Gold Coats. A few women were also present? I was told these were transgender offenders. (This answered a question I had – where are transgender offenders placed; male or female prisons? The answer, in California at least; male prisons.) Some offenders were noticed to be wearing vests? Hearing impaired and vision impaired had special observable vest so guards and others offenders (Gold Coats) would know that the vested offender who failed to respond to a call or whistle etc, had a special need and should be assisted not reprimanded.

These observations were discussed with my hosts. It was difficult for them to understand my fascination as it was their every day experience, what they have become used to, and their normal. But it is very different. I wondered why it worked the way it did. I was told that CMC was the prison most offenders in the State of California wanted to be transferred to. This was interesting in itself. There was nothing glamorous about CMC. It was an old prison. Sure, you could see the sky and some mountains and the climate was very comfortable. I remember thinking “the other places must be pretty bad”! I reflected a lot on the observed harmony; the “freedom” of staff to walk through a large cohort of offenders. CMC was behaviourally very different. My host, a senior psychologist tells me, he thought it had a lot to do with offenders having their own key to their own cell.

When you enter the housing unit, you are greeted by a guard on a raised platform desk type area that is central to two long corridors. Off each side of the corridors were the offender’s cells. As mentioned, each offender had a key to their shared cell. Most cells were shared cells some were single cells. One is immediately confronted by the small size of the cells! These cells were easily the smallest I had seen on my study tour. They were small for one person, let alone two. One bed had to be folded upwards during the day so offenders could move in the cell and use the toilet in the cell. My guess was that these cells were 2.5 metres by 1.5 metres! Each cell had a solid door with a small window and the other external window was barred and approximately 300mm x 300mm. The other two longer walls were solid concrete. Offenders were locked in during the night, approximately 2100 – 0600, by a central locking system, but during the day the doors to the cells were controlled by the offender and their “roomy”. Some rooms did not have a power outlet and some did. Some offenders had televisions. Rooms were heated but there was no cooling. There was a central showering area for each floor and a small TV room (2 metres x 4 metres with rowed seating. (I was told group counselling session also occurred in these rooms)



Google image showing the sort of corridor arrangement and cells seen at CMC

It is hard to describe one’s emotion / feeling on seeing the size of the cells. I inwardly protested and thought how inhumane these cells were, thinking “this was wrong – this was so wrong”. I could not help but comment to my host and I was somewhat embarrassed at my escaped thoughts. My host acknowledged the cell size was an issue but said it was all that they had, and the offenders did not seem

too bothered by it. We viewed some more cells and I had a chat with a couple of offenders. Again I noticed the harmony, there was definitely less agitation here. A couple of offenders confirmed, CMC was considered one to be the best prison in the State to be housed.



Picture taken from google images – but shows the size of a cell (used for hygiene here), two prisoners sleep in a cell this size

As meals were served on the third floor of each building, there were no offenders with significant ambulatory concerns at CMC. Older more frail offenders, who cannot manage their own care or ambulation, were either transferred to the hospital or another facility that was better equipped for offenders with disability needs. Unit D does house offenders who have mental health concerns and or cognitive impairment (including dementia). Offenders who were capable, self managed their medication. (Opiate and mood altering medication are controlled and dispensed through similar structures and staffing systems seen in other facilities). There was one registered nurse per quadrant who provided triage for offender's health care needs (1:600). There was a significant number of psychologists and counselling staff (approximately 1:30).

There is nothing like the moment when you have your whole world turned on its head! The assumptions you have made; the opinions you have formed; I remember inwardly smiling and thinking: The cells are very small; some don't have power; there are quite a few older offenders here; the outside yard, whilst a good size is relatively crowded; it was an old prison. Against all of these factors, what made CMC a popular prison as judged by offenders?

Was it the offenders control over the key to their cell, as my host had indicated? I was told CMC was the only Californian prison where offenders had a key to their cell. I am not aware of other US prisons with this

practice but it appears this was a practice in the UK, with some controversy - ["It's all part of providing incentives to encourage them to take more responsibility for themselves, to give them a little bit more respect and decency."](#)

Was it the significant mental health program and mental health support offered? CMC appeared to have a greater provision of mental health service than other facilities visited. All facilities visited in the USA have had, by Australian standards, significantly more mental health support; but CMC seemed to have more support than their US comparators. There was a respectful transaction noticed between correctional staff and mental health physicians that was different to other facilities visited. I had formed the opinion at other facilities that correctional concerns over-ride all other concerns; in turn this provided correctional staff with the "final say" over issues of concern. At CMC's guards were seen to defer questions of behavioural concerns to the mental health physicians; that is, their default on behaviour concerns was to the psychologists. There appeared to be a subtle difference in the custodial power relationship within CMC. One example of this occurred during my discussion with Michael the recreation therapist. Michael was youngish and full of energy (he could easily fit into the Wintringham's Recreation Team) Michael described the recreation program; there was a significant exercise routine; some of which, he told me, was about maintaining function (use it or lose it). Other activities included basketball, and other modified ball games, domino's and jigsaw. He indicated there were budget restrictions and corrections considerations that impeded some recreational ideas. Further he said he would like to get more involved with the offenders, be involved in their ball games etc, but he had been advised, by the custodial authority, that he should not – because of the risk an offender may take advantage of the situation and the possibility Michael could be hurt. This was interesting given my previous discussions with my psychologist hosts. One doubts the guards would have insisted the same concerns and precautions with the psychologists and I raised this doubt with my hosts. They tended to agree with this observation. There were other examples where the risk assessment and activity was left to the discretion of the psychologist. This did seem quite different to other institutions visited. I am left thinking, eventually this same deference of risk assessment may extend to other staff.

Could it be because of the "Gold Coat" program? The program was now about 15 years old. It involved younger offenders being trained to support a cognitively impaired prisoner. I am counselled and assured this support model does not involve assistance with personal care. If an older / cognitively impaired offender needed support with any form of personal care, they would be either transferred to the hospital or another facility. On further discussion with my host and a Gold Coat by the name of Phillip, I find the role is like a buddy role involving: prompting, advocacy, and support; the Gold Coats were, in effect, the peer support, the team leader. Examples were sited where the general prison population deferred concerns to a Gold Coat. (There were examples sited where some of the more hardened inmates might call the Gold Coats "dogs", but these occurrences are few and far between. Phill, a Gold Coat, told me, the program had given him a total new outlook on life. The themes he raised were similar to what I had heard from other prisoner supports. (I am absolutely convinced of the benefit a prisoner support model has for a correctional facility: enhanced caring culture, savings in cost of care, prompt and improved care delivery, improved self esteem of inmates and more harmonious correctional environment.)

Was it the approach to the correctional support and security overlay seemed to have a more trusting approach (of staff and offender alike) and this "culture" provided for greater harmony? – as it would in any work place.

It was probably all of those issues and more? Before this visit, I had placed a large significance on design and structural issues. I left CMC believing that whilst the design and structure are important for enhanced care of older inmates, they are not the only key issues.

I returned to CMC the next day to observe the recreation program with a group of cognitively impaired older offenders. The program was run in an indoor hall / recreation area that doubled as a gym, basket ball court area. Whilst it was aged and dated with signs of patch repairs; it was a good space, away from the business of the court yards. I was greeted by Michael the recreational therapist. Friday was movie day. My hosts were disappointed that I could only observe movie day as there were a lot of other recreation activities the older offenders were involved in but they genuinely enjoyed movie day. The film on show was Captain America (2012). About 20 offenders were observed (16 cognitively impaired / aged and 4 gold coats). The Gold Coats were evenly dispersed amongst the group. I observed the session for about 30 minutes whilst talking with my hosts and "Marti" one of the guards. At first nothing seemed too different; seeing offenders watch a movie. But, all of the "guys" were just sitting quietly and enjoying the program. After some further thought about this seemingly unremarkable event, one realised that most of these men have cognitive impairment, so to have them all sitting in harmony watching a movie is quite remarkable. One prisoner was noticed to get up and pace around a table every so often, and another staring blankly into a distant spot "somewhere". They were generally well engaged and well behaved during the show. Gold coats are noticed, every now and then to help focus some individuals.

During these observations I had a discussion with Marti, the guard. Marti had been working with this group for at least 25 years. I ask why he worked in this particular area of the prison. Marti shared he has a family member with special needs, so he understands the issues. He also said he loved coming to work. *"There has not been one day, that I have not looked forward to coming to work"*. Marti also told me, *"you have got to learn about the guys. You have to know what's normal and what's not. You need to know how to listen & not just with your ears – your eyes as well"*. I observe the offenders and Marti are on first name basis. No "Sir", "Mr". or "Boss") Marti also told me there were times he needed to correct a behaviour, but he elaborated that he also needed to understand why the behaviour occurred. He said the education he has received from the doctors has been very helpful.

Every prison needs a Marti.

I later wondered "could we possibly introduce a structured "gold coats" program at Wintringham? Could some of our younger more active residents be engaged as a support person for some of our more impaired residents?

There was no doubting that the cohort of offenders D block had support needs beyond the standard offender populations and similar to populations previously observed. They were well supported to maintain their independence so they could stay in their "home" environment. Following the review of the recreation program I engaged further with my hosts. They informed me, every new prisoner has a cognitive screen undertaken.

CMC use the QUICK assessment too <http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8328-000> Offenders who are flagged through this tool may have a follow up assessment completed using the TONI assessment tool.

Some other important considerations are discussed. California has a highly litigious culture. Several significant cases are quoted, where an offender's representative has taken legal action against the State and the resultant law suit has seen major changes to care and support within the correctional environment. The result of which drives a watchdog approach from many authorities which result in further "quality improvements" to support offenders. There is no doubting the adequacy of the support and care available at CMC.

Much thanks again to my host.

Rimutaka Correctional Facility – Upper Hutt, Wellington New Zealand

[Rimutaka prison is set to open the country's first dementia unit in late 2012.](#) The facility had not yet opened when visited, but was nearing completion. Rimutaka Prison is in Upper Hutt, north of Wellington. It is one of New Zealand's largest prisons, and opened the country's first container-cell unit in 2010. The New Zealand Government has set a corrections wide reform package with some significant and challenging targets. Prison Manager (not Warden or Superintendent) Richard Symonds explained that in order to meet the targets he, and all of corrections, had to rethink the way they did corrections – a fine tuning “around the edges exercise” would not be enough to meet the targets. He was speaking the same words heard in Mexico from Jane Von Dadelszen, Director of Policy & Research, NZ Corrections, who presented on the reform.

Given the inmate population size at Rimutaka (smaller than observed in USA) they have adopted a primary care health model that is staffed during the day. There was a visiting GP and nurse on site. Acute care needs were supported through local hospitals. Rimutaka have identified the need for aged care assistance for their older offenders, they currently housed them in a secure observation unit where inmates who are at risk of self harm are also kept. They were in the process of refurbishing an older area of the prison that used to be a youth wing (young inmates were no longer housed at the prison).

Corrections staff consulted regional aged care expertise for the refurbishment with the aim of making the facility, aged care friendly: level flooring, larger accommodation areas, and larger shower areas. It will be staffed like an aged care facility: carers supported by nurses but it will also have a corrections officer as well. The facility is at the top of the hill overlooking the entire Rimutaka complex with view of the forest behind. Access to the outside provided for light fresh breeze and sun, and was easy for the older prisoners to access.

There were a couple of Aged Care Providers who assisted with transition into the community but there were the typical challenges with the transfers; ranging from resistance from the Aged Care Provider Staff or families of other residents that may inadvertently find out, that an older prisoners is now living where their mother or father now resides.

It would be good to revisit Rimutaka after the new aged care area is open; their system looks very good and appropriate for their population size.

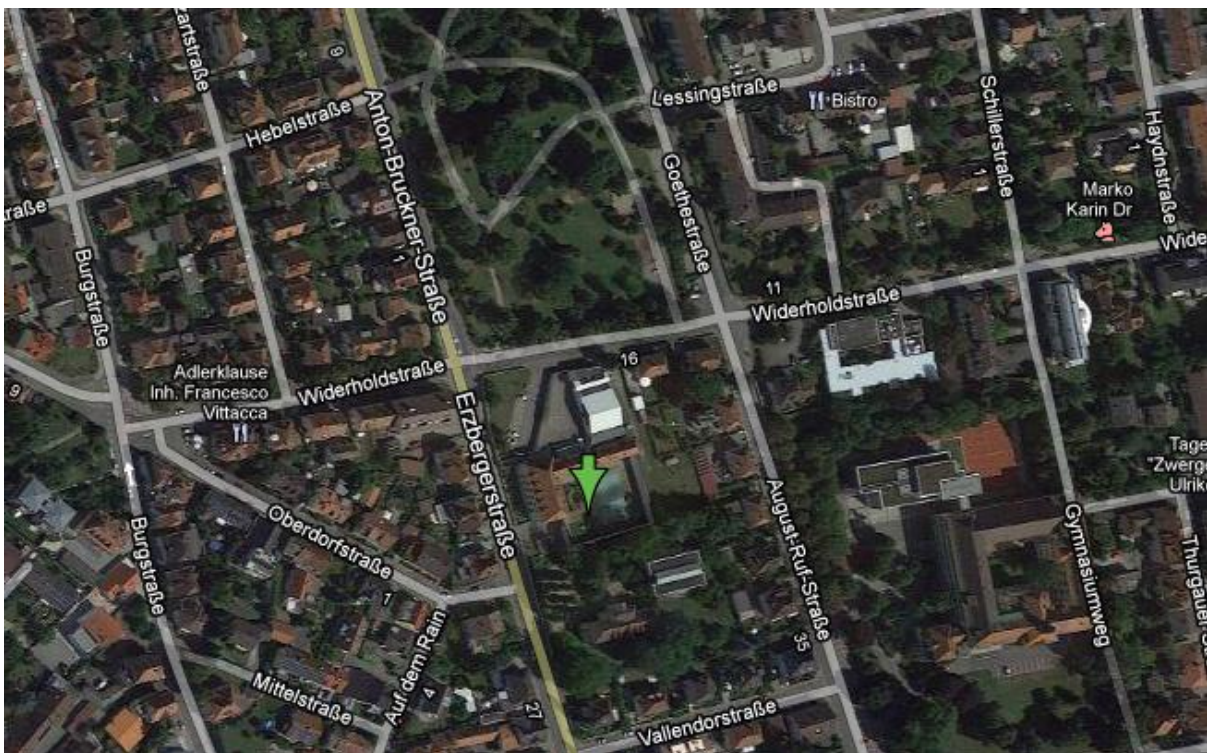
<http://wellington.scoop.co.nz/?p=51252>

Singen Germany

Visit & contribution by Helen Small – General Manager Operations - Germany

The focus at Singen was on the older person – not necessarily the older FRAIL person. The model at Singen will work for all comers provided they are happy to live community life and not threaten or terrorise other prisoners. In many ways the model of care there is like Wintringham, Wicking project – just they have the ability to move people on if they do not conform – this model works for those with mental health disorders as well as the general prisoner (I think it would also work for Wicking types too).

Singen prison sets itself apart before you enter the prison grounds. The building is located in the middle of a residential street, surrounded by homes, parks and a school. There are few visual clues in place that would lead you to assume you were approaching a prison, in fact, the prison is so well integrated into the streetscape that most people would drive or walk by without realizing it's purpose.



Mr Thomas Maus, Dienstleiter (Head of Service) at Singen, speculates that the prisons in Germany are old and often were built away from residential areas. Over time, the suburbs have moved out to surround the areas in which the jails were placed. In other words, the jails were there first and people bought and built around them knowing of their existence. Never-the-less, the fact remains that Singen is physically placed within the community with no apparent separation and no apparent neighbourhood concerns voiced by the people living in and around the jail.

The building itself was constructed in the late 1930's and is not purpose built for the older prisoners who now live there. What has been 'purpose built' is the model of care in place which focuses specifically on the social and recreational needs of older persons.



Germany is made up of sixteen Länder (federated states) which are partly sovereign constituent states. Together they form the Federal Republic of Germany. Each Länder is responsible for the prison system in that State, as a result, the prison system in Germany can vary from State to State.

Singen prison is a branch of the Konstanz Penitentiary operating within the correctional system of the Länder of Baden-Württemberg. In 1970, many of the German States enacted wide spread prison reform. At this time, Konstanz prison chose to create a specific prison at Singen for older men. This decision was based on the fact that older prisoners were growing in numbers and that their age-related needs could not easily be met in a mainstream prison environment. Mr. Maus stated that it could clearly be seen that the work needs and social, recreational pursuits of the older person were not well provided for in a mainstream jail setting where the focus was on the reconstitution of the younger person. For example, in a mainstream prison, younger people are pushed to re-educate themselves and obtain the necessary experience they will need to obtain work when they come to leave prison. While Singen does provide a work space for those who wish to work, most inmates at Singen are past working age.

All prisoners at Singen have committed a serious crime – in order to get to Singen, a prisoner must have been convicted to serve at least 15 months of jail time, be aged 60 years and over and deemed appropriate for the kind of open, community facility Singen offers. The 50 inmates of Singen are roughly divided into three equal groups in terms of crimes committed – sex offenders, those who have committed a violent crime and ‘swindlers’ or those who have committed a white-collar crime.

It is important to acknowledge that those placed in Singen are nearly always first offenders and are placed at this jail at the start of their sentence, meaning they have already successfully lived many years in the community. In most cases, they are usually from a well integrated social setting, they are all nearing or have completed a full working life and are now looking towards their retirement years and, as a group, display the same incidence of disease as do older people in the general community. As a rule, this group has not aged earlier and are generally, in their care needs, representative of the larger aged care cohort.

Most prisoners have an aged related disease such as high blood pressure or heart disease, diabetes is common. The steps within the prison and general design of the building do not readily support the use of frames and cannot support those who require assistance to transfer. At the time of the visit to Singen, the youngest prisoner was 62 and the oldest 84 with an average age of 70 years. Mr. Maus noted, that in Germany, in common with Australia, most older people do not require supportive aged care services (such as residential care) until they are in their 80's. Similarly, at Singen, the prisoners present as a comparatively active and independent group, a small number of prisoners exhibit poor mobility to the extent that they will use a walking stick and handrails to ambulate safely.

In order to best meet their specific needs, the focus of the model of care has shifted. The prisoner program, at Singen, aims to encourage and push prisoners to maintain their social networks and family supports and to work towards a socially responsible life. Obviously, within this context, there is a strong emphasis on working with prisoners so that they do not reoffend when released. Working towards discharge, in this context, is ongoing and starts when the prisoner arrives in Singen.

At Singen, staff focus on keeping the prisoners mentally and physically active. In order to achieve this outcome the prison emphasizes personal responsibility and to this end:

- Provides an open prison environment – room doors are opened at 7am each morning and not closed until 10pm each night. Some rooms are not locked at any time other than when the occupant is away from his room;
- There is open access to all areas within the prison between the hours of 7am to 10pm, prisoners may go wherever and mix with whoever they like within the prison;
- All rooms have intercom access in case the prisoner requires assistance when locked in his room;
- Singen is contracted to provide laundry services to Konstanz prison, a nuts and bolts assembly and packaging project, cooking for the facility and cleaning of the public areas. Work teams are overseen by a staff member who oversees the work of the group and provides assistance when required – the photo to the right shows the workshop and assembly area;
- Recreational activities include a large indoor area with gym equipment, a billiard table, weights room and an outdoor courtyard incorporating a games court, small pond and garden. In addition to the commercial kitchen, there are two other small kitchens, one where small groups can learn to cook and another where prisoners can cook for themselves – the photo to the right shows one of the small recreation rooms where prisoners may gather for a shared activity;
- All prisoners must participate in work and/or activities each day. They are not to sit in their rooms but must be up and about;
- The prisoners wear their own clothes and bring some items from home for their rooms – for example, doona covers and sheets may be brought from home. The staff wear uniforms clearly setting them apart from the prisoners;
- Prisoners are expected to keep their rooms clean and tidy and do their own washing in the machines located in the bedroom wings;
- The facility has a privately run shop, prisoners will either work for a wage or receive a nominal pension amount which is held in a type of trust account for them operated by the jail. Prisoners are expected to use the shop to purchase whatever goods they require for their daily lives, the shop is well stocked. Prisoner purchases are monitored, the prisoner must demonstrate that they can budget – they must explain what it is they intend to purchase, why they will be purchasing these items and then, how the purchase will affect the total funds they have available to them. The shop does not sell alcohol;
- There is a library;

- Prisoners are able to access up to 6 hours of contact time with friends and relatives and this time will be increased if required. The staff at Singen interact with the friends and relatives of prisoners and work hard to maintain social contacts for the prisoners. Unlike Australia, many of the friends and relatives of those convicted of a sex related offence do keep in touch and are willing to support the prisoner through their sentence and when they are eventually discharged from the prison;
- Prisoners who have been assessed as appropriate can participate in walking groups outside of the prison. These groups are led by a staff member;
- Each prisoner is allocated a specific staff member who is their principle contact in the facility and the staff member with whom they have the most interaction.

Medical services at the prison are overseen by a local GP who has a private practice in the town. The GP visits Singen weekly and is on call if required. The facility has a staff of three nurses, who work Monday to Friday office hours. The health needs of each prisoner is reviewed daily and referrals made to the GP whenever required. The GP in turn may refer the prisoners to specialist services in the town of Singen. On most days, a staff member can be seen accompanying a prisoner to a specialist appointment. The prison also has on staff a treating psychologist and all sex offenders must meet with the psychologist at regular intervals for treatment and evaluation.

The nurses on staff monitor the medication needs of the prisoner, most use a form of dosette box and manage their own medications however, the nurses will administer medications to those not able to do so independently and retain control of the administration of all dangerous drugs or drugs of addiction. The nursing staff work out of a small sick bay area, prisoners will line up to visit with the nurse during their hours on duty and discuss changes in their care needs. Any prisoner who suffers a serious injury or illnesses however, must be transferred to the hospital prison located at Konstanz.

Possibly the key to the sense of peace and calm at Singen is the stability of the client group. The fact that only those with longer sentences are housed here means that there is little change over time. The small number (50 prisoners) further promotes a sense of community – everyone knows everyone else, staff know each prisoner extremely well and are alert to changing care needs. Family and friends of prisoners interact with prison staff and are aware of changes in their relative's care.

For those in Singen who do not have any supportive family or friends, social workers try to establish appropriate exit plans. Plans will include transfer to a supported accommodation service (similar to our SRS's) or to a nursing home. Mr. Maus notes that residential aged care services in Germany are a community responsibility. Empty beds mean that the community may have to pay additional fees to maintain the service in their region. For this reason, Singen staff find it relatively easy to place prisoners into residential aged care homes. The caveat here, however, is the total responsibility the corrections department take for ensuring that prisoners are appropriate for transfer. German law allows a prisoner to be held past their sentence if they are considered to be a risk if they are returned to the community. Conversely, prisoners should not die in jail. Those who are clearly approaching the end phase of life are transferred back to the community for palliative care and like treatment. The notion behind this being that the prisoner is too sick to be a risk of reoffending in the community if released and on this basis, their sentence can be shortened.

To date, our work with the Department of Corrections and Forensicare has focused largely on the needs of older and frail prisoners. Singen authorities would put to us, that all older prisoners have needs that differ from the more common, younger prisoner. The focus at Singen on the human rights of the older prisoner, acknowledges this fact and has created a strongly monitored, supportive community environment.

In many ways the model of care at Singen replicates a Wintringham low-level residential aged care site. The principle differences being:

- the ability of staff to create care plans and programs of care and then enforce cooperation;
- the ability to move a prisoner away from Singen if they refuse to work towards their care plan or do not fit into the environment and constitute a threat to the other prisoners living in Singen;
- conversely, the reward for adhering to a care plan and fitting into the Singen community is ongoing residency there. Prisoners at Singen are well aware that they are far better off at Singen than they would be at a mainstream prison;
- no alcohol;
- restrictions with regards to accessing the general community.

Similar to our Wicking program, Singen relies on prisoners cooperating with the model of care. Staff are given advanced training to help them provide consistent care and behavior management of the prisoners. All in all, Singen brings to our attention a slightly different cohort – those who are aged per se rather than those who are aged and frail. Statistics indicate that only 10% of the aged population in general ever require residential aged care services. If this same demographic were to be applied to the older prison population, a facility like a ‘Melbourne Singen’ would theoretically support 45 fairly active older prisoners and 5 frailer prisoners requiring support to manage ADLs. Singen shows us that this model would work provided the building was appropriately designed to meet the needs of the frailer prisoners.

Appendices

Location Map of Prisons Reviewed

A review of on line literature in late 2011 provided the following Prisons would be most instructional: **(B)**[Fishkill Correctional Facility - New York](#); **(C)**[Laurel Highlands Prison - Somerset Pennsylvania](#); **(D)**[Deerfield Prison – Capron, Virginia](#); **(E)**[Jefferson City Correctional Centre, Jefferson City, Missouri](#); **(G)**[Estelle Unit Huntsville, Texas](#); **(F)**[Joseph Harg Correctional Centre- Lexington, OK](#); **(H)**[Central Mississippi Correctional Facility- Mississippi](#); **(I)**[California Men's Colony - San Luis Obispo, California](#). **(J)** Attendance at the [14th Annual International Corrections and Prison Association Conference in Mexico](#) – 28th October 2012 and on the return route to Australia – a visit to the [Rimutaka prison \(New Zealand\)](#) [Wellington](#) who are opening an aged care facility within their prison in December 2012



Itinerary with descriptors

Movement	Area / Institution	Dates	Reason / Expected Learning
Melbourne - New York	QF0093 0935 Melb Los Angeles 0655 (Airbus 380)	Sat 29 th Sept	
	Los Angeles(0855) to New York (1710)		
New York	Cosmopolitan Hotel Tribeca 95 West Broadway	29 – 30 Sept	Leave on the 1 st from NY to Fishkill
Drive	Fishkill Correctional Facility is a medium security prison in New York, USA . 18 Strack Drive Beacon, New York 12508-0307 00111 845831 4800 (Dutchess County) SupeIntendant William Connolly	Tuesday 2 nd Oct at 1000 Car Hire to travel from New York to Beacon Fishkill etc Travel Virginia By car	The Unit for the cognitively impaired (UCI) in Fishkill, New York, opened is a 30-bed unit of prison's medical center . It is known for having good lighting including windows, and access to an outdoor patio, and common social space. It has a specially trained interdisciplinary staff consisting of psychologists, nurses, doctors, social workers, pastors who treat UC I patients and provide prison reentry services (Hill, 2007). Focus on expertise on dementia care in prison population - see Koenignsmann Carl...
Drive Virginia USA	Deerfeild Prison , Capron, Virginia Keith W. Davis, Warden Deerfield Correctional Center 21360 Deerfield Drive Capron, VA 23829 00111 434 658-4368 Teresa Porrovecchio Institutional Operations Manager Teresa.Porrovecchio@vadoc.virginia.gov Email 24 th September	Thur 4 th 0930	Deerfield, Virginia's only geriatric prison, is where the state's inmates are sent to grow old. They're transferred to this facility in Capron, near the North Carolina border, when they're too weak to stand or feed themselves, when they don't have much time left. Deerfield Correctional, which once housed 400 inmates, has become a 1,000-bed facility with a long waiting list. Given the huge number of inmates serving life sentences -- 140,610 out of 2.3 million inmates nationwide in 2009 -- it's safe to say that more states will find themselves in the business of caring for elderly, infirm, and dying prisoners. Major transfer centre for the state of Virginia for older prisoners

Best Practice Support Model for Older Prisoners

<p><u>Somerset</u>, Pennsylvania, USA Drive to Pittsburgh Aiport? Fly to To St Louis Airport</p>	<p><u>Laurel Highlands, Prison, PA</u> SCI Laurel Highlands 5706 Glades Pike P.O. Box 631 Somerset, PA 15501-0631 00111 814 445-6501 Super Intendant secretary Miss Betsy Nightingale Voice mail (1204) Email 9/8/2012 to general inquiry</p>	<p>Approved for Tues9th Oct</p>	<p><u>Welcome to the State Correctional Institution at Laurel Highlands, the Commonwealth of Pennsylvania's only prison that is specially tasked with handling elderly prison inmates.</u> <u>Outside the small town of Somerset, 70 miles southeast of Pittsburgh and just a twenty-minute drive from field where Flight 93 plunged to the ground on 9/11, doctors and nurses provide around-the-clock medical care to more than 100 elderly and chronically ill men, offering them everything from nutritional support to end-of-life care. - many of them will die behind these walls.</u> Focus on End Of Life Care within Prison and Prison Linkages to external providers</p>
	<p>United Airlines UA1917 1340 Pittsburgh Int Air 1340 Arrive St Louis Lambert 14:25</p>	<p>10th Oct 2012</p>	<p>Drop off car Pick up car</p>
<p>Missouri Department of Corrections, Jefferson City USA, Drive from Saint Louis Airport</p>	<p><u>Aging Offenders Management Team</u> <u>The state's first geriatric wing</u>, or "enhanced care unit," opened at the <u>Jefferson City Correctional Centre</u> 8200 No More Victims Road <u>Jefferson City</u> 00111 573-751-3224 Stormy Muller director of medical email sent via hotmail to general inquiry 9/8/2011 warden – jeff norman,</p>	<p>Approved Visit Thursday 11th October</p>	<p>As the Missouri Department of Corrections Aging Offenders Management Team noted, aging offenders with mild to moderate levels of need for health services can “do well in a ‘modified’ general population setting where they have reasonable accommodations for their mobility, medical and mental health needs.” The team recommended the development of Enhanced Care Units which would have no top bunks, daily rounds by health services staff, organized activities to keep offenders busy and oriented, assistance from other offenders trained to be helpers, and special assistance with meals. In response to this recommendation, the department has piloted its first Enhanced Care Unit “to keep offenders as functional as possible while providing appropriate health and housing services to accommodate their special needs.” Focus on reviewing their activity and support for older prisoners</p>
	<p>Leave St Louis Airport – Intl Apt (1) Flight UA3680 05:50am Arrive Denver 0710 Devnver Int Airport UA 4869 08:07 – Oklahoma City 10:52</p>	<p>14 October</p>	

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<p>Oklahoma, USA, Lexington, OK</p> <p>Oklahoma City Airport</p> <p>Then drive to Lexington</p>	<p>Oklahoma's Department of Corrections Joseph Harp Correctional Centre, Lexington, OK Correctional Center P.O. Box 548 Lexington, OK 73051-0548 00111 405 527-5593</p> <p>pat.sorrels@doc.state.ok.us – email sent 13-8-2011 response 22-8-2012</p>	<p>16th October</p>	<p>Medical Unit</p> <p>The medical unit was established in 2007 to provide housing for those offenders meeting one of the following criteria: Dementia/Alzheimer patient; vision impaired/blind; wheelchair bound; uses walker/crutches; 65 or older. There are four isolation cells for those with infectious/contagious diseases such as tuberculosis. The unit is ADA compliant taking into consideration doors, drinking fountains, toilet and shower stalls, etc. Trained medical orderlies are offenders assigned to assist the offender residents of this specialized unit, providing basic skills to assist those who are physically disabled.</p> <p>Look at training program – prisoners providing prisoner care</p>
<p>Walker County Huntsville Texas</p> <p>Drive</p>	<p>Estelle Unit 264 FM 3478, Huntsville, TX 77320-3320 00111 936 291-4200 (**032) Warden Cody Ginsell</p> <p>Ms. Shell Hanson - 3605 sdhanson@utmb.edu sent email 13-08-2013</p>	<p>Fri19th Oct</p>	<p>The Texas Department of Criminal Justice has special geriatric units, located in different state prisons, to provide accommodations for offenders who are age 60 or older and who have specific difficulties with daily activities. In these units, the prisoners have longer periods of time to dress, eat, move from place to place, and shower. Texas also provides a higher level geriatric facility for male inmates located at the Estelle Unit next to the Estelle Regional Medical Facility to ensure accessibility to clinical staff. This unit provides “access to multiple special medical services, such as physical, occupational, and respiratory therapy; special wheelchair accommodations; temperature-adjusted environments; dialysis; and services for inmates with hearing and vision impairments.”</p> <p>Focus on different daily structures that allow for older prisoners frailties ie. How do they differ to the normal structured day</p> <p>See spring 2003 Some extra information on Estelle</p>

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<p>Mississippi, Pearl, 3794 Hwy 468</p> <p>Drive to Jackson Evers Airport</p>	<p>Central Mississippi Correctional Facility CMCF II - 720 is a special needs facility for male offenders who have medical or physical conditions that require special treatment.</p> <p>Mississippi State Penitentiary Parchman, MS 38738 Hwy 49 West Mr Earnest Lee - superintendant (662) 745-6611 elee@mdoc.state.ms.us</p>	<p>23rd October</p> <p>Car Hire</p>	<p>At Mississippi State Penitentiary, men who, whether due to age or for other reasons, need more support and assistance than is available in regular general population units are housed in Unit 31, a special housing unit. 103 Prisoners can stay there until they deteriorate to the point at which they can no longer care for themselves, even with the help of other inmates. They are then moved to the hospital.</p> <p>Focus on care transition – how is the older prisoners care acuity measured / identified for transition from to the unit and then to hospital (is there a hospice?)</p>
<p>UA3266 - Jackson Thompson Field - 11:35 Houston In Apt Term C - 12:32UA1149 Houston (Term C) 13:45 Los Angeles 15:32 UA5387 LA 16:08 San Luis 17:05 24 Oct</p>			
<p>California San Luis Airport</p>	<p>California Men's Colony (CMC) Highway 1 San Luis Obispo, CA 93409 00111 805 547-7503 Chief med officer P.O. Box 8101 San Luis Obispo, CA 93409-8101 Dr Carmel Muller (pronounced Car Mel) carmel.muller@cdcr.ca.gov email sent 13-8-2013 "Jack" Dean Spears – Lieutenant Herbito Sanchez – Psychologist</p>	<p>Thursday 25th October</p>	<p>The California Men's Colony in San Luis Obispo, California has a dementia unit that can be described as a "peer support ." The program aides consist of six volunteer inmates or "social aides" who have records of 10 years of exemplary behaviour and receive training in dementia care giving. Their responsibilities include making sure they receive medical care, provide social support, and protect them. Because prison is an often - dangerous prison environment in which older adults with cognitive disorders are vulnerable to victimization , the use of peer support can be a source of protection (Ubelacker, 2011). The California Men's Colony is using convicted killers to care for inmates who can no longer care for themselves. Gold Coats California Men's Colony (CMC) contains a special unit which houses inmates with moderate to severe dementia along with those who have developmental disabilities The initial results show that prisoners with dementia who participated in the program significantly improved in terms of irritability, social skills, depression, and attention.</p> <p>Focus on Gold Coats – how are prisoners identified as potential carers, what is the training program, can it be replicated</p>

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Mexico	<p>National Penitentiary System Oct 2012</p> <p>Presidente InterContinental Mexico City Hotel</p> <p>Campos Elíseos 218, Col. Polanco, C.P. 11560 México, D.F.</p>	<p>Conference Accommodation</p>	<p>\$875 \$1020</p>	<p>Sat27th Oct – Fri2nd Nov 6 nights @ \$170</p>	<p>The theme of the ICPA Conference this year is "Different Paths, One Vision: Transforming Corrections".</p> <p>This year's event will explore the way in which different strategies have been employed in different jurisdictions across the globe with the aim of improving prison conditions, enhancing public safety, reducing re-offending and enhancing leadership and staff professionalism.</p>
	<p>AS0245 Alaska Air Mex 16:18 – LA 19:14 NZ0001 Air New Zealand LA 22:15 – Auckland 07:15 (4th Nov)</p>			<p>2 Nov</p> <p>4th Nov</p>	
	<p>NZ0417 Auckland 09:25 – Wellington 10:25</p>			<p>4 Nov</p>	
Rimutaka prison (New Zealand) Wellington	<p>Prison Manager: Richard Symonds (acting) 0011 64 4 529 0800 Freyberg Rd extension Trentham Upper Hutt Wellington</p>	<p>Interview & Observation</p>		<p>Mon4th – Wed6th November</p> <p>2 days</p>	<p>Rimutaka prison (New Zealand) is set to open the country's first dementia unit later this year. The Corrections Department confirmed the "high dependency unit" will be created for some of the 120 inmates aged over 65 who struggle with daily tasks, such as showering themselves .http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10817081</p> <p>Rimutaka Prison is in Upper Hutt, north of Wellington. It is one of New Zealand's largest prisons, and opened the country's first container-cell unit in 2010</p> <p>Contact mark.lemoray@corrections.govt.nz - does not open until December 2012 – may be best to visit in the new year – or on way home – refer email 30-7-2012 Focus on modern design – is it aged friendly?</p>

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Not included in proposal – for later consideration		
Dartmoor & Shepton Mallet, England	HMP Dartmoor, HMP Shepton Mallet	
Bournemouth, England	RECOOP; AgeConcern; Older Offender Project	
Singen, Germany	Opa Gefaengnis," or Grandpa Jail	

Correctional Service Assessment - Aged Care

Long Bay - Kevin Waller Unit & A (8) Wing House

Age of Facility	Long Bay = 100 Plus years – these units have been redeveloped and updated in the last year. They are traditional cells – limited space – iron bars remain in unit – stairs for egress but ramps have been installed – they started a wing for “old Guys” a few years ago and it has developed from there	
Assessment Tool How prisoners are assessed for aged care need	Yes / NO	An assessment tool has been developed using ACAS information that identifies care needs against behavioural needs – it numerically rates a “disabled” prisoner's needs and is said to have been very successful in authenticating prisoner's needs to either the hospital or the Kevin Waller Unit – there was no evidence of this but the tool was offered to share (waiting)
Access Paths Doors Design Showers Toilets	Yes / NO	Access for aged was overall OK. Ramps had been considered but there were still quite a few trip hazards (some stairs, raised curves on paths). Some door ways were narrow and where there were showers in individual rooms they had raised trip hazard areas Group shower with non slip mat across entire floor – use of existing facility – large area that Discussion with one aged prisoner indicated how much he liked this unit – the main reason “I don't have to get up and be outside in the cold and rain – I feel the cold you know” (consider this for standard corrections practice – ie. Discount on expectations for older prisoner) “I also feel safer here – the young ones can't hassle you”
Beds High Low Non Bunk	Yes / NO	No High Low Bed. Fixed height beds at about 500mm. No Bunks were obvious Most rooms have 2 prisoner per room and space was limited (in comparison to aged care services) . Given the age of the building and availability of funding – the renovations were well considered and went quite a way to meeting an aged person's needs
Aids Access to walkers , wheelchairs, sticks, continence, medication	Yes / NO	There was evidence of access to walkers and wheelchairs but the process for access was explained to be difficult resulting in delays provision of the need. Not really sure if an incontinent prisoner has access to incontinence pads – there were examples of prisoners needing assistance when incontinent but Process now in place where equipment was earmarked as Prisoner Property so the equipment would move with the prisoner
Custodial Staffing Model – v Care Staff Model		Custodial staff, (“put in” unit – so motivation of some officers not the best) Nurses in Outpatients capacity that assisted with medications (and insulin) – but not care.... “Sweepers” = younger prisoners that assisted cleaning and bed changing –
Care Model Prisoner / carer	Yes / NO	“Sweepers” = younger prisoners that assisted cleaning and bed changing – we were told there is no personal care given by the sweepers but comments were made that inferred this probably does happen – my observation of two older prisoners led me to believe they would be unable to shower and toilet without assistance - accommodation for sweepers was being established soon for 24/7 availability
GP / Nurse Review	Yes / NO	Available in this unit – linked through the outpatient service which was “next door”

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Specialist Care Physio Dietician Acute care	Yes / NO	Referral to hospital if required Great support model with SMOPS (Aged Care Mental Health – Statewide – one nurse and sessional psych Psychologist, Neuropsychologist 1.4, Educational Officer, Links to OT and Physio as required, CNC,
Diet / Diet Review Soft diet etc and how monitored	Yes / NO	Reliant on prisoner food – no obvious speciality review for aged care needs – suggested referrals to outside could be made
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes / NO	No formal OT or Recreation / diversional therapy staff Staff indicated a need for it Staff were working on supporting prisoners but not individually focused – group activities – comments about poor take-up but improving over time Computers (no www, library, jigsaw, cooking area , TV
Transition Program Linkages to release care	Yes / NO	We were told No – but SMOPS was establishing a strong relationship with another aged care provider – have given card for hope that we can be put in contact with each other (I was told it was not Hammond Care - sounds very impressive)
Quality Review	Yes / NO	Some obvious hanging points – but ? aged prisoners deemed low risk?
Funding model	Yes / NO	Correctional, Disability, Acute Care and Mental Health
Other	Yes / NO	Information System – central collection of health information that is shared across the system and outside the system – sounds VERY impressive Story of QUAD in Jail – (another story about QUAD in Vic!) Donna wanted to know if Wintringham is an RTO for training of corrections

Long Bay 8 Wing / Aged Care Rehabilitation Unit (ACRU)

Age of Facility	Attached to Long Bay within secure walls – it is a new unit (4 years old) The unit has been built with a hospital and correctional design imperative – overall very good – could have some further refinements with Aged Care design principals.	
Assessment Tool How prisoners are assessed for aged care need	Yes	An assessment tool has been developed using ACAS information that identifies care needs against behavioural needs – it numerically rates a “disabled” prisoners needs and is said to have been very successful in authenticating prisoners needs to either the hospital or the Kevin Waller Unit. (Brochure indicates selection: 55 +, aboriginal 45+, anyone can refer but it will be reviewed by the Aged Care Steering Committee The team also provide a guide / recommendation to care of aged prisoners (see brochure) An Aged Care identification tool has been developed to be incorporated within the Reception Triage Process for all clients on presentation at the reception centres
Access Paths Doors Design Showers Toilets	Yes	Access for aged was very good. Flat level surfaces throughout area with only very few trip area Wide doors, non slip surfaces, larger rooms, wide shower area, grab rails overall OK. The Aged Care and Rehabilitation Unit provides inpatient geriatric and rehabilitation services to the increasing aged population of patients in the criminal justice system as well as specialised palliative care to patients at end stage of life. Planning for transitional care will be utilised to ensure patients discharged from the Unit are appropriately accommodated to enable self care in a correctional environment where possible.
Beds High Low Non Bunk	Yes & NO	Beds were high low – but acute hospital style not aged care – ie would not lower to floor and had bed rails as a standard (not a convention now in aged care)
Aids Access to walkers , wheelchairs, sticks, continence, medication	Yes	There was evidence of access to walkers and wheelchairs but the process for access for explained to be difficult resulting in delays provision of the need. Refer Kevin Waller Unit write up
Custodial Staffing Model – v Care Staff Model		Nursing model with custodial staff Prison officer doing aged care cert 3 course (great initiative) – further developments will no doubt occur as he identifies improvements through his care placement
Care Model Prisoner / carer	Yes / NO	Nursing model as it is a hospital based model versus an aged care model Could further develop to a carer model if it started as a aged care model – less expensive and no evidence of reduction in quality. Need to consider hospital / health needs and aged car needs in a different way otherwise the eventual model will be more expensive.
GP / Nurse Review	Yes	Available in this unit
Specialist Care Physio Dietician Acute care	Yes	All available in this unit
Diet / Diet Review	NO	Reliant on prisoner food – no obvious speciality review for aged care needs – suggested referrals to outside could be made

Soft diet etc and how monitored		
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes / NO	No formal OT or Recreation / diversional therapy staff Staff indicated a need for it Staff were working on supporting prisoners but not individually focused Evidence of Wii / TV as well as gardening program / Pet therapy – will consider a pet full time in the unit Open door initiative where door between units had been opened (quite a statement of trust and risk tolerance – culturally very significant for the correctional staff and inmates)
Transition Program Linkages to release care	Yes / NO	We were told No – but SMOPS was establishing a strong relationship with another aged care provider – have given card for hope that we can be put in contact with each other (I was told it was not Hammond Care - sounds very impressive)
Quality Review	Yes / NO	ACHS – considered a hospital (see hyper link to NSW Justice Health)
Funding model	Yes / NO	Correctional, Disability, Acute Care and Mental Health
Other	Yes / NO	Information System – central collection of health information that is shared across the system and outside the system – sounds VERY impressive Story of QUAD in Jail – (another story about QUAD in Vic!) Transport requires a special certificate but it is becoming much easier to organise Worth reading the Justice Health NSW service brochure http://www.justicehealth.nsw.gov.au/publications/JHCapabilitybrochureWEB.pdf Compare to http://www.justice.vic.gov.au/home/prisons/prisoner+services+programs/health/

Fishkill Correctional Facility, Fishkill, New York State

<p>Age of Facility NYS has approximately 50,000 prisoners (compared to 4,500 in Vic Aus) Dr Carl Koensberg Super Intendant Willaim Connolly Dr Joseph Avantzo Paula Butler, Lynn Cortella</p>	<p>Fishkill Correctional Facility is a medium security prison in New York, USA and was constructed in 1896. It began as the Matteawan State Hospital for the Criminally Insane. Fishkill also houses the Regional Medical Unit (RMU) for Southern New York's prisons. For 80 years, Matteawan State Hospital was one of the nation's most famous institutions for the "furiously mad." It began to phase out in the 1960's when the courts restricted the state's power to imprison the mentally ill. Fishkill's newly built 30-bed Unit for the Cognitively Impaired opened in 2006 to provide a calm, comforting and safe environment for inmates. It specialize in the treatment of inmates with dementia-related conditions such as Alzheimer's disease. The average age of inmates housed in the unit is 62 — 25 years older than the average age system wide. Spread over 738 acres, 148 buildings , 7 miles of perimeter fencing (work on 50 + as the age group)</p>	
<p>Assessment Tool How prisoners are assessed for aged care need</p>	<p>Yes / NO</p>	<p>There is a assessment tool and Joseph Avanzato said he would email / post the assessment tool as well as th power point presentation. Not all the tool is now used with referrals taken from other prisons based on information shared during the referral process – it is developing into an assessment centre. A key issue in discussion was risk issues: risk prisoner presents of offence or violence, - risk perception of system Risk adverse) , risk perception by public (crime if significant interest)</p>
<p>Access Paths Doors Design Showers Toilets</p>	<p>Yes / NO</p>	<p>There are 80 beds in total. – over 3 stories \ The secure facility is more Spartan and clinical than draconian and correctional in character, with the “white-walled” feel of a nursing home rather than the steel and concrete finish of a prison. Wide doors Well ventilated – some areas have ante chambers for infection control</p>
<p>Beds High Low Non Bunk</p>	<p>Yes / NO</p>	<p>There was evidence of high low beds with cot sides but no aged care high low beds (bed goes all the way to the floor) – on discussion staff indicated they could and would access such a bed if required.</p>
<p>Aids Access to walkers , wheelchairs, sticks, continence, medication</p>	<p>Yes / NO</p>	<p>There was obvious access to equipment, walkers, wheelchairs - state laws mandate this</p>
<p>Custodial Staffing Model – v Care Staff Model</p>		<p>Fully funded by the state of NY – corrections: The complex runs like a regional hospital (Australia) or medical unit (US). It incorporates “inpatient” beds 30 UCI, 30 LTC (aged Care) & 20 bed infirmary (sub acute care). It is staffed with Dr, Psychiatrist, Psychologist, RNS (Div 1 & 2 Oz translation) and carers. There is also a social worker a recreational therapist (positioned not currently filled) and pastoral care linked to the unit</p>
<p>Care Model Prisoner / carer</p>	<p>Yes / NO</p>	<p>See above There is a correctional officer overlay – with less obvious correctional officers seen in the aged unit and CIU than the infirmary. Staff are dedicated to improving care and situation for older and ill prisoners with examples of humanity shared during discussion. Some prisoners are trained in hospice care support but not in direct care. Key issue is the risk associated with care error and potential litigation – hence the need for professional staff. (example of litigation by a prisoner for the effect of smoke from a staff member smoking!)</p>

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GP / Nurse Review	Yes / NO	Definitely – works like a 80 bed hospital . specialialities include: radiology, pharmacy 4 (6000 prescriptions a month) , dental care (5 staff) , emergency care, primary care, dialysis =6 chairs, and other spezizlity care like phototherapy; telemedicine
Specialist Care Physio Dietician Acute care	Yes / NO	Fishkil operates as one of 5 the regional medical units for the state for the state prison system and the UCI occupies the entire third floor of the prison’s four-story medical center. The unit is akin to a maximum-security environment inside a medium-security prison, allowing it to accept inmates of any security classification from any facility throughout the state system.
Diet / Diet Review Soft diet etc and how monitored	Yes / NO	Dietician on staff
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes / NO	Among the programs operated at Fishkill is the Correctional Industries (Corcraft) program. Inmates manufacture beds, chairs and computer furniture for sale to state and local governments. They also fabricate to order heavy gauge steel specialty items, such as security doors and windows, for correctional and psychiatric institutions. Rcreation stff member not currently employed – no ob vious recreation program at time of visit. They do have puppies behind bars
Transition Program Linkages to release care	Yes / NO	They have a transition program and a person (Lynn Cortella) managing teh program – Lyn indicated that there were about 14 – 17 prisoners that could be released but as they had no facility who would accept them – they remained in prison. They were trying to build a formal relationship with an service provider . Overall it was not a problem for bed or wheelchair bound clients – the more active clients presented the problem.
Quality Review	Yes / NO	Accredited by ACA
Funding model	Yes / NO	Total NYS corrections – legislated both Federal and state
Other	Yes / NO	Most early release efforts are refused – There are examples where they have been granted – young man with terminal cancer. But seems rare. Great staff; dedicated and compassionate working in a risk intolerant and highly litigious environment. Very difficult to effect change.

Deerfield Correction Facility – Capron, Virginian

Age of Facility	Opened 1994 as a Geriatric Prison Security Level 1 - Assignment Criteria: No Murder I or II, Robbery, Sex-related crime, Kidnap/Abduction; Felonious Assault (current or prior), Flight/Escapes; Carjacking; Malicious Wounding; Assault/Flight/FTA pattern; No Escape Risks; No Felony Detainers; No Disruptive Behaviour.	
Assessment Tool How prisoners are assessed for aged care need	Yes / NO	Deerfield, Virginia's only geriatric prison, is where the state's inmates are sent to grow old. They're transferred to this facility in Capron, near the North Carolina border, when they're too weak to stand or feed themselves, when they don't have much time left.
Access Paths Doors , Design, Showers , Toilets	Yes / NO	All level Doors good width Showers were not seen, Toilet's were not seen
Beds High Low ,Non Bunk	Yes / NO	57 Bed Dorm, some high low beds
Aids Access to walkers , wheelchairs, sticks, continence, medication	Yes / NO	Many wheelchairs and walkers observed Prisoners needs are assessed and they receive items as required – it is required by law
Custodial Staffing Model – v Care Staff Model		Infirmery on site – fully staffed by “skilled “ staff (Hospital is 18 plus 2 beds; (2 beds are infection control, negative pressurised beds for TB etc) The 18 bed infirmery operated like a small hospital / emergency unit and was staffed 24/7 with registered nursing staff. There appeared to be a good triage system where inmates requiring more intense medical support were transferred to the local Southhampton Memorial Hospital (about 20 miles away) where “13 secure beds” were provided
Care Model Prisoner / carer	Yes / NO	Offender carer support – for transport and some ADL's All housing units had a custodial staffing overlay. The presence of the custodial staff was subtle and interactions were noted to be respectful between both parties and not overladen with power structures. These observations are difficult to measure; they are what one feels on observation
GP / Nurse Review	Yes / NO	Full time medical staff – similar to Fishkill; they enjoy the work – interesting and less stressful and received positive feedback most of the time
Specialist Care Physio Dietician Acute care	Yes	Well supported specialist care either on site or off site Dental program Therapies Note sure on dietetic
Diet / Diet Review Soft diet etc and how monitored	Yes	
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes	A well structured recreation program was evident and supported by a recreational staff member. There was a fully functioning gym and basket ball court area. There was a medical overlay to this type of recreation. Older medically challenged prisoners needed medical clearance / permission for certain activities.
Transition Program Linkages to release care	Yes / NO	Discharge Re-entry planning presents similar challenges to Deerfield as it has to all facilities I have thus far visited. Deerfield have a well developed process that starts six months prior to planned releases where “difficult to re-enter society cases” are presented on a monthly

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		basis to a group which includes a number of disciplines: counsellor, medical, mental health, nursing, social work and security staff
Quality Review	Yes	ACA
Funding model	Yes	Custodial
Other	Yes / NO	<p>Scrambling to handle the surge, the state has built a 57-bed assisted living facility at Deerfield, with rows of hospital beds filling a room the size of a high school gymnasium. They've added a special meal for the facility's legion of diabetics, and they've hired nurses to keep round-the-clock watch on the infirmary's 16 inmates.</p> <p>Fewer than 5 percent of inmates charged before 1995 have won reprieves since Allen's initiative passed, compared with 42 percent of eligible inmates who were granted parole in the years preceding the change in law. Those over 60 face even slimmer odds. Only 15 of 1,000 eligible elderly inmates have won release. That record has led to a class-action lawsuit against the state. "The law says these inmates are eligible for parole, but the Parole Board is acting as if they're not," said Bill Richardson, an Arlington attorney representing 11 inmates.</p> <p>Issue of Parole not been given</p>

Laurel Highlands – Somerset, Pennsylvania

Age of Facility	Laurel Highlands, as a prison opened in 1996 in buildings that once was the Somerset State Hospital; it is now a minimum security facility (Level 2 of 5) The building went through another update / upgrade about 7 years ago (2005) The average inmate age is 44, the highest in the state system; which you would expect as it is the key referral centre for older prisoners in need of extra support. Betsy Nightingale	
Assessment Tool How prisoners are assessed for aged care need	Yes	There is an assessment tool, used for referral. Not every old or sick inmate makes it to Laurel Highlands.
Access Paths Doors Design Showers Toilets	Yes	One of the benefits of retrofitting an old hospital for prison use is that many aged related design issues (flat surfaces, wider corridors, lighter doors, larger bathroom and shower areas have been already addressed. There are no bars on the windows (some medical treatment areas do have bars for security). There are grab rails and all floor areas are level. There were no obvious trip hazards. Showers are equipped with seats. There are even shower tables for inmates who can't sit up.
Beds High Low Non Bunk	Yes	Yes
Aids Access to walkers , wheelchairs, sticks, continence, medication	Yes	For inmates with mobility problems, staff bring meals, rehabilitation and religious services to the unit. There were obvious wheelchairs and walking frames around the facility. Day and lunch rooms were of a “grand” size and much of the building was light and “airy”.
Custodial Staffing Model – v Care Staff Model		There are about 320 inmates who live in the prison's medical unit, which offers both “skilled” and personal care. Not all of the 320 are elderly; many are younger with disabilities and or medical needs that require daily medical support. Many need assistance with activities of daily living: they may need to be reminded to take showers, or require help cutting their food or dressing and undressing.
Care Model Prisoner / carer	Yes	There is a prisoner helper system; similar to what was observed at Deerfield prison where prisoners assist with “non direct/personal care”: cleaning, assistance with ambulating, assistance with different support programs like recreation and hospice support. Correction officers are on guard in the units 24 hours a day; like Deerfield, the guards presence was subtle (most of the time) and mostly respectful. It is important to remember it is a prison and there are also younger more agile prisoners in the mix, that no doubt from time to time need reminding of acceptable behaviours. As it is a low security prison and many inmates are frail, dors to inmates' rooms are not locked, but prison staff
GP / Nurse Review	Yes	There is one employed Director of Medicine and other contracted physicians. The prison skilled staff includes approximately 26 registered nurses, 42 licensed practical nurses and 30 certified nursing assistants.. There is an onsite dental service, physiotherapist, social worker, counsellors.
Specialist Care Physio Dietician Acute care	Yes / NO	The prison has two “skilled care units” housing a total of about 100 inmates, many of whom are transferred from other prisons within the state. The prison's medical team also provides such advanced services as tuberculosis treatment and ventilator support. Laurel Highlands' annual per-inmate cost is nearly 30 percent higher than the state-wide

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		average; something you would expect as there is a higher cost to care for prisoners who need extra assistance with care.
Diet / Diet Review Soft diet etc and how monitored	Yes	Yes – did not get great discussion
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes	There is also a well defined recreation program arranged by one dedicated recreational therapist, who engages a team of prisoner volunteers to coordinate recreational programs – “ A League” of a variety of activities that adds some stimulation and interest to prison life.
Transition Program Linkages to release care	Yes / NO	Transition for older prisoners was coordinated by a full time social worker Most prisoners who were old and very frail were usually able to be accommodated in nursing homes as there is a State and Federal reimbursement system that made the care of this group viable for aged care providers. More notorious (public interest prisoners) in this frail aged category were more difficult to place but if really required there were State “owned” / run aged care facilities that would usually house this sort of prisoner. (Something that could be further considered by Victoria who has State managed aged care facilities)
Quality Review	Yes	<ul style="list-style-type: none"> •The importance of providing a secure and accountable medication system. All medications were in extra / extra secure areas and many more medications were crushed than you would normally expect in your average aged care facility (this is about ensuring ingestion and preventing “resale” of medication) •All sharps, instruments, needles, syringes, razors, podiatry equipment etc were accounted for (as you would for medications) by a count system; supported by several routines such as bundling in packs of fives, tens, twenties or fifty; the use of “shadow boards for equipment like scissors, nail trimmers scalpels etc.- to make counts easier. •The use of canvas pouch bags for carrying items like syringes to prisoners for insulin and or other injectables. Each bag had a “count in” and “count out” procedure •The use of in house sterilising to more easily account for movement of instruments in and out of the prison system •Many cupboard and or medical packs (like a resuscitation bag) had plastic lock systems. If the plastic lock had been broken a full count of all equipment in the bag / locker was required. •Routines for medication seem linked custodial processes like count times and or different movement of prisoners •There was a far greater accountability for every item of stock; a more thorough stock in a stock out process
Funding model	Yes	And see transition – state aged care beds!
Other	Yes / NO	It was not that easy for older prisoners to access the outside; but the outside views and areas were the best I have seen: Large grasses areas with large cyclone fences and razor wire. Laurel Highlands is in an undulating rural area so the autumnal views were quite spectacular and comforting (the interior felt less prison like) There was no segregation of prisoners because of certain offences they had committed – this was questioned, and I was told offences were a private matter. (this will need further analysis and understanding)

Jefferson City Correctional Centre – JCCC, Jefferson City, Missouri

Age of Facility	Operated by the Missouri Department of Corrections. (Category 5 of 5) It houses about 2000 inmates, with a staff of 660. The current JCCC was opened on September 15, 2004, replacing the Missouri State Penitentiary - Jefferson City which first opened in 1836	
Assessment Tool How prisoners are assessed for aged care need	Yes / NO	The standard of the maximum security prison designs sees the ECU in a pod of 36 cells linked together over 2 stories. Inmates with ambulatory deficits were kept to the ground floor with more able bodied prisoners and / or “Daily Living Assistants” (DLA’s) housed in the upstairs cells. (There were also examples where DLA’s were housed in the same cell as the older inmate because the older inmate had greater care needs.) This design is not so different to that seen at Port Phillip Prison, Victoria.
Access Paths Doors Design Showers Toilets	Yes / NO	Given JCCC is only 7 years old, pathways are wide, doorways are wide and rooming (cells) are generally roomier than others previously seen, with good ventilation and adequate lighting. Bathrooms and toilets were found to be accessible with minimal trip hazards. (General Showers had a lip to the flooring area, but there was at least one fully accessible shower and toilet area (completely level with no trip hazards) making it easier to manage the care of a more disabled aged <ul style="list-style-type: none"> •More regular “counts” – up to six a day – establish periods of time where inmates are usually confined to their cell or a particular area to assist count procedures: •All doors to cells are large solid and heavy •All doors are regularly locked this confining the inmate to the cell environment •Cells, whilst of a good size for two inmates provide limited space for walking frames and high low beds. Walking frames and or wheelchairs are stored in internal court yard proximal to the inmates cell •Greater cultural adjustment has been required by correctional staff and health staff who have been used to working in the maximum security environment
Beds High Low Non Bunk	Yes / NO	The 36 bed ECU houses aging and disabled offenders in wheelchairs who may require oxygen or who have early signs of dementia, or other age related illness that diminishes the capacity of the aged inmate. Each offender assigned to the ECU has access to all services, such as canteen items, library, meals, educational, vocational and re-entry programs In addition, they receive assistance, as necessary, with grooming, socialization and daily activities.
Aids Access to walkers , wheelchairs, sticks, continence, medication	Yes / NO	Yes A key difference found with medication management at JCCC was many non addictive and non mood altering medications are essentially self managed by inmates. (Inmates are given a month supply of medications and expected to manage these medications themselves. This strategy prepares an inmate for release as most likely they will need to self manage their own medications on release. As mentioned the exception to this medication is narcotic (addictive) medications and mood altering medications, owing to the concern of “onsale” and medication abuse with such drugs. There are approximately 650 to 700 prisoners on medications and they are prepared by on offsite pharmacy and managed through the infirmary.
Custodial Staffing Model – v Care Staff Model		As the facility is a maximum security prison, all correctional procedures and support structures are influenced by the same security level. This is a very similar situation to Long Bay Gaol (Sydney) and Port Phillip Prison

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		(Melbourne); as such movement around and through the prison is geared more highly around accountability for prisoners, their safety, staff safety and ultimately the safety of the public. These same structures and procedures govern the whole prison, and hence influence the surround, housing and support structures for the older cohort within the same prison walls.
Care Model Prisoner / carer	Yes / NO	DLA's provide complete care to assist an older prisoner with their activities of daily living. They function as a personal care attendant would in the Australian Aged Care Environment, providing assistance with activities of daily living (not skilled nursing care). DLA's are trained by an external agency and from what was observed and discussed provide very supportive care to the older inmate. This DLA model is the first, thus far, observed where complete care is provided by a trained inmate (not shared with other professional car staff); and was developed as correctional authorities identified a need for the support of the older prisoner and sort to provide assistance in a fiscally constrained environment; and an environment where there is great scrutiny on the cost of correctional expenditure to the citizens of the State of Missouri.
GP / Nurse Review	Yes / NO	There is a strong mental health model within the JCCC with multi-skilled mental health physicians who meet regularly with case managers (mostly evolved from previous correctional staff), correctional staff and other health professionals as necessary. Case meetings review an inmate's behaviour from either a behavioural or mental health context, with the aim of providing some governance around how to provide appropriate correctional - behavioural strategies with a focus on an inmate's cognition. There were examples of the system work well and other examples where the
Specialist Care Physio Dietician Acute care	Yes / NO	As an elderly inmates care needs increase to the point that they need specialist nursing care (skilled care) they are transferred to the Prison Infirmary. The Infirmary is a 29 bed hospital like facility. Again the design of the infirmary is influenced by the maximum security overlay, with single secure rooms, as well as 2 padded secure rooms for acute mental health / uncontrolled inmates requiring seclusion and safety from self harm during an acute mental health episode. The infirmary also provides; post acute care, medical care for younger inmates, a very active outpatient clinic for various clinical activities as well as an XRAY and dental service. Staffing and health service is facilitated through an external provider. Custodial staff and provider staff work collegiality together for inmate welfare.
Diet / Diet Review Soft diet etc and how monitored	Yes / NO	In hospital care (ECU)
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes / NO	JCC also have an active Puppies on Parole program; the program is a partnership between the Missouri Department of Corrections and animal shelters/advocate groups. There are 18 DOC facilities across Missouri that have adopted dog programs. The program matches shelter dogs with selected offender handlers. Handlers help the dogs through socialization training to make them more readily adoptable. Having seen a similar program at the Fishkill service and the response of inmates and staff alike to the dogs in the the system, there is no doubt that such a program would be worth considering with the Victorian custodial context. Access to TV's Braille Books and prison industry activity

Transition Program Linkages to release care	Yes / NO	Not really
Quality Review	Yes / NO	Have very basic Care plans for behaviour managment
Funding model	Yes / NO	All justice
Other	Yes / NO	Hospice care is provided in the infirmary and prisoners who are nearing end of life have more flexible visiting arrangements. Children are not allowed to visit within the prison, children are only allowed to visit in the specified visiting area.

Joseph Harp Correctional Centre, Lexington, Oklahoma

Age of Facility	The Joseph Harp Correctional Center is a 1370 bed (up to 1405) medium security institution located near the town of Lexington, in central Oklahoma. A medical unit was established in 2007 to provide housing for those offenders meeting one of the following criteria: Dementia/Alzheimer patient; vision impaired/blind; wheelchair bound; uses walker/crutches; 65 or older. Trained medical orderlies are offenders assigned to assist the offender residents of this specialized unit, providing basic skills to assist those who are physically disabled.	
Assessment Tool How prisoners are assessed for aged care need	Yes / NO	There is a medical Medical Unit, with approximately 258 beds, which opened in 2007 to provide housing for those offenders meeting one of the following criteria: Dementia/Alzheimer patient; vision impaired/blind; wheelchair bound; uses walker/crutches; 65 or older. There are four isolation cells for those with infectious/contagious diseases such as tuberculosis. The unit has been adapted for aged care needs with wider doors, lower drinking fountains, age adjusted toilet and shower stalls, with no obvious trip hazards.
Access Paths Doors Design Showers Toilets	Yes / NO	The design of teh facility is sympathetic to aged care needs About 37% of prisoners are over the age of 45 and 235 prisoners are 56 or older. Over 48% (666) prisoners were sentenced for some form of assault (including sexual assault) and had sentences averaging 20+ years. About 70 % of offenders are on some sort of mental health medication. Yes – good access to
Beds High Low Non Bunk	Yes / NO	NO
Aids Access to walkers , wheelchairs, sticks, continence, medication	Yes / NO	Yes - the offender orderlies “Kirby”. Kirby described his training as being over 8 weeks with homework. He was well briefed in vital signs, hygiene care, pressure care, infection control principles (gloves, hand washing PPE), minor dressings, ADLS, catheter care. – He was as well briefed as Patient Care Attendants (Australian Equivalent of his role). Kirby indicated he received a basic a wage for his work – about \$27.00 a month (I think); this was slightly less than some of the other paid roles (Prison Industry) but Kirby saw other benefits in the role: teaching him great skills for his release, he lived in the medical unit and was away from the general harshness of the prison environment, the Medical Unit was the only Unit that had air-conditioning and he really liked the air-conditioning. There was a warmth and caring nature to Kirby’s interaction. The key learning from the discussions at Joseph Harp is: with appropriate selection and appropriate training an offender / carer model can provide high quality, low cost care to older prisoners.
Custodial Staffing Model – v Care Staff Model	JHCC is supported by an outpatient style facility providing medical support with a full time physician and two full time physician assistants (similar to Nurse practitioners - Australia). There is an onsite dental service, visiting radiological service and other visiting specialist clinics available. Whilst there is no infirmary on site at JHCC, there is a strong linkage to the nearby Lindsay Municipal Hospital. JHCC is the host facility for the DOC clinic located at the Lindsay Municipal Hospital (LMH), providing corrections officer assignment to the clinic. They conduct counts, do cell/ward searches, and in brief maintain supervision, discipline, control and order in the clinic. The LMH DOC Clinic provides surgery, recovery, emergency room and non-emergency appointments for offenders.	

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Care Model Prisoner / carer	Yes / NO	There is a strong Mental Health Service including medication management, suicide prevention, individual psychotherapy, group psychotherapy, and psycho-educational groups. The facility is supported by a range of skilled health professionals: Mental Health: Coordinator, psychologist x 3, psych clinicians x 4, social workers x 2 Nursing: Manager, 20 RN's and 5 PCA's There is no after hours nursing coverage in the medical unit. Trained medical orderlies are employed - offenders assigned to assist the offender residents of the medical unit, providing basic care to the more disabled older offender. The unit is dormitory style with chest high walls separating each sleep area. There are also corridors of 4 bed cells. No bunks are used in this area. All beds are fixed. There are no high low beds
GP / Nurse Review	Yes / NO	Yes Have an EMR
Specialist Care Physio Dietician Acute care	Yes / NO	About 70 % of offenders are on some sort of mental health medication. (similar to Jefferson City; opiate and mood altering medications are dispensed by nursing staff and non opiate and non mood altering medications are essentially self managed; unless and older prisoner needs assistance with medication management); Medication rounds are dispensed twice a day.
Diet / Diet Review Soft diet etc and how monitored	Yes / NO	Yes – there are multiple diets; diabetic, renal etc
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes / NO	NO
Transition Program Linkages to release care	Yes / NO	Hospice care is not provided on site; essentially older prisoners whose failing health requires more skilled care are transferred to the LMH, or may be eligible for Medical Parole / early release. Again, as has been discussed with other facilities visited, early release processes are governed by external reviews and owing to the sensitivities associated with early release; the process is long and tightly managed; ultimately the State Governor (Premier equivalent Victoria) makes a final decision after a recommendation has been made by the correctional authorities. Needless to say, whilst early release / parole is applied for; it is seldom approved before an offender dies in custody. There are few, if any options for transition of older prisoners in need of aged care who are eligible for release. Again there was great interest in Wintringham service and the Australian aged care system which made Wintringham services possible.
Quality Review	Yes / NO	ACA
Funding model	Yes / NO	
Other	Yes / NO	Corrections review on the day of visit – there are 680 sex offenders and they are non segregated

Estelle Unit, Huntsville, Texas

Age of Facility		The Estelle Unit is about 20 Miles from the town of Huntsville, surrounded by woods with the longest entry of all prisons visited so far. Prisoners, dressed in white are seen working, clearing trees, with mounted guards providing supervision. The Estelle Unit opened in 1984. The Estelle High Security Unit was designed in response to an increase in prison violence in the Texas prison system. Around 1991 Texas Department of Custodial Justice (TDCJ) planned to build a separate facility for elderly inmates. In 1995 the unit received its current name.
Assessment Tool How prisoners are assessed for aged care need	Yes / NO	There is a 66 bed dormitory for “low care “ offenders. If an inmate requires supported care, they are assessed and transferred to the medical area
Access Paths Doors Design Showers Toilets	Yes / NO	The management of the medical unit at Estelle is contracted to the University of Texas Medical Branch http://www.cmhcc.state.tx.us/ . (A similar arrangement to Port Phillip and St Vincent’s Health Care) There is a 66 bed dormitory (half walls separate inmates) Geriatric Centre, that houses older prisoner who can essentially self care. The shower and toilet area has been adapted to enable wheelchair and walker access. Flooring is flat with minimal trip hazards. All bed are fixed. There are a few “double size” spaces for inmates that have extra equipment to maintain their independence. .
Beds High Low Non Bunk	Yes / NO	Yes and no Dormitory No Infirmary yes
Aids Access to walkers , wheelchairs, sticks, continence, medication	Yes / NO	Yes
Custodial Staffing Model – v Care Staff Model		There is no doubting there is a different approach to security at Estelle than other facilities I have visited. (The Estelle WWW indicates that prisoners are classified from 1 to 4 (rating to 5) which is a similar of classification to other units visited)..... Guard towers are manned, and you may not enter the secure prison grounds unless you are accompanied by an official staff member. After the first two barred gates; one undergoes X-ray scanning, shoes off, metal detector scanning, all pockets emptied, belt off and back through metal detector gate and a final body frisk. Then you pass through another barred gate where you Exchange ID for a visitor pass (DO NOT LOSE THAT PASS) Given the high security arrangement at the Estelle and Ellis units; the interactions observed between guards and inmates were noted to be very formalised.
Care Model Prisoner / carer	NO	Cleaning of the Geriatric centre is performed by younger inmates but there is no carer / orderly inmate model at Estelle. The medical unit will transfer acutely unwell inmates to a Corrections Approved Hospital – accompanied by 2 corrections officers.
GP / Nurse Review	Yes / NO	The medical area is staffed by a range of Nursing, nursing assistant, medical, mental health and allied health staff and offers a large range of health supports for prisoners of all ages (including older prisoners):24/7 emergency care and triageYes
Specialist Care Physio Dietician	Yes / NO	Comprehensive outpatient service, Complete medication management, Comprehensive therapy support for rehabilitation, Hospice care, Significant renal dialysis program (29 chairs, 165 treatments / week) ,

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Acute care		Radiological service, Mental Health Service, Electronic Health record. There are three main “housing Units” that provide health support. 50 beds, 33 beds and 37 beds, with a varying arrangement of single bed, single bed secure, single bed isolation and two, three and four bed rooms. Given the Unit provides health support for a range of custody level inmates; there are clear guidelines for how a inmates will be housed depending on their classification, ranging from GP 5 & “Ad – Seg” (including Death Row) = single cell – door locked at all times, to GP Level (1-4) may be housed anywhere. Some rooms are extra secure with no power outlets to prevent incidents of self harm.
Diet / Diet Review Soft diet etc and how monitored	Yes / NO	Full dietary management of inmate’s needs is overseen by a dietician, providing various supported diets for renal impairment, diabetic and other specialised diets.
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes / NO	There is no formalised recreation program. Inmates have access to televisions and books.
Transition Program Linkages to release care	Yes / NO	Transition arrangements for hospice inmates may include transfer to an aged care provider, if one can be found, only if the inmates receive clearance through the corrections process. Most older prisoners do not receive such clearance. Other transitional arrangements are arranged through the parole division and were not observed or fully discussed during this visit. Options for transition into the community were not obvious. There were no known aged care providers who would accept ex prisoners and a review of the parole divisions WWW
Quality Review	Yes / NO	ACA
Funding model	Yes / NO	Correctional
Other	Yes / NO	

Mississippi State Penitentiary, Parchman, Mississippi

Age of Facility	Mississippi State Penitentiary (MSP), also known as Parchman Farm, is the oldest prison and the only prison with a maximum security section for men in the state of Mississippi, USA., MSP commenced operation 1901, and was constructed largely by prisoners; It is located on about 28 square miles (in the Mississippi Delta region. There is accommodation for 4,840 inmates. Parchman and it is many miles from anywhere. Indianola is a decent size town close by	
Assessment Tool How prisoners are assessed for aged care need	Yes / NO	MSP is a very different prison to any others I have visited; its boundaries are not immediately obvious and it initially presents as rural community. (If MSP Parchman Farm was not where it was, there would be no Parchman) Given its geographical isolation, I learn that many staff have accommodation on the actual prison grounds
Access Paths Doors Design Showers Toilets	Yes / NO	There are approximately 4,500 inmates & 1,100 staff . The units of particular interest to this tour are: Unit 31 – currently 90 beds which serves as the unit for inmates with disabilities – these may be aged related, physical or cognitive – but offenders must be able to attend to their own ADL’s & Unit 42, the prison hospital, which has 54 beds and also serves female inmates throughout the MDOC system. The hospital also has a Palliative Care Unit for dying prisoners, in the hospital
Beds High Low Non Bunk	Yes / NO	The facility has very good access to the outside fenced and grassed area; an aged offender can easily feel the sun and a fresh breeze on their face if they so desire. The unit has air conditioning and heating. Showers and toilets are noticed to be accessible. Televisions are allowed and for offenders without a television there is a communal television. Many beds are height adjustable, some beds are fixed. There is a range of multi bed “wards” and some single bed rooms.
Aids Access to walkers , wheelchairs, sticks, continence, medication	Yes / NO	Unit 31 also has housing for about 6 younger inmates “Camp Supports”. Their key role is one of fire officers for the whole MSP. (they are conveniently housed in Unit 31 as the fire station is close by) The “Camp Supports” also provide “non direct care” to the Unit . Cleaning, meal services and laundry duties are what are observed. The skilled staff indicate the “camp supports” do not do direct care, but questioning of what occurs after hours if one of the offenders needs assistance leads me to believe there may be informal direct care provided.
Custodial Staffing Model – v Care Staff Model		The theory behind the disperse geographical design is to prevent large cohorts of offenders thus minimising the potential for mass rioting – it also provides for a tighter, more supportive and less hostile community arrangement amongst the offenders. There are different coloured uniforms for differently classified offenders; there are different restrictions and different correctional controls for differently classified offenders. Green Stripes are low risk offenders who can be seen working in the community. (I engaged three offenders just the previous day at Greenville who were gardening around the tourist bureau. The discussions I had with them were so similar to discussions you could have with a Wintringham clients...) There are black and white horizontal stripes, all orange, all yellow and all red. The distinction is obvious and helpful for staff to know what custodial risk each offender poses.
Care Model Prisoner / carer	Yes / NO	Unit 31, the 90 bed disability unit has a registered nurse, a custodial care manager, corrections staff and a LPN (Div 2 Equivalent) staffing the facility 16 hours a day; after hours, only custodial staff are present. If an offender in unit 31 has care needs that require after hours care, they

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		are transferred to unit 42 (the hospital). Some offenders were known to disguise their needs so they could delay (prevent) the transfer to unit 42. This is not a statement about the care or service in Unit 42, it is more about the older offender considering a move to unit 42 as a “final transfer” and a reluctance to leaving the “family” they have bonded with in Unit 31. (there are obvious parallel’s to a hostel clients behaviour; delaying transfer to high care where they can)
GP / Nurse Review	Yes / NO	Unit 42 is a registered hospital. The security arrangements to access the hospital are similar to other facilities I have visited: ID, sign it, metal detector and frisk search. Having said that, there is a difference to the approach, staff are warm courteous and friendly during the security intervention. Unit 42 provides a 24 / 7 nursing support to inpatient offenders as well as providing a triage service to other units. Offenders who become acutely unwell may be transferred to regional hospital. Offenders requiring surgery will also be transferred to a regional hospital. A comprehensive array of allied health support also operates from the hospital: Therapies, mental health, medical, dental service, radiology and an in house pharmacist for the Unit. Offenders requiring dialysis are transferred to another regional unit. Female offenders are treated in the hospital and are isolated from male offenders. Palliative care is provided for offenders in need of this service. Families, including children, are invited into the unit towards end of life care.
Specialist Care Physio Dietician Acute care	Yes / NO	Unit 31 also has outpatient’s type area., where offenders health is reviewed and any offender who is in the unit for rehabilitation is assessed for return to their usual unit. As has been witnessed in other correctional facilities; offenders who are capable can manage their own “non mood altering and non opiate medications. The latter medications are managed by the nursing staff, who have a disciplined count system for these medications as well as all sharps, including scissors etc.
Diet / Diet Review Soft diet etc and how monitored	Yes / NO	Meals are delivered to the unit (a sort of cook chill arrangement) and are served in a communal dining areas with fixed tables and chairs similar to the style I have seen in other correctional facilities. I am told a dietician reviews all meals and special diets are available for offenders who require them
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes / NO	I There is no recreation program or support. inmates work on the prison farm and in manufacturing workshops. It holds male offenders classified at all custody levels. It also houses the male death row; all male offenders sentenced to death in Mississippi are held in MSP's Unit 29. The death sentence is enacted by lethal injection in a specific unit at the MSP. Other lethal techniques have been used over the years
Transition Program Linkages to release care	Yes / NO	Deceased offenders are buried, with a simple service / ceremony in a marked grave on site at Parchman. There appears to be some options for transition for older prisoners into the community. Staff reported there were several nursing homes in the country areas that will take some of the “high care” offenders. On further discussion it becomes apparent that offenders, who have previous histories of assault, have few options and further to this offenders who have “low care” needs do not have many options and some just stay in prison.
Quality Review	Yes / NO	

Funding model	Yes / NO	
Other	Yes / NO	Mississippi State Penitentiary permits imprisoned men to engage in conjugal visits with wives; The practice began on an unofficial level around 1918.

California Men’s Colony, San Luis Obispo, California

Age of Facility	The main “East Facility” that was visited houses medium security (level 111) inmates, with individual cells, housing two prisoners in each cel; it has a fenced perimeter with armed guard coverage from watch towers. The housing is divided into four quadrangles. Each quadrangle has its own dining room, work rooms, recreational area and two three-story housing units. As of March 2012, the CMC’s total population (East & West) was 5,524, which is 143.9 percent of its design capacity of 3,838. The West Facility opened in 1954, and the East Facility opened in 1961; whilst the facility is somewhat old and seemingly overcrowded, it is essentially well maintained and an air of harmony within the prison walls is sensed	
Assessment Tool How prisoners are assessed for aged care need	Yes / NO	every new prisoner has a cognitive screen undertaken. CMC use the QUICK assessment too http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8328-000 Offenders who are flagged through this tool may have a follow up assessment completed using the TONI assessment tool. During these observations I have a discussion with Marti, the guard. Marty has been working with this group for at least 25 years. I ask why here. Marty shares he has a family member with special needs, so he understands the issues. He also says he loves coming to work. “There has not been one day, that I have not looked forward to coming to work”. Marty also tells me, “you have got to learn about the guys. You have to know what’s normal and what’s not. You need to know how to listen & not just with your ears – your eyes as well”. I observe the offenders and Marty are on first name basis. (no Sir, Mr. or Boss) Marty also tells me there are times you need to correct a behaviour, but you need to understand why the behaviour occurred. He says the education he has received from the doctors has been very helpful. Every prison needs a Marty.
Access Paths Doors Design Showers Toilets	Yes / NO	These cells are the smallest I have seen. They are small for one person, let alone two. One bed must fold upwards during the day so offenders can move in the cell and use the toilet in the cell. My guess is that these cells are 2.5 metres by 1.5 metres! Each cell has a solid door with a small window and the other external window is barred and approximately 300mm x 300mm. The other two longer walls are solid concrete. Offenders are locked in during the night, approximately 2100 – 0600, by a central locking system, but during the day the doors to the cells are controlled by the offender and their “roomy”. Some rooms do not have a power outlet and some do. Some offenders have televisions. Rooms are heated but there is no cooling. There is a central showering area for each floor and a small toilet in each room
Beds High Low Non Bunk	Yes / NO	As meals are served on the third floor of each building; there are no offenders with significant ambulatory concerns at CMC. Older more frail offenders, who cannot manage their own care or ambulation, are either transferred to the hospital or another facility that is better equipped for offenders with disability needs. Unit D does house offenders who have mental health concerns and or cognitive impairment (including dementia). Offenders who are capable, self manage their medication. (Opiate and mood altering medication are controlled and dispensed through similar structures and staffing systems seen in other facilities). There is one registered nurse per quadrant who oversees and provides triage for offender’s health care needs (1:600). There is a significant number of psychologists and counselling staff (approximately 1:30).

<p>Aids Access to walkers , wheelchairs, sticks, continence, medication</p>	<p>Yes / NO</p>	<p>CMC appear to have a greater provision of mental health service than other facilities visited. All facilities visited in the USA have had, by Australian standards, significantly more mental health support; but CMC seems to have more support than their US comparators. There is a respectful transaction noticed between correctional staff and mental health physicians that is different to other facilities visited. I had formed the opinion at other facilities that correctional concerns over-rod all other concerns; in turn this provided correctional staff with the “final say” over issues of concern. At CMC’s guards were seen to defer questions of behavioural concerns to the mental health physicians; that is, their default on behaviour concerns was to the psychologists. There appeared to be a subtle difference in the custodial power relationship within CMC</p>
<p>Custodial Staffing Model – v Care Staff Model</p>		<p>Guards are visible on the route to each quadrant, but once you are in the quadrant, you have to look hard to see guards. There are towers on the most external corner with armed guards, these seem unobtrusive and no threatening despite their presence. Again, this whole security overlay is different to what has been observed. There are at least 100 to 200 offenders intermingling in the court yard. Some playing ball, some sitting and talking some doing exercises some just pacing. It reminds me of the high school yard I spent many years at (it was a quadrangle to – run by the Christian Brothers) I am struck by the large amounts of offenders grouped in one area and the apparent harmony.</p>
<p>Care Model Prisoner / carer</p>	<p>Yes / NO</p>	<p>There is also a fully licensed hospital located centrally to the four quadrants that provides a comprehensive range of medical services; those services that are not provided on site are provided either at other correctional institutions (Haemodialysis) or the general hospital system (specialist surgery). The facility has a comprehensive Mental Health Delivery System in the form of an Enhanced Outpatient Program and Outpatient treatment for inmates. Offenders may also be assigned to the Correctional Clinical Case Management System, as well as a Mental Health Crisis Bed Unit.</p>
<p>GP / Nurse Review</p>	<p>Yes / NO</p>	<p>Through the hospital</p>
<p>Specialist Care Physio Dietician Acute care</p>	<p>Yes / NO</p>	<p>• Could it be because of the “Gold Coat’ program? The program is now about 15 years old. It involves younger offenders being trained to support a cognitively impaired prisoner. I am counselled and assured this support model does not involve assistance with personal care. If an older / cognitively impaired offender needs support with any form of personal care, they are either transferred to the hospital or another facility. On further discussion with my host and a Gold Coat by the name of Phillip, I find the role is like a buddy role. They prompt, they advocate, they support; they are in effect the peer support, the team leader. Examples are sited where the general prison population defer concerns to a Gold Coat. (there are examples sited where some of the more hardened inmates might call them “dogs”, but these occurrences are few and far between. Phill (gold coat) tells me, the program has given him a total new outlook on life. The themes he raises are similar to what I have heard from other: orderlies/prisoner supports. I am absolutely convinced of the benefit a prisoner support model has for a correctional facility: enhanced caring culture, savings in cost of care, prompt and improved care delivery, improved self esteem of inmates and more harmonious correctional environment.</p>

Diet / Diet Review Soft diet etc and how monitored	Yes / NO	yes
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes / NO	Michael describes the recreation program; there is a significant exercise routine; some of which, he tells me, is about maintaining function (use it or lose it). Other activities include basketball, and other modified ball games, domino's and jigsaw. He indicates there are budget restrictions and corrections considerations that impede some recreational ideas.
Transition Program Linkages to release care	Yes / NO	Same problems as most other facilities – no real options for older prisoners -
Quality Review	Yes / NO	
Funding model	Yes / NO	
Other	Yes / NO	I also notice a few women? I am told these are transgender offenders. (This answers a question I had in the back of my mind – where are transgender offenders placed – male or female prisons? – In California at least, in male prisons. Some offenders are noticed to be wearing vests. Hearing impaired and vision impaired have special observable vest so guards and others offenders (Gold Coats) will know that an offender who fails to respond to a call or whistle etc, has a special need and should be assisted not reprimanded.

Rimutaka Prison is in Upper Hutt, north of Wellington


Age of Facility		Rimutaka prison is set to open the country's first dementia unit later this year. The facility had not yet opened when visited, but was nearing completion. Rimutaka Prison is in Upper Hutt, north of Wellington. It is one of New Zealand's largest prisons, and opened the country's first container-cell unit in 2010. The New Zealand Government has set a corrections wide reform package with some significant and challenging targets. Prison Manager (not Warden or Superintendent) Richard Symonds explained that in order to meet the targets he, and all of corrections, had to rethink the way they do corrections – a fine tuning “around the edges exercise” would not be enough to meet the targets. He was speaking the same words heard in Mexico from Jane Von Dadelszen, Director of Policy & Research, who presented on the reform.
Assessment Tool How prisoners are assessed for aged care need	Yes / NO	Given the inmate population size at Rimutaka (smaller than observed in USA) they have adopted a primary care health model that is staffed during the day.
Access Paths, Doors , Design, Showers Toilets	Yes / NO	They are in the process of refurbishing an older area of the prison that used to be a youth wing (young inmates are no longer housed at the prison). Corrections staff consulted regional aged care expertise for the refurbishment with the aim of making the facility, aged care friendly: level flooring, larger accommodation areas, and larger shower areas.
Beds High Low Non Bunk	Yes / NO	To be determined
Aids Access to walkers , wheelchairs, sticks, continence, medication	Yes / NO	Rimutaka have identified the need for aged care assistance for their older offenders and they currently house them in a secure observation where inmates who are at risk of self harm are also kept
Custodial Staffing Model – v Care Staff Model		It will be staffed like an aged care facility: carers supported by nurses but it will also have a corrections officer as well. The facility is at the top of the hill overlooking the entire Rimutaka complex with view of the forest behind. Access to the outside provides for light fresh breeze and sun, and is easy for the older prisoners to access.
Care Model Prisoner / carer	Yes / NO	See above – prisoners not involved in care
GP / Nurse Review	Yes / NO	There is a visiting GP and nurse on site. Acute care needs are supported through local hospitals..
Specialist Care Physio Dietician Acute care	Yes / NO	As above
Diet / Diet Review Soft diet etc and how monitored	Yes / NO	Not reviewed
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes / NO	Minimal – guards assist
Transition Program Linkages to release care	Yes / NO	Currently there are a couple of Aged Care Providers who assist with transition into the community but there are challenges with the

Best Practice Support Model for Older Prisoners

		transfers; ranging from resistance from the Aged Care Providers staff or families of other residents that may inadvertently find out, that an older prisoners is now living where there mother or father now resides.
Quality Review	Yes / NO	
Funding model	Yes / NO	
Other	Yes / NO	It would be good to revisit Rimutaka after the new aged care area is open; there system looks very good and appropriate for their population size. http://wellington.scoop.co.nz/?p=51252

Singen – Germany

Justizvollzugsanstalt Konstanz - Außenstelle Singen Konstanz Penitentiary – Singen Branch

<p>Age of Facility</p>	<p><u>Reviewed by Helen Small General Manager Operations - Wintringham</u> The current building was constructed between 1939 – 42. The building was not constructed with older people in mind. While some adjustments have been made over the years, the facility is four storied and has no lift access.</p>	
<p>Assessment Tool How prisoners are assessed for aged care need</p>	<p>Yes / NO</p>	<p>The following criteria apply with regards to entry to Singen:</p> <ul style="list-style-type: none"> • Male • 60+ years • Serving a term of greater than 15 months <p>Most of the inmates at Singen serve their entire sentence in this facility – it is preferred that they are placed at Singen (rather than any other correctional facility) at the start of their sentence. As a result it is unusual for a prisoner to come to Singen mid-term although, on occasion, a ‘prisoner swap’ may occur.</p> <p>Prisoners live together at Singen under clear, community and social based rules. Should a prisoners violate these rules they will be given one or two opportunities to redeem themselves, but if they continue to offend they will be moved to another, mainstream prison.</p> <p>All prisoners are monitored daily by one of the three nursing staff. Nurses work office hours only and maintain records of the health of all prisoners on site.</p>
<p>Access Paths Doors Design Showers Toilets</p>  <p>Typical single room at Singen</p>	<p>Yes / NO</p>	<p>As mentioned previously, Singen was not purpose built for older people. Wherever possible, however, access in and around the building has been modified to make it easier for older people to get around.</p> <p>On the day of the visit to Singen one older man using a walking stick was noted going up and down the stairs – relying heavily on the use of the bannister rails.</p> <p>Singen cannot support prisoners who are not able to navigate the stairs independently.</p> <p>Doors are standard width, showers are shared and located in shower blocks at the end of each ‘bedroom’ wing. Some rooms have their own toilets and some toilets are also located in the bathroom areas at the end of the ‘bedroom wing’.</p> <p>Approximately half the rooms at Singen are single occupancy. The rest are shared with up to four men sharing one room.</p>
<p>Beds High Low Non Bunk</p>	<p>Yes / NO</p>	<p>Beds are rudimentary (see picture above) – generally a wooden frame with a mattress on top. There are no bunks at Singen.</p>

Aids Access to walkers , wheelchairs, sticks, continence, medication	Yes / NO	<p>Prisoners are able to use walking sticks, but stairs at Singen would make it almost impossible for prisoner with a frame to manage at the facility.</p> <p>In part this is due to the indoor exercise areas which are located at the top of the building. In Winter, prisoners need to be able to access these areas as the outdoors is not a pleasant place to be.</p>
Custodial Staffing Model – v Care Staff Model		<p>It was strongly stated that the staff at Singen were selected on the basis of their interest and desire to work in a different model to the general prison environment and to work with older people, while they have received advanced training to help them meet the needs of the prisoners, it is their attitude and desire to work at Singen which makes the program successful.</p>
Care Model Prisoner / carer	Yes / NO	<p>Typical residential aged care environment with enhancements:</p> <ul style="list-style-type: none"> • Ability to insist that prisoners follow a care plan • Strong oversight of spending to the point where staff can control what the prisoner spends in the shop • A balance between a focus on working together rather than staff control and understanding when staff must control a situation <p>Generally, however, those requiring a lot of help with ADLs are not housed at Singen.</p>
GP / Nurse Review	Yes / NO	<p>GP – weekly Nurse - Daily</p>
Specialist Care Physio Dietician Acute care	Yes / NO	<p>Additional services available to prisoners:</p> <ul style="list-style-type: none"> • Psychologist • Occupational Therapist • Social Worker <p>Specialist services used in the general community (ie dentists, podiatrist)</p>
Diet / Diet Review Soft diet etc and how monitored	Yes / NO	<p>Special diets are in place.</p> <p>Cooking for the facility is one of the jobs available to prisoners – the menu is set and provides appropriate meals for those requiring a special diet.</p>
Recreation Program Linkages to family and or external agencies as well as meeting areas of interest	Yes / NO	<p>Yes and forms a mandatory component in each prisoner’s day.</p> <p>Some recreation programs are run by Singen staff and some by community volunteers.</p>
Transition Program Linkages to release care	Yes / NO	<p>Aim to retain and strengthen existing community links so that the older prisoner has a discharge point and someone to support him</p>

		<p>at discharge.</p> <p>For those without family or friends, there is a transitional facility. Social workers here will work with the prisoner to find an appropriate placement at the end of their sentence.</p>
Quality Review	Yes / NO	<p>Outcomes at Singen are closely monitored. The effects on the ongoing operations of the prison should a prisoner escape, especially if they cause community concern during the escape period, would be immense and extremely detrimental.</p> <p>For this reason, prisoners at Singen are closely monitored and reviewed. Records and assessments of prisoners are ongoing and based on a multi-disciplinary approach.</p> <p>Basically, staff at Singen know the prisoners well.</p>
Funding model	Yes / NO	<p>Singen is funded by the corrections system of Baden-Württemberg. There is no specific funding model used at Singen, however, there is fairly low staff to prisoner ratios and a number of specialist staff available which indicate that the cost of this model would be higher than a residential aged care model and the general prison model.</p>
Other	Yes / NO	

Mexico City 14th ICPA Conference – 28th October 2nd November. – Brief Notes

I meet 2 Canadians over drinks: Darryl Churney Director Corrections Policy (Darryl.Churney@ps.gc.ca),

& Bob Brown – Independent Criminal Justice Consultant (brown.reb@shaw.ca); who has worked with the Canadian Justice systems for many years (knows Rod Wise). After some discussion both indicate they are unaware of anyone in Canada working in the aged care space of corrections. They are aware of the issue.

They thought that this is an area that homeless and Mental Health services would cover.

There is a theme of concerns for “pre trial conditions” – remand – this has not been looked at (how do aged care needs get assessed at this level?)

Theme – universally recognised that the mental health populations in most prisons are concerning and efforts must be made to limit the incarceration of mental health offenders – there needs to be better community options.

Walter MacGowan – UK consultant = 40 years experience “the more controls and security overlays, the more resistance offenders will produce. On discussion about inmates having keys – UK don’t have armed guards.

Kevin Skipper (NZ living in Texas) – works in correctional locking systems Southern Folger – structurally sound and have various controls and freedoms but ... are strong and will last – may be useful for facilities where door damage has been an issue – Eunice Seddon

Community Corrections Plenary

UK – 86,000 prison population = 152 / 100, 000 population

High % of reoffending 12 months post release compared to community – 50% ish

Purpose of sentencing: Punishment, reduction of crime, reform and rehab, protect of public, reparation

Restorative justice being looked at.

National Assessment tool = OASYS http://www.emcett.com/offender/one/offender_assessment_system.html

Community corrections – payment by result (PbR) ... (if this comes to Australia – will we be part of that including use of GPS tracking systems) – current pilot underway

Presented by - Martin.Copsey@noms.gsi.gov.uk head of the Community Commissioning Group UK

Mandatory aftercare in Singapore

Singapore – 5.3 million, 13000 prisoners, 2000 officers, 400 – all in one single giant prison complex

Criminogenic Needs http://ojj.la.gov/ojj/files/What_Are_Criminogenic_Needs.pdf

Mandatory aftercare needs – target high risk inmates

http://www.vcsc.virginia.gov/risk_off_rpt.pdf with the use of “befrienders” prior to release (this could be case management) – we could be as bold to suggest that all aged prisoner should have aged care case management post release – CACP minimum but possible CACP MH.

Denmark – Alternatives to Imprisonment

Suspended sentence dates back to 1905

Crime rate gone up – doubled in the last 30 years, but no / little expansion of prison bed numbers.

5.5 million inhabitants 400 prisoners 10000 community 3800 staff plus 600 in community

Belief prison is last resort and short sentence

PACCOA, the Probation and Community Corrections Officers' Association, is a not for profit national group which works to promote understanding of, and discussion about, issues surrounding offender management, particularly community-based interventions.

<http://www.paccoa.com.au/conferences.html>

<http://www.justice.vic.gov.au/emanuals/VSM/default.htm>

Corrections in society / society in corrections – Norway (bombing mentioned) – 21 years sentence (referred to as terrorism)

It is harmful to be isolated for a long time (single cells not a good idea)

Inmates should have the same rights as other members of society except freedom / liberty (voting, health care etc)

White paper – punishment that works – supported by all political parties (google)

Purpose, human, due process, convicted have paid their debt, normality

Increase the use of community based interventions

Home curfew – with or without Electronic Monitoring (EM) – better integration, prison capacity – prisons fully booked, cost less than imprisonment (but it needs to be a better system for correctional behaviour – teh convicted has to apply for EM) in Norway - offenders must apply. Offenders are satisfied – work and family main reason – 10% recidivism (less than imprisonment) may be used as a pre trial. EM is considered harsher. Not used for more serious crimes.

Community sanctions – Norway – there is a high degree of flexibility; can be used as an alternative to imprisonment for up to a year. Assault charges excluded. 21% recidivism.

Tailored programmes – drunk drivers (as an example) – no reduction in reoffending.

Consider use of other institutions for “sentence” – drug, mental health..... aged care?

The smaller the difference between imprisonment and free world the less integration support will be required.

Met Mr Peter Severin <http://www.correctiveservices.nsw.gov.au/about-us/commissioner-peter-severin>

Peter Severin joined Corrective Services NSW (CSNSW) as the new Commissioner on 3 September 2012.

Mr Severin has extensive senior executive experience and knowledge in corrections from working in the portfolio for more than three decades.

Before joining CSNSW, Mr Severin was the Chief Executive of the South Australian Department for Correctional Services for nearly 10 years.

New SA corrections Boss = David Brown <http://www.abc.net.au/news/2012-09-18/new-sa-prisons-boss-appointed/4268054>

<http://www.corrections.sa.gov.au/reports-and-media/annual-reports>

Peter Mwaura – Kenya Nairobi (capital)

Church thanks giving – officers and offenders together

Lang'ata women's prison <http://wikimapia.org/15733044/Lang-ata-Womens-Prison>

Toon Molleman – Netheralands

Affect of staff on Prisoners – right staff prisoner relationship are not too close and not too distant, they are characterised by respect and fair sue of authority

Harmony values – respect trust support

Security value – consistent rules and regulations – predictability

Motivational interviewing – encouraging environment

www.wodc.nl – Netherlands correctional publication – in English

Mexican Reform

Health Care - 6000 inmates!

2010 surge of Cholera – catastrophic events in Haiti

15489 visitors – real issue related to over crowding

Main objective was to provide good quality water

Training of security staff and then inmates

Chlorine dispenses – especially in facilities with poor water supply

Carpets with chlorine for entry and exit

Old Model prisons

Population affected La Victoria 5300 inmates) 557 diarrhoea (10%) - 12 fatalities

Nayayo 3090 inmates 281 diarrhoeal (9%) - 1 fatality

New model prisons

Population affected Barohona 738 inmates 44 diarrhoea (6%)

El Seibo 975 58 diarrhoea (6%) - 1 fatality

Mexican constitution – articulate care / health care requirements in prison

Health is a universal right / an obligation – he depends on the system to provide care – it is a responsibility of the system – this is a new correctional model

5 points of re-entry – work training sports education and health

Chronic degenerative disease –

A lot of work being done but a lot more to do

Most did not have a proper health record

Medical consultant does not pay very well (not great benefits) – it is not attractive to new doctors – a significant HR issue. It is not ideal but they are good persons and are working well under difficult situations.

There are 2 general surgeons

Use of mobile medical units – buses fitted out – diagnostic, surgical dental and medical

High technology in the units- they provide support providing care for 19702 inmates

A long way to go but we have done a lot

There needs to be a national approach to care -

Met –

Patrick Craig – International Criminal Court – Chief Custody Officer – essentially a remand service; once sentenced an offender is sent to a particular country (negotiated)

Army – Police – now dealing with war criminals – translation services and international issues

Presentation on Mental Health issues in correction services

Prisoners with cognitive impairment – Port Phillip – Marlborough Unit

Dennis Roach – Director of Custodial Services – G4S Oz & NZ

Aus population = 29950

Vic = 4884 – presented that 3% are registered as intellectually disabled

Port Phillip – 823 prisoners

St Johns = 20 beds - St Augustine (St V's) – 10 beds

Marlborough = 35 beds

135 registered as IDS of 4884

Disability Forensic Assessment and Treatment Service – (DHS) – has a psychiatrist on staff

Security and Safety are the key issue

Looking to develop units in medium and minimum security prisons.

Port Phillip provides Peer support program – prisoners working with intellectually disabled prisoners

Listeners

Mentors

Induction workers

It is about prisoners interacting with at risk prisoners

Used across the whole of Port Philip

“We don’t know if it helps reduce reoffending” – we have a sense that it is having an effect.

<http://www.justice.vic.gov.au/home/prisons/research+and+statistics/prisoners+with+disabilities+research>

JTP response – stop, think calm down; take time out; warning; directed to cell

They have a WII

Community Engaged

Street soccer program- may be worlds first

Prisoner is the word not offender or inmate

(very average presentation)

See <http://www.vota.org.au/news/reading/thu%20g5%201600%20murphy.pdf>

James McGuire UK Mental health in prisons – Liverpool

Rate of mental health in prison is significantly higher than general public (stats and papers discussed)

HM Liverpool have a mental health in reach team

Primary care psychology service 1 psych plus support mh staff

Stepped Care Model- google <http://bjp.rcpsych.org/content/186/1/11.2.full>

Large amounts of anxiety, sleep problems, anger control, difficulty with expression

Prison care model – improved relation with staff, the value of support changed the relationship

Suggestions - Human Rights issue

Aged Care Support and Assessment of Prisoner Needs

Aged Care in Prison (not Hospital Care), Community Care and Residential Style

Aged Care support and planning for release

Early Release Options <http://www.sacbee.com/2012/12/28/5079257/incapacitated-prisoners-too-costly.html>

Template Request Letter / Email



Dear XXXXXX,

Re: Request to Visit XXXXXX Correction Facility

Your details were given to me by your administration as the person to address my inquiry.

I am a senior manager and registered nurse working with [Wintringham Specialist Aged Care](#).

Wintringham are working with our [Government Authority \(Victoria, Australia\)](#) to improve care for our older prisoner population.

There a few other places in the world as instructional on key issues affecting older prisoners as the USA; I was hoping to visit your facility, as it is one of six identified in my study which provide best practice to older prisoners.

This correspondence serves as a request to visit your facility on xx & xx October 2012.

A key aim of my project is to undertake an analysis of older prisoner populations within the USA to determine the “housing”, medical care, and programs that respond to their unique needs and vulnerabilities. From this analysis, I expect to develop plans to improve care for the population of older prisoners in our jurisdiction.

As mentioned, I work for Wintringham, an [internationally recognised](#) specialist aged care agency; providing innovative approaches to housing and support of marginalised older Australians. There is no doubt Wintringham will learn much from meeting you and your staff and seeing your best practice work. You can view the bona fide of Wintringham by visiting our online video <http://www.wintringham.org.au/overview.aspx>

I trust you will be able to provide me details on what is required for me to visit your correctional facility.

Thank you in advance for assisting me with my request. (I have included my Date of Birth, Drivers License Number and Resume via LinkedIn - details below). My email address is also included if this suits future correspondence.

Phillip Goulding (*redacted personal information*)

Email whilst on tour

From: Phillip Goulding

Sent: Wednesday, 17 October 2012 11:41 AM

To: Helen Small

Subject: some feedback on my visits so far for the working party (if you are attending - if you would like to share.

Hi Helen,

I hope you and the family are well and all is well at Wintringham.

I have just received Donna's email about next weeks working party and see you are on the CC list.

I have now visited five (5) prisons (I reviewed Oklahoma Joseph Harp today) and thought I would forward you some thoughts on what I have seen so far.

You may like to share these / some of these with the working party or you can sit on them until we discuss them further (and any further thoughts) when I return:

All prison's visited have a well advanced working model to support older prisoners within the prison system.

Prisons in the USA have a high percentage of mental health management – they are delivering the mental health care fairly well, supported by on site mental health practitioners and there is informal acknowledgement that the “deinstitutionalisation” of mental health was more like a “**reinstitutionalisation**” (to the custodial system); we know we have a high percentage of mental health issues in Victorian prisons but I don't think the prisoners are receiving the same intensity of mental health care / support that I see in the USA. (we could well do with the support in our facilities – sort of Wicking like really.

Older prisoner housing options, within prisons, were found in both maximum and minimum security facilities – minimum security facilities could more easily adapt their environments to age appropriate care (both structurally -building works and culturally -custodial officer attitude etc)) All care options have been influenced by an acute hospital care model of care ; not an aged care model of care; It is easy to see that an aged care model of care will be less costly and provide more aged appropriate care. (i.e. Hospital beds and costsides are used, if used at all.)

Only some older prisoners who were VERY frail (HIGH CARE) have a viable transitional option – essentially, there are NO transitional care models for “low care” aged prisoners, and all Prisons visited so far would welcome a viable transition option like Wintringham – they are all universally intrigued by our funding arrangements and our Mission (most had reviewed our video as I had emailed the link prior to our visit)

Prisoner carer models (younger prisoners providing care in prison) do exist, younger prisoners are offered training and function as a PCA – this is by far the best model I have seen (Jefferson City and Joseph Harp have excellent training options – I have been able to talk one on one with prison carers and they really enjoy their work and are well trained.

If you are an old prisoner and have no ADL care needs, transition arrangements for support into the community (rooming houses essentially) starts 6 months prior to release – for these prisoners – prison is probably a better quality of life (sad to say but true) and it is thought many older prisoners reoffend to get back into the system

Whilst early release, based on medical grounds and health is an option, it is near impossible to get an authority to make a decision to grant this option as the risk of a serious re-offence is seen as to

high (there has just been a murder by a younger release on Parole – and it is all over the news – there is no rationality about older frail prisoners – just IMMENSE fear of getting it wrong. As an example, in Oklahoma, the Governor (Premier equivalent) has the final say! The same sensitivity will no doubt exist in Victoria as I am pretty sure the old guys we are referring to have a higher degree of public sensitivity than others.

There is good rationality for the different models:

risk of prisoners taking legal action in regards to care neglect (New York) prompting a fully paid for nurse and carer model (no use of prisoner carers)

no funding for care support, prompting a prisoner care option (Deerfield, Jefferson City & Joseph Harp)

Placement of facility in maximum security versus low security seems to be based on available space, budget and perceived risk of the older prisoners (public opinion and political interference)

My current best care suggestion is – we should continue work towards an improved transitional care model for aged prisoners (better advanced planning) with some other aged care providers and Justice Victoria.

And we should be working towards an aged care appropriate facility within prison walls, preferably a low security prison that can provide support for aged prisoners; probably with younger prisoners as care workers. There would need to be a linkage to a local hospital (this probably exists) AND as the older prisoners care needs increase; Have an aged care facility linked closely (but on the outside of) the low security prison, with ongoing minimal custodial presence (24/7) supported by Justice Victoria. (I have seen some merit in subtle custodial presence) This last option could be quite attractive to Vic Custody and a possible option in terms on accessing Aged Care dollars – it would need a review of sentencing practices which is all part of the equation here and I think there is discussion of the same in Victoria and NSW.

Any how – just some thoughts at this stage and as I said – you can share them or keep them at your discretion.

Phillip Goulding
Deputy General Manager Operations

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