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Aging in Correctional Facilities: Challenges, Programs, and Service Adaptations

Abstract

As the aging American population grows, so does the aging population within the penal system. Historically, correctional institutions were designed for young, able-bodied inmates. Today, correctional institutions are finding the need to make accommodations for the unique physical and cognitive needs of those over age 55. Due to lack of health care and illicit behaviors, individuals who are incarcerated typically experience negative outcomes of aging earlier than those in the general population. With increased sentence lengths and a decline in physical and cognitive abilities, correctional facilities are finding it necessary to identify and create modifications. Some of the challenges correctional institutions are facing include structural changes to buildings, programs to aid with physical and cognitive decline, assistance with activities of daily living, as well as palliative and hospice care services. This literature review discusses the challenges and adaptations needed as inmates age in place, as well as outlines some successful trainings to educate corrections employees on the unique needs of aging inmates.

Keywords

Aging, older adults, correctional institutions

Aging in Correctional Facilities: Challenges, Programs, and Service Adaptations

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As the aging American population grows, so does the aging population within the penal system. Historically, correctional institutions were designed for young, able-bodied inmates. Today, correctional institutions are finding the need to make accommodations for the unique physical and cognitive needs of those over age 55. Due to lack of health care and illicit behaviors, individuals who are incarcerated typically experience negative outcomes of aging earlier than those in the general population. With increased sentence lengths and a decline in physical and cognitive abilities, correctional facilities are finding it necessary to identify and create modifications. Some of the challenges correctional institutions are facing include structural changes to buildings, programs to aid with physical and cognitive decline, assistance with activities of daily living, as well as palliative and hospice care services. This literature review discusses the challenges and adaptations needed as inmates age in place and outlines some successful trainings to educate corrections employees on the unique needs of aging inmates.

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Introduction

Inmates in the United States face many physical and cognitive challenges as they age in prison. Due to the dramatic increase in the number of older inmates in correctional facilities, aging in place for this population is a growing concern. The purpose of this review is to highlight the challenges that aging presents for older inmates and correctional institutions as well as the programs and adaptations that have been created to respond to these increased needs. The National Commission on Correctional Care defines “older” inmates to be 50 or 55 years of age (Williams, Goodwin, Baillargeon, Ahalt, & Walter, 2012). To be consistent with reporting by the Bureau of Justice Statistics, this review will define “older” inmate as a woman or man 55 years of age or older and serving time within a correctional institution (Carson & Sabol, 2016).

As the general population in the United States ages, the aging inmate population is also expected to rise. In 2003, there were approximately 36 million individuals age 65 or older in the United States (Abner, 2006). According to the Federal Interagency Forum on Related Statistics, that number grew to 46 million people age 65 and older living in the United States in 2016. According to Carson and Sabol (2016) of the Bureau of Justice Statistics, the number of inmates in the United States age 55 and older has increased from 26,300 to 131,500 over the past

twenty years, with a median age increase from 30 to 36 years.

Inmates age 55 and older are the fastest growing population in correctional facilities, in part due to increasingly stringent laws (Abner, 2006; Carson & Sabol, 2016). Mandatory minimum and longer sentences, limitations on parole, and mandatory life sentences for third violent or other serious felony convictions have led to a significant increase in the inmate population in the United States (Loeb & AbuDagga, 2006; Nowotny, Cepeda, James-Hawkins, & Boardman, 2016). According to Carson and Sabol (2016), there has been an increase of 54 percent in arrests for drug offenses between 2003 and 2012 for individuals age 55 and older, whereas arrests for individuals younger than 54 years of age have decreased by 10 percent. The older inmate population, on average, is serving longer sentences than younger inmates due to the type of crimes committed. Specifically, there is a greater percentage of violent offenders in the 55 and older inmate population, and they have a higher mean sentence length than those in other age categories. In 2013, inmates aged 55 or older had a mean sentence length of 82 months, compared to 69 months for inmates aged 18 to 39, and 71 months for inmates aged 40 to 54 (Carson & Sabol, 2016). Inmates serving longer sentences for more violent crimes will naturally age into older cohorts in the correctional facility (Carson & Sabol, 2016).

Effects of Aging

Inmates are found to age faster, physically and mentally, than individuals in the general population (Abner, 2006; Williams, et al., 2012), and it is estimated that their physiological age is 10-15 years older than their chronological age (Abner, 2006; Aday, 1994; Grohs, 2015; Hoffman & Dickinson, 2011; Williams, et al., 2012; Williams, Lindquist, Sudore, Strupp, Willmott, & Walter, 2006; Williams, Stern, Mellow, Safer, & Greifinger, 2012). This trend can be attributed to years of poor personal healthcare, including inaccessibility to healthcare services, poor diet, and substance abuse (Abner, 2006; Hoffman & Dickinson, 2011; Rikard & Rosenberg, 2007; Williams, et al., 2006). Prior to incarceration, inmates typically are impoverished and exhibit high-risk illicit behaviors and often enter correctional institutions with chronic medical issues and untreated mental illnesses (Hoffman & Dickinson, 2011; Williams, et al., 2012).

Older adults typically experience reduced social support systems, and for the aging inmate population, this decrease of support is amplified. The friends and family members of inmates struggle with the shame and social stigma of having their loved ones incarcerated, finding it stressful to make continued visits to the institution and often ending visits altogether (Travis & Waul, 2003). Many incarcerated parents do not receive visits from their children, and many inmates do not want their children to visit them in a correctional facility, believing these visits may be too emotional for their children (Snyder, van Wormer, Chadha, & Jaggars, 2009). Additionally, family members of older inmates are aging, may be in poor health, and may be unable to provide any beneficial social support to their loved ones (Aday, 1994). This diminished support system brings additional stress to inmates, contributing to their developing age-related health issues earlier than those in the general population (Abner, 2006; Hoffman & Dickinson, 2011).

With the increase in older incarcerated adults, and the early aging that occurs with inmates, correctional facilities are challenged to develop and incorporate adaptations and programs that are necessary for aging inmates. Specific adaptations and programs needed fall within the following areas: a) cognitive changes and decline; b) physical changes and needs; c) housing modifications; d) socio-environmental concerns; and e) palliative care needs. Each of these challenges and related adaptations and programs that have been implemented are discussed below.

Cognitive Changes and Decline Among Inmates

Depression, mood disorders, and dementia are common among older inmates (Greifinger, 2006). In one study, researchers focused on mental health disorders among older men in a state prison nursing home (Meeks, Looney, Van Haitsma, & Teri, 2008). They found that inmates with mental illnesses were at a higher risk for injury, victimization, and longer prison stays than inmates not suffering from mental illnesses. The nursing home inmate population also has a higher risk for depressive disorders due to medical conditions than do older individuals in the general population (Meeks, Sublett, Kostiwa, Rodgers, & Haddix, 2008). These inmates are susceptible to inadequate services and opportunities within the institution and are likely to experience more disciplinary measures for failing to respond to orders sufficiently, potentially resulting in lengthier sentences and increased isolation (Greifinger, 2006; Meeks, et al., 2008). State and federal correctional facilities offer psychological and psychiatric services, yet only approximately 78 percent who have been diagnosed with major depression are treated with anti-depressants (Baillargeon, Black, Contreras, Grady, & Pulvino, 2001). Many inmates decline anti-depressants due to personal choice, and unpleasant side effects, or they hide the medication for non-therapeutic purposes (Baillargeon, Contreras, Grady, Black, & Murray, 2000).

In response, mental health programs have been developed to address these concerns. BE-ACTIV, a behavioral treatment program for depression is one example of an effective program developed by Meeks et al. (2008). After first implementing this 10-week behavioral, activities-based intervention for depression in a nursing home serving the general population, they intentionally focused on older male participants in the Kentucky state prison system nursing home. Participants were diagnosed with depression and treated with anti-depressants. As part of the intervention, a recreational therapist staff member was trained in the BE-ACTIV program and asked to implement pleasant events for participants. Specifically, the recreational therapist identified possible pleasant activities which could be integrated into the inmate's daily routine, such as including a morning cup of coffee or receiving compliments. As part of the research design, participants rated their mood weekly during the course of the assessment. After the fifth or sixth session, 75 percent of participants reported stabilization of negative affect. According to the researchers, inmates had more control over their activities, and consequently, they had more

control over their moods (Meeks, et al., 2008). However, the confines of a correctional facility limit the success of such a therapy, as the inmates have little control over pleasant activities. Meeks et al. (2008) also explained that therapists lacked time, money, and privacy to successfully implement the behavioral treatment program.

In 2011, a group of 29 professionals, including independent doctors, correctional health care providers, chief medical officers, psychology and psychiatry experts, inmate advocates, lawyers, and foundation officers convened to discuss specific concerns for appropriate physical and mental healthcare for aging inmates (Williams, et al., 2012). This group proposed nine areas of priority to be addressed in a new policy agenda, including defining functional impairment among inmates and screening for dementia. According to Morgan and Fellow (2017), as many as 26 percent of state prisoners have a mobility, hearing, or visual disability that limit their ability for self-care. When cognitive disabilities among prison inmates are included in those reports, this percentage increases to 32 percent. Morgan and Fellow (2017) report that it is not uncommon for inmates with physical disabilities to be neglected and denied mobility devices, forcing a reliance on other inmates to assist them in carrying out their daily activities. Inmates with physical disabilities are also found to be at risk for placement in solitary confinement as a solution to overcrowding.

Inmates are especially susceptible to dementia because of increased risk factors such as traumatic brain injury, drug and alcohol abuse, and low education attainment (Williams, et al., 2012). As suggested by the professionals concerned with appropriate healthcare for aging inmates (Williams, et al., 2012), one programmatic response to the increased risk for dementia among older adults in correctional facilities focused efforts in the California Men's Colony (CMC) state prison (Hodel & Sanchez, 2012). In this effort, specialized programs were developed for inmates who have mental health symptoms (Hodel & Sanchez, 2012). Inmates with dementia also are housed together in one unit, which is shared with inmates who are at risk of victimization due to their physical disabilities. The Special Needs Program for Inmates with Dementia (SNPID) utilized by CMC focuses on making changes in the physical and social environment, as well as providing activities to the inmates with dementia, with the goal of reducing socially inappropriate behavior and agitation. Skill training is offered, which includes emotion management and health education. This long-term special-needs program has

successfully reduced agitation and behavioral problems among inmates with dementia and allows them to have a reasonably good quality of life within the prison environment (Hodel & Sanchez, 2012).

Physical Changes and Needs Among Inmates

In addition to cognitive changes, many inmates face physical challenges during incarceration. Physiologically, inmates are older than their actual age and may experience significant physical ailments usually associated with much older individuals. Health issues such as hypertension, heart problems, diabetes, emphysema, arthritis, and cancer (Aday, 2005) are common in the older inmate population, are presented earlier than in the general population, and inmates are more likely to experience one or more chronic conditions than their non-incarcerated counterparts in the United States (Williams, et al. 2006). Comorbidity is common with older inmates, as they often experience an average of three chronic illnesses during incarceration, which may include arthritis, diabetes, heart disease, hypertension, prostate problems, cancer, Hepatitis B and C, HIV infection, AIDS, and tuberculosis (Abner, 2006; Hoffman & Dickinson, 2011; Williams, et al., 2012). They may also suffer from diminished vision and hearing, which may result in falls, depression, and isolation (Greifinger, 2006). While the general population typically reports these age-related changes, most individuals outside of correctional institutions have access to some health care resources, nutrition, and appropriate services to aid in their well-being that encourage a healthier later life when compared to older adults who are incarcerated. Due to the Medicaid Inmate Exclusion Policy (MIEP), inmates can only receive federal Medicaid matching funds when they are hospitalized for at least 24 hours. Clinics and hospitals for the general population that receive Medicaid funding must meet standards set by Center for Medicaid and Medicare Services. Prisons and jails do not, often leading to lower standards of care (Winkelman, Young, & Zakerski, 2017). Increased age-related physical changes in the aging inmate population are requiring correctional institutions to evaluate how best to care for them. Studies and trainings are continually being conducted to better address inmates' physical needs to provide adequate care.

Williams et al. (2006) conducted a study of 120 older female inmates to determine the frequency of functional impairment among this population and ways the prison environment could contribute to these impairments. Prisons were designed and built for young, able-bodied

inmates. As a result, they may require inmates to engage in physical activities such as climbing onto a top bunk that they would not normally encounter if they were living independently (Williams, et al., 2006). Focusing on a California prison site, researchers determined that the occurrence of functional impairment and comorbid conditions were high. Female inmates aged 55 years and older required assistance with activities of daily living (ADL) at twice the rate of women age 65 and older in the general population. The high functional impairment of these inmates is associated with a lower health status than older women who are not incarcerated (Williams, et al., 2006).

Some states are addressing the unique physical needs of the aging inmate population. Pennsylvania State Correctional Institution at Laurel Highlands is equipped for wheelchair users, and only houses older inmates and those who need assisted-living or long-term care. In another program in Pennsylvania, inmates are trained to assist older inmates as caregivers in the use of assistive devices such as wheelchairs (Williams, et al., 2006). Medical students in Florida have the opportunity to be trained in geriatrics so they may care for aging inmates (Mitka, 2004). It is believed by officials that housing those inmates who have age-related health challenges in a single location enables institutional staff members to provide better health care and save money. These facilities also experience fewer disciplinary incidents because the older inmates are prevented from being victimized by younger inmates (Abner, 2006).

Housing Modifications

Creating adequate housing for the aging inmate population also was recommended by roundtable participants in 2011 (Williams, et al., 2012). Specifically, many institutions were built with the younger offender in mind. Today, older inmates find challenges navigating stairs as well as long distances to the cafeteria and other parts of facilities. These challenges can cause older inmates to withdraw, heightening the social isolation many of them already experience due to reduced contact with those living outside of the correctional institutions (Aday, 1994; Hoffman & Dickinson, 2011), and fear of victimization by younger inmates (Snyder, et al., 2009).

A nationwide survey focusing on institutional policies, services, and housing for the aging prison population found that most correctional institutions make housing and work assignments based on individual health, security level, and geographic location of family members (Aday, 1994). Older inmates who have several health

problems were found to be given special treatment based on their health status. In Washington, inmates with age-related ailments may be transferred to the state penitentiary, which has cells designated for inmates with such conditions. Inmates requiring long-term inpatient care also may be sent to the state reformatory, which has a large inpatient unit (Aday, 1994).

In 1970, South Carolina prison officials began providing special facilities for older inmates (Aday, 1994). South Carolina is known for its long prison sentences, resulting in a large number of “long-termers.” Due to the need for increased housing for the older prison population, inmates were moved to State Park, a former tuberculosis hospital, in 1983. Currently, twenty-four-hour medical coverage is available here, and a doctor and 13 nurses are assigned to this facility. The medical staff provide educational programs specific to the institution population’s needs. Inmates needing chemotherapy and dialysis are transported daily to a nearby hospital (Aday, 1994).

Socio-environmental Concerns

Older inmates are vulnerable to victimization by younger, stronger inmates (United States Department of Justice, 2016). Many older inmates choose to limit their participation in activities and exercise to avoid interacting with those they fear (Krabill & Aday, 2007). This fear can cause a decline in the physical activities of older inmates and increase social isolation (Snyder, et al., 2009). Due to the Americans with Disabilities Act’s (ADA) requirement to prohibit discrimination against inmates with disabilities, correctional facilities are increasingly housing older inmates separately from younger inmates, demonstrating increasing awareness of the older inmates’ unique needs (Snyder, et al., 2009).

In addition to the stress that older inmates experience within the walls of the correctional facility, their relationships with friends and family members on the outside often become strained (Travis & Waul, 2003). Obstacles to maintaining social connections with family members include lack of financial resources, long-distance traveling to the institution for visitation, inconvenient visiting hours, and the social stigma of having an incarcerated family member (Snyder, et al., 2009).

These combined fears of victimization by younger inmates and lack of social support often lead to a decline in psychological health, which then contribute to declines in physical and social engagement (Krabill & Aday, 2007). With the recognition that many programs for inmates are

designed for the young offender, Snyder et al. (2009) highlighted the need for recreational, educational, and rehabilitation programs designed specifically for older inmates, such as music, board games, shuffleboard, horseshoes, and movies. These programs allow for the slower pace and differing physical abilities among older inmates when compared to their younger peers. Program topics that focus on chronic illness, isolation, depression, and end-of-life issues also are important for this population (Snyder, et al., 2009).

The Hocking Correctional Facility in Ohio has implemented programs designed for older male inmates (Snyder, et al., 2009). The services and programs offered at this medium-custody housing unit include chair aerobics, a jogger/walker fitness program, adult basic education, job training, and GED classes. Inmates also may receive assistance with applying for Social Security benefits, Medicaid, and Medicare, as well as writing their wills (Snyder, et al., 2009).

Palliative Care Needs

The aging inmate population has increased the need for palliative medicine and care that focuses on controlling symptoms and providing comfort for individuals with serious illnesses (Williams, et al., 2012). Enhancing prison palliative care programs also was one of the resulting recommendations from the roundtable discussions in 2011 (Williams, et al., 2012). Terminally ill patients may encounter social abandonment when friends and acquaintances stop visiting them due in part to their uncertainty as to how to support inmates when dying. This abandonment is even greater within the prison population, as their social support has limited visiting opportunities. Hospice care attempts to fill the gap of decreased social support to these inmates (Hoffman & Dickinson, 2011). The hospice programs in prisons are very similar to the hospice programs found in communities. In community hospice programs, a patient agrees to forego further curative treatments, must have a prognosis of not more than six months to live, and must sign a do-not-resuscitate order. Prison hospice programs generally require patients to agree to waive treatments as a prerequisite for admission to the program. Just over half of the prison hospice programs also require the inmate to not have more than six months to live. However, 31 percent of prison hospice programs allow for up to 12 months to live to qualify (Hoffman & Dickinson, 2011). As of 2011, 75 state and federal prisons (approximately four percent of all state and

federal U.S. prisons) offered formal hospice services (Hoffman & Dickinson, 2011).

Inmate hospice caregivers are trained to work long hours, providing comfort and companionship during the inmate patient's final hours. As companions, caregivers often read to patients, feed them, and write letters to families. Many also bathe and dress patients, and some provide spiritual support if their spiritual views are consistent with patients' views (Hoffman & Dickinson, 2011). These inmate hospice services provide emotional comfort and support during an inmate's final days.

Training for Staff

As the prison population changes, institutions are finding it necessary to provide age-related training for their employees. One such training program, "Issues in Aging for Correctional Workers," is a six-hour program developed at Northern Michigan University (Cianciolo & Zupan, 2004). This training is provided to correctional employees in several institutions in the region and includes units on perceptions of aging; normal and abnormal aging; prevalent chronic conditions related to aging; laws impacting the treatment of older adults in prison; and resources addressing health and social service needs for the older inmates (Cianciolo & Zupan, 2004). Correctional employees reported leaving the training better equipped to recognize age-related obstacles within the institution and were more able to manage resources necessary for the older population's unique needs.

Using Cianciolo and Zupan's (2004) training approach, the Nebraska Department of Correctional Services participated in a two-day training program led by the Department of Gerontology at the University of Nebraska Omaha and the Division of Geriatrics and Gerontology at the University of Nebraska Medical Center. This training was designed to educate corrections staff on the unique challenges and opportunities in the aging inmate population. The training provided an introduction to the cognitive, physical, and social aspects of aging, as well as an overview of Social Security, Medicare, and Medicaid, to the different levels of corrections staff in Nebraska (Masters, Magnuson, Bayer, Potter, & Falkowski, 2016). The 69 corrections participants left the training with a greater understanding of how the inmate population has changed, and will continue to change, in the coming decades. This training was filmed and DVDs were made available to correctional facilities in the Midwest (Masters, et al., 2016). In general, institutional managers have recognized the value of

ongoing training for their employees, and similar training is now found in prisons throughout the United States.

Conclusion

As the aging inmate population increases in the United States, correctional facilities are finding it necessary to make changes to both the physical buildings in which the inmates are housed and programs in which the inmates are involved, so that the unique needs of this population are appropriately met. Designed for a younger population, institutions that serve older inmates tend to increase their vulnerabilities rather than mitigate them. The older inmates are often harassed and injured by younger inmates, so separating these two populations better protects the older individuals. Lack of mental health services has contributed to increased vulnerabilities to inmates with depressive symptoms. Additionally, physical decline often makes it challenging for older inmates to navigate their living environments, and their diminished vision and hearing result in falls and isolation. Well-aware of the changing needs across the United States, correctional facilities are making structural changes to better accommodate the aging inmate.

Correctional facilities are successfully developing and providing training to their staff so they are better equipped to meet the needs of this population. As the aging inmate population is expected to continually grow, policies, trainings, and health care services within prisons will need to be continually evaluated and updated to continue to meet the needs of this population. Applying geriatric multimorbidity care models, which focus on prioritizing chronic medical conditions affecting quality of life, is well-suited for older incarcerated inmates. When applied to institutional settings, long-term care costs may be lowered, overall well-being may be improved, and rate of recidivism may decrease (Williams, et al., 2012). Further research on programs, trainings, and structural changes in correctional facilities in other countries would be beneficial.

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