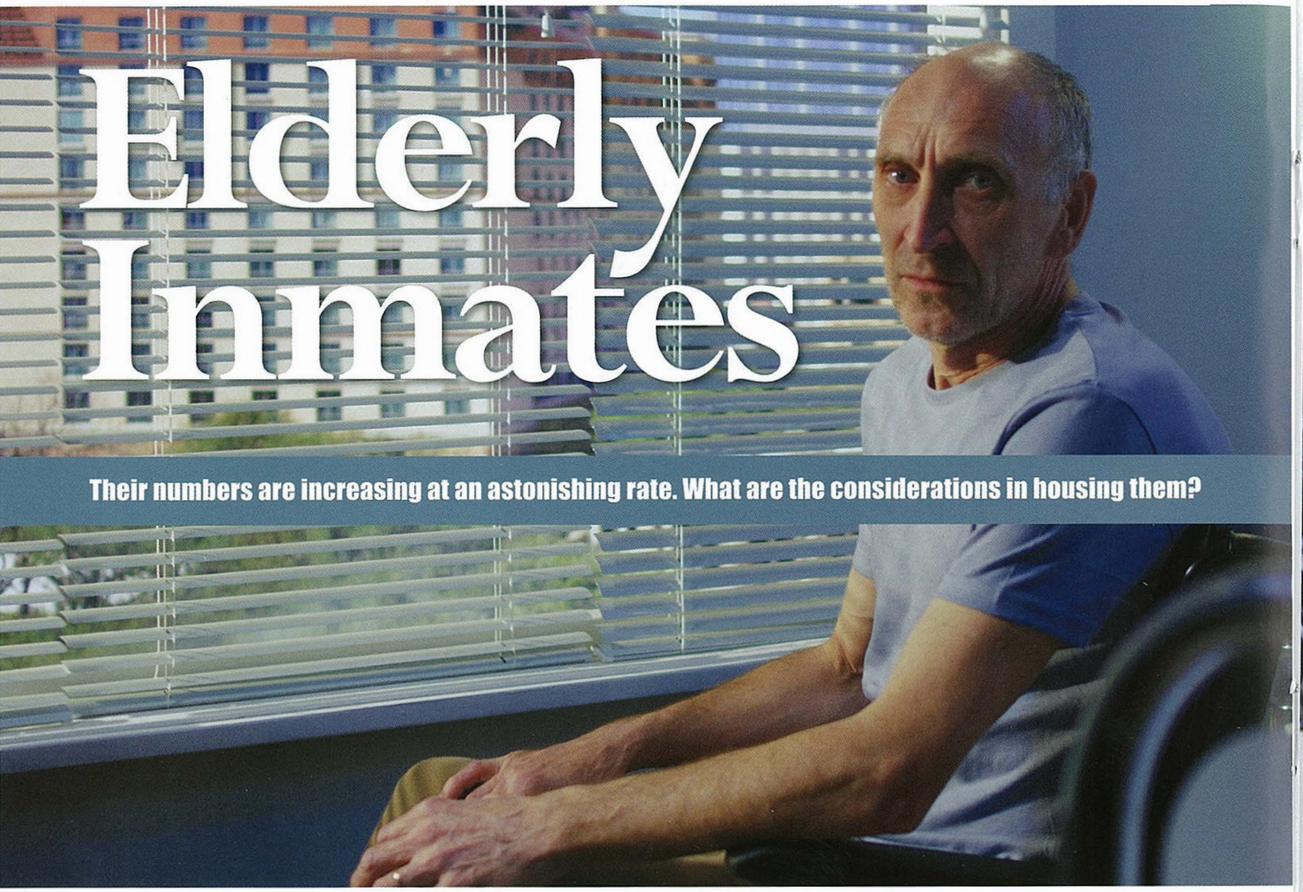
BY MICHAEL GROHS, CONTRIBUTING EDITOR

Elderly Inmates



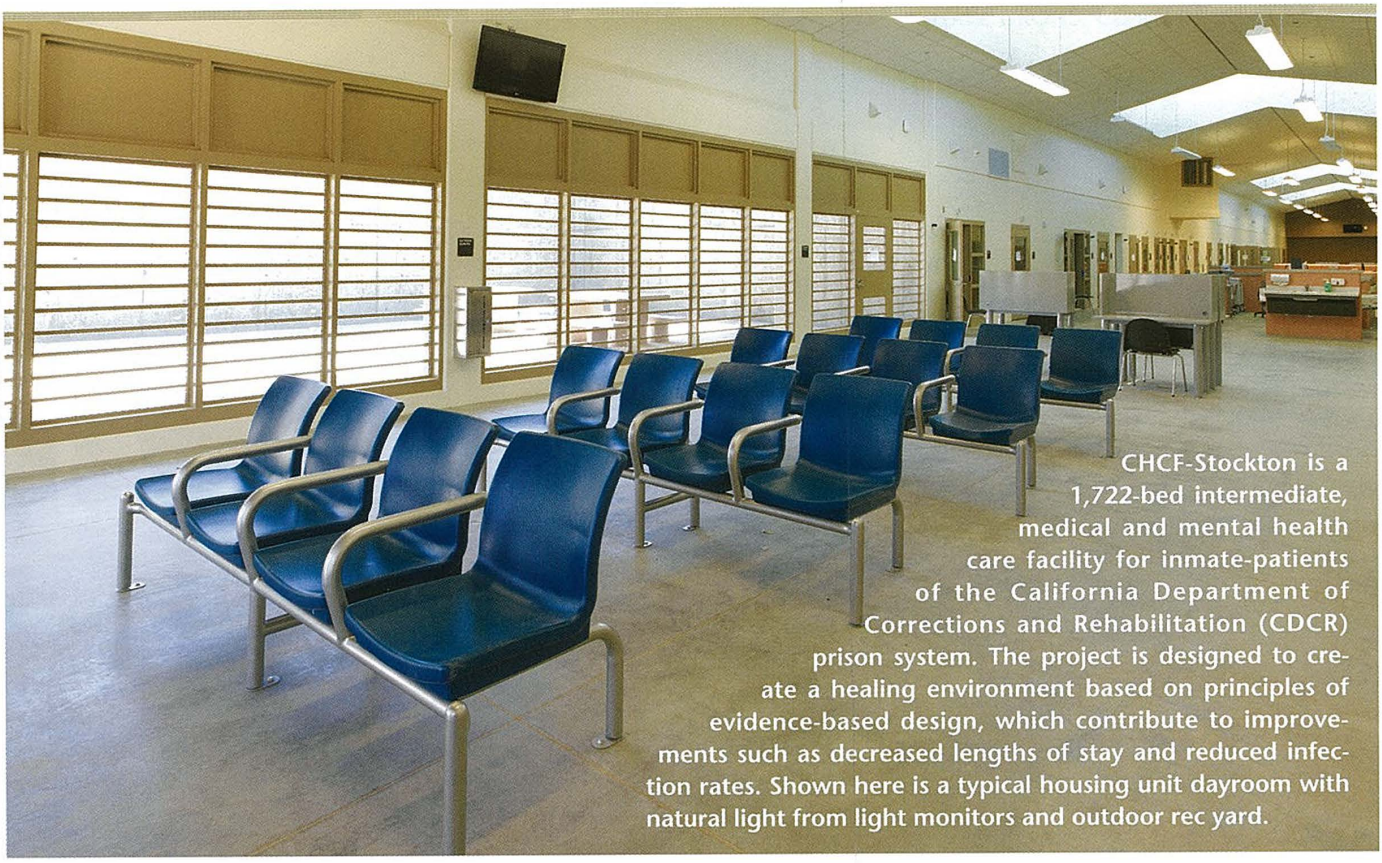
Their numbers are increasing at an astonishing rate. What are the considerations in housing them?

AS Dr. John May, Centurion's Chief Medical Officer, points out, "The simple fact is that many correctional facilities were built for young males and without consideration for ADA accommodations or long-term care placement and care for these individuals." It is estimated, furthers architect Dave Redemske at HDR, Inc., an Omaha-based firm that specializes in engineering, architecture, environmental and construction services, that by 2030, a mere decade away, the elderly inmate population in the U.S. is anticipated to be 400,000. (In 2016 there were 164,400 elderly prisoners in state and federal prisons, according to a PEW study.) On top of that, when it comes to inmates, being *elderly* is globally considered to begin at 55 because of lifestyle and the fact that inmates "age faster."

Chronic Issues

Dr. Tom Lehman, Corporate Medical Director at Wexford Health, notes that the aging inmate population includes a higher percentage of patients with comorbid ailments including heart disease, stroke, cancer, COPD, dementia, and renal failure. As a result, these inmates require more clinic visits, prescription drugs, physical and occupational therapy, lab work, x-rays, MRIs, and CT scans. May furthers that older people are also typically on more medications, develop more complications, require more specialty and inpatient services, and are more prone to injury, falls, and abuse. While many of the health care providers can provide geriatric care, the math has changed. "The resources necessary for the care of 2,000 healthy young men is a fraction of the resources needed to provide care to 2,000 elderly inmates with multiple chronic disease conditions and increased risk of dementia and mobility issues."

Among the biggest concerns, says Redemske, is housing. There are two primary classifications for the elderly population. *Mainstreaming* is keeping the elderly inmates with the younger



CHCF-Stockton is a 1,722-bed intermediate, medical and mental health care facility for inmate-patients of the California Department of Corrections and Rehabilitation (CDCR) prison system. The project is designed to create a healing environment based on principles of evidence-based design, which contribute to improvements such as decreased lengths of stay and reduced infection rates. Shown here is a typical housing unit dayroom with natural light from light monitors and outdoor rec yard.

ones. *Congregating* is putting the older inmates together. The thought was that with congregating, there was a better order of magnitude, but older inmates sometimes felt segregated. When mainstreaming, older inmates might have a calming effect on younger ones, but the older inmates also might be victimized.

Some issues are corrections specific, such as accessing the top bunk and getting to the dining hall. In correctional facilities, chronic conditions happen at a higher rate and are often co-occurring. Treating such conditions is a costly endeavor, especially if the inmate is not treated on site. Usually, says Redemske, states that do not have a large elderly inmate population contract with local services, which requires two correctional officers to accompany inmate patients to appointments. Furthermore, he says, during his yearlong study of inmate medical care, he learned that such additional costs were not tracked very well and overtime costs were lumped into transportation, so recordkeeping was difficult to determine.

May points out that there is an expectation that correctional facility health care providers will provide care onsite as much as possible. Few states have established programs to utilize community nursing homes or have a designated facility for skilled nursing care. "It is difficult to find community nursing homes and dementia units to accept incarcerated patients as Medicaid beds are already limited to begin with for community patients, and there is a stigma that exists of mingling offenders with community patients. Thus, these inmates simply are managed as best as the facility can muster resources."

Cost Concerns

Naturally, cost is a primary concern. Says Lehman, "To prevent the need of sending frail, elderly inmate patients out for their care, many facilities are looking to pay to bring mobile service companies onsite. Others still are paying to build appropriate, dedicated areas in their health care units or facilities to provide specialty chronic clinics and lab work, etc."

As May points out, the lion's share of correctional health care dollars are spent on the last months of an inmate's life. Correctional systems' health care budgets have been slashed over the past decade, yet patients' needs continue to increase as they age in the system. Young, healthy offenders are able to enter programs and get out on good time and other incentives, but the mentally ill and elderly tend to remain in the system and are alienated or separated from family. "They simply cannot survive in the community with the hurdles of housing, securing a job, and/or food insecurity, let alone following the rules of accessing health care in the community, such as arranging transportation and setting up appointments all over the map with specialists on one side of the state and their mental health provider at the other end. It has been our experience that patients have

sought refuge and security by remaining in the correction system rather than trying to fend for themselves in the outside world even if they have Medicaid in place."

Mental Health/Dementia

Mental health is a primary concern with elderly inmates. For one, says May, social isolation becomes increasingly problematic for aging prisoners who are not able to participate in regular activities. They can withdraw, develop depression, and become less agile. Says Lehman, as the population of inmates increases in age, so does the prevalence of dementia. This is difficult to manage in a jail or prison. "Fortunately all of our facilities have mental health professionals to work with this population along with medical providers to provide a holistic approach for the care of this population. Yes, it is better to house geriatric inmates in a specialized unit or facility. Dispersing a correctional agency's elderly population across multiple sites can result in duplication of services (and associated increased costs) and decrease in the quality of care provided. By centralizing the location, Wexford Health can implement rigorous and ongoing education for all staff involved. Clinical and operation training (including sensitivity training) for staff members that interact with a geriatric population on a daily basis is a vital part of ensuring that these inmates receive respectful supervision."

May refers to dementia as the elephant in the room. "Classification and medical systems are often not doing enough screening, nor do they have enough resources to develop objective data to support supplemental budget requests while fighting legislatures that do not support the priority. While it is onerous to screen individuals and these individuals tend to be difficult to manage for both security and medical, changing 'business as usual' becomes necessary. These folks tend to get infractions and decompensate in restricted housing, yet still they pose a risk of self-injury or to others. A tendency to isolate can be increasingly problematic for demented persons and likely increases their deterioration against their needs."

Paul Nagashima, AIA, LEED AP, associate vice president, design principal also at HDR, notes other considerations that have been coming down the line, especially in California. As a result of Assembly Bill 109 and Law 1170, jails are now taking in those with longer sentences. One inmate is in for 42 years, which means he will serve a minimum of 21 years in a facility not intended for long-term stays.

Nagashima notes that with older inmates, it is not just a consideration of such details as stairs but also smaller things. Stakeholders don't talk enough about acoustics. Therapy is based on conversations, and inmates need to hear the clinician but don't want everyone else hearing. There are also bigger considerations. If an inmate is in the yard, and they are ordered to hit the deck, it could be bad. Getting up could be worse.

Recruiting and retaining staff is becoming more difficult. COs have even complained about new recruits' poor social skills due to phones. Nagashima agrees that mental health is a huge issue, as is comorbidity. Furthermore, treatment is much more complex when it comes to such things as dialysis. "Having a process and a facility is a serious challenge." He furthers that there is now a whole other classification of inmate that requires much more from the staff. If staff is not trained in mental health problems, they might think the inmate is just being non-compliant and throw him or her in solitary "which is the last thing they need."

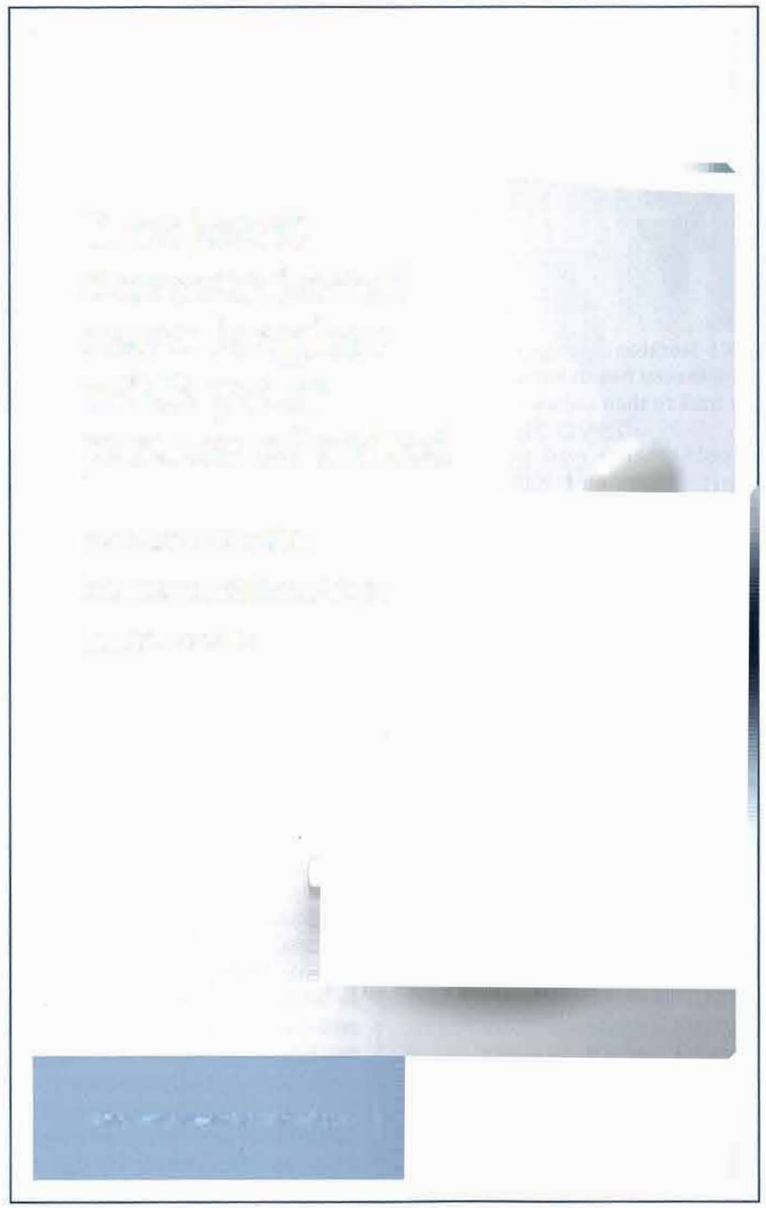
Prisons may have been designed for young men, but time stops for no one. Retrofitting facilities, says May, is often expensive or limited due to space constraints, though some facilities have been able to dedicate living areas to elderly persons, eliminate bunk beds, brighten the environment with new lighting and images, improve access to programs, introduce crafts, and provide more opportunities for direct supervision.

"On the other hand, when the opportunity for new construction is available, modern designs can be transformational and therapeutic. While still adhering to all security concerns, innovative designs allow more open space, recreation areas, natural light, outdoor spaces, accommodations for disability and fragility, social interaction, and activities. Simple features such as electrical outlets near beds for equipment such as CPAP machines, call buttons in rooms, or flat surfaces without stairs can improve the safety and functionality of spaces for elderly persons," May adds. That is precisely what HDR has done for the California Department of Corrections and Rehabilitation (CDCR).

Elder Care Design

HDR worked closely with CDCR when the department was under a court order to deliver a constitutional level of medical care. Among the primary steps, says Nagashima, was taking an interdisciplinary team approach and considering the patient part of the team. A problem, he says, is patients need to take more responsibility. Inmates are generally told to do everything when incarcerated. "This didn't help when they got to the community."

The California Health Care Facility-Stockton is designed to be like a village. There is a Medical Street, a Low and High Acuity Mental Health Street, and a Main Street. Inmates can go to



CHCF-Stockton is designed to consolidate facilities for long-term medical inmate-patients, as well as acute and intermediate mental health inmate-patients in one central location. Medical Street, where inmates can go to appointments and get back to their units on their own, features shade canopy, mister cooling system and wayfinding graphics.

appointments and get back to their units. A study was employed so inmates could navigate not only the campus but the medical system as well. (Surprisingly, 40% were found to be color blind.) The study also found a significant amount of illiterate inmates and those who did not speak English. In such cases, inmate patients can navigate by relying on shapes and numbers.

The village, says Nagashima, was designed so as to not look like facilities in "The Shawshank Redemption" in which characters Brooks, and to a lesser extent, Red, had become institutionalized. The village has plenty of natural light, a rec space, counseling, and negative pressure rooms. Nagashima points out that psychotropic drugs can make it difficult to deal with the heat. The village has mist sprayers and water fountains available. Everything was designed by "really thinking ahead." There are suicide-proof grab bars by the sink and nurse call buttons. It is tricky, he says. Facilities need to be robust to withstand abuse, but there is a move to soften such things. More attention is being given to light and furniture than ever before. "Interior designers are very important. Color choice is based on evidence-based information."

Facilities like the one in Stockton represent a reason Wexford Health recommends specialized housing for the geriatric inmate population. Centralized housing is more easily modified to accommodate inmates with mobility issues such as widening doorways, showers and bathrooms to easily accommodate wheelchairs; installing sufficient and appropriate lighting; and utilizing low-level bunks/beds and other fall preventive modifications. Things can change quickly. Says Nagashima, once HDR had built a unit, and a section had to change from being medical to mental care before it even opened. The switch was not a problem.

So what should be done? Lehman advocates for increased education and training of health care personnel in prisons and jails regarding geriatric care; training on the specialized needs of elderly inmate patients for security personnel/corrections officers; a coordinated, collaborative review of the health care; and operational infrastructure for jails and prisons. May further recommends that criteria should be developed and utilized across correctional systems to allow for alternative sentencing so that offenders can remain in the community while only serious violent offenders are held behind the walls.

One thing seems certain. As Redemske points out, "There is no 'do nothing' solution." ✪