

# ANNUAL REPORT OF THE CMA INCARCERATING ELDERLY AND AGING INMATES: MEDICAL AND MENTAL HEALTH IMPLICATIONS

## **I. Introduction**

The 2000 Florida Legislature required the Department of Corrections (department) to establish and operate a “geriatric” facility for elderly inmates at the River Junction Correctional Institution (RIJCI) in Chattahoochee. The Legislature also required the Correctional Medical Authority (authority) and the Florida Corrections Commission to each submit an annual report on the status and treatment of elderly inmates in the state-administered and privately operated institutions, as well as such information on RIJCI. The reviews are to include an examination of promising geriatric policies, practices, and programs currently implemented in other correctional systems within the United States. The reports, with specific findings and recommendations are to be submitted to the Legislature on or before December 31 of each year (Senate Bill 2390).<sup>1</sup>

This report will focus primarily on the medical and mental health issues relevant to the management of elderly and aging inmates. The report will summarize recent, comprehensive studies of elderly inmates presented to the Governor and Legislature by the Florida Corrections Commission in January 2000,<sup>2</sup> and the Florida House of Representatives Criminal Justice & Corrections Council Committee on Corrections, in December 1999.<sup>3</sup> The department’s responses to both reports will be outlined. Data obtained from the department will be presented on the medical and mental health status of elderly inmates and on costs for a variety of community-based medical services provided to inmates. As of June 30, 2000, profiles will be provided of the ten most recently incarcerated first-time offenders age 60 or older; the ten oldest repeat offenders with the most incarcerations; the ten longest serving inmates; and the ten oldest inmates. Also, the authority’s survey findings related to age will be outlined for Fiscal Years (FY) 1998-2000. A proposal to inform policy choices in the management of Florida’s elderly and aging inmates will be presented in the conclusion to the report.

The executive summary provides an outline of the report’s findings and recommendations.

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<sup>1</sup> Section 944.8041, 2000 Florida Statutes. Senate Bill 2390 was signed into law on June 5, 2000.

<sup>2</sup> Florida Corrections Commission 1999 Annual Report.

<sup>3</sup> *An Examination of Elder Inmates Services: An Aging Crisis*, Florida House of Representatives Criminal Justice & Corrections Council Committee on Corrections.

## **II. Executive Summary**

The growth in the aging population in Florida is reflected in the growth of the aging population behind bars. Given Florida's demographics, and national and state laws mandating longer prison sentences, the physical health, psychological health, and social needs of elderly and aging inmates will result in increasingly important management and budget decisions for the Legislature and prison administrators.

It is likely that Florida will require a range of policy and program options to manage the inmate population as it ages, including segregated services for the aged and infirm and programs that support elderly inmates more suited to living in the general prison population. Accordingly, these options should be explored for the best delivery alternatives, including private contracts, the use of volunteers, and collaboration with community health care programs and universities.

However, sound policy and programmatic decisions cannot be made without reliable information. In this regard, there are two areas of significant concern. First, the department does not have the capacity to collect average cost data by age for key components of its operation including health services. Furthermore, key health care utilization and cost data is not currently collected regarding health services provided within the department. The department does collect data on the costs incurred when inmates are transferred to community facilities for treatment; however, the Offender Based Information System which stores this information is not capable of timely or consistently reliable data retrieval. Secondly, most existing research on older prisoners is based on small and non-random, potentially unrepresentative samples and does not examine the relationships between age, ethnicity, gender, and race. Sound research is needed as a basis for managing the aging inmate population in Florida. This information is key to proactive decision-making, including budgetary decisions.

The following recommendations are intended to address these two areas of concern.

### **III. Recommendations \***

- 1. Implement a data collection, retrieval and analysis system that will ensure reliable age-based data regarding health care utilization and costs.**
- 2. Conduct a methodologically sound research study on the health-related concerns of aging and elderly Florida inmates. Present recommendations to the Legislature for current and future management of this population.**

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❖ The authority is prepared to support the department's requests for resources to implement such a system.  
❖ The authority is prepared to assist in the design, implementation, and analysis of a study on the health-related concerns of aging and elderly inmates in Florida.

## **IV. Background**

### **a. Florida Corrections Commission 1999 Annual Report**

On January 1, 2000, the Florida Corrections Commission published its 1999 Annual Report. The report included an extensive literature review on elderly inmates with accompanying findings based on data provided by the department. The following findings from the Commission's report remain key to decisions regarding the management of Florida's elderly inmate population. (Refer to pages 1-40 of the Florida Corrections Commission 1999 Annual Report).

- “Prisons are experiencing an increase in the number of older inmates. Because of its large elderly population, Florida is especially susceptible to this trend.”
- “The cost of incarcerating a geriatric prisoner is three times that of a younger inmate.”
- “Because of the impact of lifestyle, medical care, and environmental factors in the aging process, correctional agencies should adopt age 50 as the chronological starting point for defining elderly offenders.”
- “Three basic groups of older inmates have been identified: first-time offenders, career or habitual criminals, and inmates who have grown old in prison.”
- “Inmates over age 55 suffer from, on average, three chronic health problems that often require highly specialized and expensive medical care.”
- “Fifteen to 25 percent of elderly offenders have some form of mental illness.”
- “The main question for prison administrators concerning elderly inmates is whether to mainstream or segregate this population.”
- “Policies and procedures that encourage older inmates to improve their lifestyle and maximize their level of functioning will reduce institutional management concerns and the cost of care.”
- “Elderly inmates have the lowest recidivism rates.”
- “Not all terminally ill inmates are suitable for release. A formal prison hospice program can focus on managing pain, emphasize humane care, and cost less than traditional treatments.”
- “Correctional staff's lack of training in recognizing the medical and mental health conditions of elderly inmates often exacerbates problems.”
- “Failing to collect data on the elderly offender population could cause future difficulties for administrators and planners.”

- “The National Institute of Corrections has issued recommendations regarding elderly inmates in the areas of assessment; accessibility and adaptation; special units; medical care; staff training; and community involvement.” (Note: these recommendations encourage preventive health maintenance measures and encourage independent functioning of elderly inmates).
- “The 5,082 offenders age 50 years or older in Florida’s prisons represent a 54.9% increase since 1995.” (Note: as of June 30, 2000, there were 5,605 offenders aged 50 years or older and a total offender population of 71,233).
- “By June 2010, it is estimated that (Florida’s) elderly inmates will account for 8.2% of the projected inmate population.”
- “74% of elderly offenders in Florida are incarcerated for violent offenses.”
- “62.8% of elderly inmates (in Florida) are assigned either an unrestricted or minimum medical grade, making them eligible for most work and program assignments.”
- “No correctional institution in Florida is designated as a “geriatric” or “elder inmate” facility.” (Note: according to data provided by the department, as of August 1, 2000, RIJCI work camp served an offender population with an age range of 40 to 67 years. Seventy-seven percent of the population was over the age of 50; however, the majority of the inmates were age 52 or younger).
- “The Florida Department of Elder Affairs has developed a course for certified officers, “Elder Abuse, Neglect, and Exploitation,” to train them in the issues concerning the elderly.”

### **Summary of Florida Corrections Commission Recommendations**

The Florida Corrections Commission recommended the department adopt the age of 50 as the chronological starting point in the definition of the elderly inmate. This definition was adopted by the 2000 Florida Legislature in Senate Bill 2390.

The Commission recommended the department develop an integrated set of policies and programs for elderly inmates, and that a study be conducted to determine current and projected long-term needs. Also recommended was the increased use of citizen volunteers in programs for elderly inmates, and training to increase staff awareness of the needs of elderly inmates.

The Commission recommended funding be sought to support research and programming; data be collected on medical costs by age; and the growth and associated needs of the elderly inmate population be incorporated into the department’s comprehensive correctional master plan.

The Commission recommended that the department designate a sufficient number of current facilities as “elder inmate institutions” with suitable security, appropriately trained staff, and adequate resources. Finally, the department was encouraged to devote an entire facility to health care for all seriously ill or infirm inmates with special units reserved for the elderly.

**b. House Corrections Committee December 1999 Report**

The findings and recommendations of the House Corrections Committee report were based on the literature review completed by the Florida Corrections Commission; a survey questionnaire administered to ten state corrections departments; site visits to specific Florida prisons; and data provided by the department. The Committee findings, noted below, also remain key to discussions regarding the management of elderly inmates. (Refer to *An Examination of Elder Inmates Services, An Aging Crisis*, Florida House of Representatives Criminal Justice & Corrections Council Committee on Corrections, December 1999).

- “Kidney failure, advanced heart disease, lung cancer from increased smoking, other cancers, as well as complicated diseases are more prevalent among the elderly than among the younger inmates.”
- “Older first offenders are more likely to be sentenced for violent offenses against a person, usually involving a family member, or for sexual offenses committed during a middle age crisis or later.” (Note: in its response to the House Committee report, the department stated that first time offenders in Florida often had previous commitments in other states; no data were provided. The department also noted that it did not have data to indicate whether the elderly inmates who committed violent offenses did so against family members. The department stated an interest in working with other agencies and the community to prevent elders from committing crimes).
- “Elderly offenders who have committed crimes in their later years have a hard time adjusting to incarcerated life.”
- “Assessment of older inmates at intake and during their stay in prison is an important factor for meeting the needs of the offender and system planning.”
- “Conditions and status can change rapidly with older inmates.”
- “There is a problem with adequately defining an “elderly inmate.”<sup>4</sup>

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<sup>4</sup> The following quote is from a recently published book consisting of 16 studies on elders, crime, and the criminal justice system which provide a current analysis of the literature in this field. “Although a significant number of criminologists have reviewed the problems associated with trying to define a cutoff point beyond which one is considered old in criminological research, no clear consensus has emerged (Fattah & Sacco, 1989; Forsyth & Gramling, 1988; Newman, 1984). Governmental programs often recognize age 65 as the cutoff because retirement and social security benefits are tied to this age, but many criminologists and criminal justice systems usually consider “55 and over” as old (Newman, 1984). Still other criminologists (Morton, 1992) advocate for even lower cutoffs (age 50 and older)...extant research varies in age-related cutoffs used to define populations under examination...” Kerbs, John J., “The Older Prisoner: Social, Psychological, and Medical Considerations” in Max B. Rothman, Burton D. Dunlop, and Pamela Entzel, (Eds.), *Elders, crime, and the*

- “Elderly inmates are especially prone to feelings of depression.”
- “There are some arguments against segregation of elderly inmates.” (The Committee report notes that mainstreaming encourages equal access to programs and visiting privileges; makes federal requirements for mainstreaming the elderly and disabled easier to meet; and may have a stabilizing effect on younger inmates. Not all inmates identify with their age groups).
- “Steps, crowding, limited climate control, regulation of light, and architectural barriers to those with physical disabilities are additional problems older inmates encounter in prison.” (The Committee report notes that the arguments for establishing special units are also powerful. Special units may provide a concentration of specialized staff and resources; geriatric health problems can be identified, monitored, and treated as they develop; money is saved by providing care which prevents high-cost illnesses and by reducing the need for correctional officers; and close custody beds may be freed for younger, more violent inmates).
- “Younger inmates may prey upon elderly inmates.”
- “Older inmates have a greater need for privacy, safety, structure, and emotional feedback than younger inmates.”
- “Wherever they are housed, special considerations should be given to safe accommodation of the handicapped and less physically able, including the elderly.”
- “Older inmates who have some sense of control over their daily lives adjust better.”
- “Prison staff may discourage elderly inmates from participating in programs because they view such programs as designed for younger inmates.”
- “In most prisons, counseling is geared to rehabilitating younger inmates rather than coping with issues such as chronic illness or death.”
- “Many inmates have outlived or alienated their families, or they are too sick to work.”
- “Because older inmates are less likely to commit more crimes, the recidivism rate will decline.”

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*criminal justice system: myth, perceptions, and reality in the 21<sup>st</sup> century* (Springer Publishing Company, Inc., New York, NY, 2000) page 208, citing: Fattah, E. A., & Sacco, V.F. (1989). *Crime and victimization of the elderly*. (New York: Springer-Verlag). Forsyth, C.J., & Gramling, R (1988). Elderly Crime: Fact and artifact. In B.R. McCarthy & R.H. Langworthy, (Eds.), *Older offenders: Perspectives in criminology and criminal justice* (p. 13). (New York: Praeger). Newman, D.J., (1984). Elderly offenders and American crime patterns. In E.S. Newman, D.J. Newman, & M.L. Gewirtz (Eds.), *Elderly criminals* (pp. 3-16). (Boston: Oelgeschlager, Gunn and Hain, Publishers, Inc.). Morton, J.B. (1992). *Administrative overview of the older inmate*. Washington, DC: National Institute of Corrections.

- “In general, the cost of hospice care is less than that of traditional treatment.” (Note: eleven states and the federal prison system have hospice programs).
- “The ADA (American With Disabilities Act) affects how correctional facilities deliver their programs and services to inmates with disabilities.”
- “A lack of adequately trained prison staff is a barrier in responding fully to the special needs of the aging inmate.”
- “Florida and South Carolina are the only two states which have programs for older women.” (Note: the department operated a “special unit” for older females at Florida Correctional Institution, prior to the institution’s conversion to a youthful offender facility. No such program is in operation at this time. The department’s *Operational Plan for Female Offenders* has several goals addressing health and wellness services for elderly females; these are discussed in the section of the report detailing the department’s response to the Florida Corrections Commission and House Corrections Committee reports).

### **Summary of House Corrections Committee Recommendations**

Like the Florida Corrections Commission, the House Corrections Committee also recommended the department adopt the age of 50 as the chronological age at which to initially define elderly inmates, and that health care cost data be collected by age.

The Committee recommended simple and inexpensive preventive health measures be piloted such as walking programs; that elder inmates be regularly assessed to prevent their illnesses from becoming unnecessarily acute and costly; and that current programs and activities aimed at the elderly population be evaluated for effectiveness.

The Committee recommended institutions housing elderly and impaired inmates be assessed for conditions and structures that are dangerous and inhibit mobility, and appropriate training be provided to correctional officers working with this population.

The Committee recommended an assessment be conducted of the security risks posed by the general elderly offender population, and that savings in security costs may be realized as a result of segregation of this population. The Committee further recommended the department develop a pilot program segregating minimum-security elderly inmates.

The Committee recommended that the Legislature expand statutory authority for alternatives to incarceration for elderly inmates who no longer pose a risk to society due to declines in physical functioning and specific medical conditions. Finally, the Committee recommended community based programs be developed which would intervene before elders commit violent crimes against family.

### **c. Florida Department of Corrections Response**

Key components of the department's May 2000 response to the Florida Corrections Commission report and April 2000 response to the House Corrections Committee report are outlined below.

#### **Definition of an elderly inmate**

The department suggested an appropriate age for "older inmates" was 59 and above. This assumption was based on the department's review of chronic health conditions experienced by inmates aged 58 or younger and 59 and older. The department's conclusion was inmates who are 59 and older are experiencing more health problems and functional limitations than younger inmates.

#### **Costs of housing, programs, and medical care – data deficiencies**

The cost of providing housing, programs, and medical care to elderly inmates has been estimated at three times that of younger inmates in studies carried out in other states.<sup>5</sup> The department questioned the validity of this estimate for Florida's elderly inmates.

#### ***Authority Comments***

Notably, the department does not have the capacity to collect average inmate cost data by age for health services, or for the operations and education components of housing inmates. The department does not collect certain key health care utilization and cost data for services provided within its institutions. For example, in its April 2000 response to the House Corrections Committee, the department acknowledged key data couldn't currently be determined. These include the frequency of reasons for sick call visits; the number of inmates diagnosed with specific conditions; the frequency and costs of various health care procedures provided statewide; changes in health conditions of new inmates; health care costs for individual inmates; the number of sick call visits that result in specialty referrals, surgery, or community treatment; treatment outcomes; or the relationship of cost and medical classification.

While the costs of community care provided to inmates is collected, the department's Offender Based Information System (OBIS) was designed primarily to store information and is not capable of complex data retrieval functions or data analysis functions. Furthermore, the data retrieved from OBIS is based on active cases at the time a data query is submitted; relevant cases that are no longer active, but occurred during the period of inquiry may not be identified and counted.<sup>6</sup> (Note: despite the limitations of OBIS, data provided by the department on the cost of community delivered health care suggest the significantly higher cost of housing elderly inmates; see Medical Service Utilization & Cost Data for Community Care Episodes, in section VI c. below).

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<sup>5</sup> See the Florida Corrections Commission 1999 Annual Report (pp. 1-2) for a discussion of relevant literature.

<sup>6</sup> The limits of OBIS were discussed in a telephone call between Murdina Campbell, CMA Analyst and Larry Purintun, OHS on October 19, 2000.

The Office of Health Services (OHS) has stated that an electronic medical record system would alleviate problems with the reliability of health care data collection and retrieval and support informed health care decisions. In 1996, the Office of Program Policy Analysis and Government Accountability (OPPAGA) recommended the department research the costs of developing an electronic medical record system.<sup>7</sup> Such a system has not been implemented to date.

### **Mainstreaming versus segregation**

The department reported that historically, elderly inmates have been mainstreamed throughout the system in major institutions, work camps, work release centers, and private prisons. The department reports two exceptions to this practice; one, elderly death row inmates, and the other, elderly inmates housed in reception center medical units for specialized medical care under the health care consolidation plan. With regard to dedicating an entire facility to seriously ill, impaired, and elderly inmates, the Central Florida Reception Center (for HIV/AIDS patients) and the North Florida Reception Center medical unit represent the extent to which the concept of special units is currently considered practical by the department.

The department considers many of its existing general population practices and programs appropriate for elderly inmates, with an emphasis on preventive health measures. In particular, the following programs are considered appropriate: GED, literacy and special education programs offered the general population; vocational programs such as cabinetmaking, environmental services, and horticulture; wellness education; wellness facilities and betterment programs that are age-specific; and substance abuse programs. The department stated policy decisions concerning inmates are not based on one single factor such as age. The classification system considers multiple factors in determining risk, need, and custody issues. The department also stated an inmate's chronological age is considered when associated with a medical condition that may preclude certain institutional assignments. The department further stated many inmates are non-compliant in assisting with their health care.

With regard to the concept of establishing a pilot program that segregates minimum-security elderly inmates, the department identified 341 eligible male inmates as of December 30, 1999. Inmates were excluded from consideration if they were close custody status inmates, murderers, sex offenders, or otherwise violent offenders. Medically impaired inmates were also excluded from consideration; as were inmates who demonstrated less than satisfactory institutional adjustment and/or received a disciplinary report for one or more of the major violations in the 12 months prior to the review. Subsequent legislation required the establishment of the RIJCI as a "geriatric facility." (Note: the department presented data on escapes and attempted escapes among the over 50 population. Since 1980 there have been 227 escapes or attempts among inmates over 50 years).

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<sup>7</sup> OPPAGA Report No. 96-22, *Review of Inmate Health Services Within the Department of Corrections*, November 27, 1996, page 7, strategy No.3: "Improve Data for Effective Health Care Cost Containment."

The department describes the creation of special provisions for elderly inmates regarding the conditional medical release program as inappropriate. The Older Americans Act and the ADA are seen by the department as providing sufficient protection for the elderly and disabled. The department considers creating specific conditions based on age as contradictory to these laws.

### **On-going assessment of elderly inmates**

The department indicated that its policies allow for regular and unscheduled assessment of each inmate throughout his/her incarceration. The inmate's medical condition and age impact institutional assignments, work assignments, housing assignments, and bed assignments within housing areas. Scheduled reviews occur for inmates within end-of-sentence and for those with life and death sentences. Close management, work release, and transition plan assessments are regularly scheduled. Reports document program changes, Parole Commission reviews, and transfers to other institutions. Other programs requiring review of the inmate include the conditional medical release program, and impaired inmates special needs reviews and institutional committees.

### ***Authority Comments***

In its response to the Florida Corrections Commission and the House reports, the department did not indicate that any additional programs or procedures for the evaluation of elderly inmates were needed.

### **ADA requirements**

In 1993, the department surveyed its facilities to determine if the programs, services, and activities were accessible to disabled inmates as required by the ADA. Institutions housing significant numbers of elderly and impaired inmates were given priority for removal of identified structural and programmatic barriers. With regard to physical barriers, in its response to the Florida Corrections Commission and House reports, the department indicated that renovations and repairs continue to be made within the scope of appropriations.

### ***Authority Comments***

The department's ADA Coordinator indicated that institutions and facilities housing aged and disabled inmates are currently being re-surveyed for structural barriers.<sup>8</sup>

### **Staff training**

The department agreed there is a need for staff training regarding the management of elderly inmates, including health care staff, and correctional and probation officers. The department stated a significant cost would be attached to this issue. Correspondence from the department indicated that the Criminal Justice Standards & Training Commission approved the Florida Department of Elder Affairs curriculum *Elder Abuse, Neglect and Exploitation*, on August

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<sup>8</sup> October 30, 2000, telephone conversation between Murdina Campbell, CMA Analyst and Martie Taylor, ADA Coordinator, Florida Department of Corrections

17, 2000.<sup>9</sup> However, the curriculum was approved as a 40-hour, salary incentive, advanced course and not as part of basic training for correctional and correctional probation officers.

### ***Authority Comments***

The department plans to offer basic training to correctional officers in 2001 and 2002 regarding working with elderly inmates.<sup>10</sup>

### **Elderly female inmates**

Objective 6.4 of the department's Operational Plan for Female Offenders emphasized the recruitment of volunteers to facilitate monthly support groups and other activities addressing the needs of female inmates over 50 years of age.

In August 31, 2000, correspondence to the authority regarding progress on objective 6.4, the department stated: "As of August 18, 2000, there were 158 female offenders over 50 years of age housed in Department facilities, with 39 of them within one year of release. These offenders are housed in ten separate locations including major institutions, work release centers and a forestry camp. Thirty-nine offenders represent approximately one-tenth of one percent of all female offenders. A targeted population consisting of extremely small numbers in various locations complicates programming efforts and, at this time, does not warrant extensive programming developed specifically for elder females. Elderly female offenders polled at Dade Correctional Institution desired not to live in a segregated dorm. It may be more constructive to continue mainstreaming elderly female offenders until their numbers are large enough to designate a separate facility."<sup>11</sup>

The department further indicated supportive functions for elderly female inmates are currently being carried out through the chaplaincy, wellness, vocational training, hobby craft, betterment, transition and other programs. Additionally, the department indicated needs assessments of elderly female inmates had been conducted for planning purposes, and funding sources were being sought for programs for elderly female inmates.

### **Planning for elderly inmates**

The Florida Corrections Commission 1999 Annual Report recommended the department conduct a study in partnership with a state university to identify the current and projected long-term care needs of the older inmate population. The department concurred this may be necessary to determine the most appropriate management of this population. The department also indicated that a study would be necessary to determine whether elderly inmates function better in age-segregated housing environments. Additionally, the department indicated that

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<sup>9</sup> Letter from Richard Nimer, Director of Program Services, Florida Department of Corrections to Murdina Campbell, CMA Analyst, dated August 31, 2000.

<sup>10</sup> October 30, 2000, telephone conversation between Murdina Campbell, CMA Analyst and David Delifus, Bureau of Staff Development, Florida Department of Corrections.

<sup>11</sup> Letter from Richard Nimer, Director of Program Services, Florida Department of Corrections to Murdina Campbell, CMA Analyst, dated August 31, 2000.

its Office of Program Services is creating a comprehensive Operational Plan for Elderly Offenders.<sup>12</sup> The Operational Plan for Elderly Offenders will require budget and staff resources.

***Authority Comments***

The Operational Plan for Elderly Inmates is currently in draft form. The proposed objectives address the needs of inmates throughout the system and at River Junction Correctional Institution Work Camp. Objectives concern program development aimed at reintegration into society; vocational skill development; staff training; holistic approach to the management of physiological, psychological and substance abuse needs; and inmate safety.

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<sup>12</sup> According to October 30, 2000, telephone conversation between Murdina Campbell, CMA Analyst and Ginny Grimsley, Office of Program Services, Florida Department of Corrections, the Operational Plan for Elderly Offenders in draft form. The expected approval and implementation date of the plan has not been finalized.

## **V. Elderly and Aging Inmate Profile**

The data presented in this section of the report are from the department's Bureau of Research and Data Analysis.<sup>13</sup>

### **a. Inmates 50 years and older by age-group, race, and gender**

On June 30, 2000, Florida's correctional institutions housed 5,605 inmates aged 50 years and older. These inmates represented 7.8% of the total prison population of 71,233, compared to June 30, 1980, when the 50 and over population was 4.5% of the total. This 7.8% represents approximately a 55% increase in the over 50 inmate population since 1995.

In FY 1979-80, 230 inmates 50 years and older were admitted to the department. In FY 1999-00, 1,130 such inmates were admitted. The projected admissions for FY 2004-05 are 1,589 inmates 50 and older.

Of the 5,605 inmates 50 years and older identified on June 30, 2000, 58.8% were white, 38.8% black, and 2.4% "other." The majority, or 75.7% fell into the 50-59 age group (of these, 55.8% were white, 41.8% black, and 2.4% "other"). The 60-69 age group comprised 19.7% of those 50 years and over (of these, 66.6% were white, 30.7% black, and 2.7% "other"). Inmates over the age of 70 represented 4.6% of the 50 plus population (of these, 74.1% were white, 23.2% black, and 2.7% "other"). Notably, the percentage of black inmates in each of the age groups decreased with age.

Finally, as of June 30, 2000, 96.3% of the 50 and over population was male and 3.7% female (the percentages of male and female inmates remained relatively constant within the 50-59, 60-69, and 70 plus age groups).

### **b. Average age of Florida inmates**

On June 30, 1980, the average age of Florida inmates was 28.9 years. On June 30, 2000, the average age of Florida inmates was 34.4 years.

### **c. Most common primary offenses**

The five most common primary offenses committed by inmates 50 years and older on June 30, 2000, were capital murder followed by capital sexual battery, second degree murder, drugs (manufacture, sale, or purchase), and lewd and lascivious behavior. Of those inmates 50 years and older at admission to the department for the first time, the most common primary offenses were sexual/lewd behavior, drug offenses, murder/manslaughter, and other violent offenses.

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<sup>13</sup> These data were provided by Dr. William Bales and Chrissy Gest of the Bureau of Research and Data Analysis, Florida Department of Corrections. These data were provided to the authority in July and August 2000.

**d. Length of sentence**

As of June 30, 2000, approximately 30% of inmates 50 and older were serving life sentences. Of those serving life sentences, 20% were serving life without parole. The majority of those admitted at 50 or older were serving sentences of six years or greater.

The number of inmates 50 and older sentenced under the 85% law (requiring inmates to serve 85% of their sentences) is increasing. On June 30, 1998 there were 914 such inmates. On June 30, 2000, there were 1,961 such inmates. The department projects there will be 2,981 such inmates as of June 30, 2002.

**e. Custody levels**

As of June 30, 2000, the majority of inmates 50 years and older were held at either close or medium custody levels. Notably, the percentages were approximately the same for the 50-59, 60-69, and 70 plus groups.

**f. Literacy levels**

As of June 30, 2000, approximately 40 % of the 50 and older inmate population, for whom data were available, demonstrated basic literacy skills (grades 4.0 – 8.9). Approximately 38% of the 50 and older population had functional literacy skills (grades 9.0 – 12.9). Approximately 22% of the 50 and older population had less than basic literacy skills (grades 1.0 – 3.9).

**g. Housing location**

As noted above, inmates aged 50 years and older are housed throughout the system in major institutions, work release facilities, work camps, and private prisons.

## VI. Health Status of Florida's Elderly and Aging Inmates

### a. Medical Status of the Elderly Florida Inmate

As of June 30, 2000, 32% of the inmate population over the age of 50 (for whom data was available) was classified as medical level 3 and 4. These inmates require services to manage chronic, sometimes multiple illnesses (level 3), and some have progressed to the level of significant functional impairment (level 4). With regard to the 60 and over population, 52% were classified as medical level 3 and 4. Of the 70 and over population, 72% were medical level 3 and 4. Notably, 25% of inmates in the 50-59 age group were medical level 3 and 4. (Note: medical level 1 & 2 inmates require a less complex level of services available at their permanent institutions).<sup>14</sup>

#### Medical Level by Age as of June 30, 2000

<i>Medical Level</i>	<b>14 &amp; younger</b>	<b>15-29</b>	<b>30-49</b>	<b>50-59</b>	<b>60-69</b>	<b>70+</b>	<b>Un-known age</b>	<b>TOTAL</b>
<b>1</b>	4	20,923	26,048	1,530	217	19	1	<b>48,742</b>
<b>2</b>	0	3,535	9,232	1,571	350	52	1	<b>14,741</b>
<b>3</b>	0	692	3,476	967	451	136	0	<b>5,722</b>
<b>4</b>	0	42	306	115	73	50	0	<b>586</b>
<b>Missing data</b>	0	512	856	60	12	2	0	<b>1,442</b>
<b>TOTAL</b>	<b>4</b>	<b>25,704</b>	<b>39,918</b>	<b>4,243</b>	<b>1,103</b>	<b>259</b>	<b>2</b>	<b>71,233</b>

\* Source: Florida Department of Corrections, Bureau of Research & Data Analysis

### b. Psychological Status of the Elderly Florida Inmate

As of June 30, 2000, 9.4% of inmates over the age of 50 (for whom data were available) were classified as psychological grade 3 (S3) and above. Ten percent of the 50-59 age group were classified as S3 and above; as were 7.2% of the 60-69 age group; and 7.7% of the population aged 70 and over (chart 2). Psychological grade 1 (S1) inmates are considered normal with regard to mental health functioning; grade 2 (S2) inmates suffer from mild impairment; S3 inmates are moderately impaired; psychological grade 4 and 5 (S4 & S5) inmates are severely impaired and require inpatient care.<sup>15</sup> Psychological grade 3 and above inmates are typically prescribed psychotropic medications

<sup>14</sup> For an explanation of medical grades refer to Technical Instruction, 15.03.13, *Assignment of Health Classification Grades to Inmates*, Florida Department of Corrections, June 2000.

<sup>15</sup> For an explanation of psychological grades refer to Technical Instruction, 15.03.13, *Assignment of Health Classification Grades to Inmates*, Florida Department of Corrections, June 2000. S1-3 inmates are housed in the general population and receive outpatient mental health services. S4 inmates are housed in Transitional Care Units (TCUs); the TCU is an inpatient setting for chronically mentally ill and/or mentally retarded inmates who cannot survive in the general inmate population. S5 inmates are housed in Crisis Stabilization Units (CSUs); the CSU is an inpatient setting for inmates in crisis, e.g., suicide attempt or psychotic break. Inmates requiring psychiatric hospital level services and/or court-ordered involuntary psychotropic medication are

Estimates of the proportion of elderly inmates who suffer from some form of mental illness are generally higher than the Florida data indicate (see the Florida Corrections Commission Report which, based on a review of the literature estimates 15-25% of older inmates have some form of mental health condition). There does not seem to be a consensus in the literature regarding older inmate's psychological needs and characteristics. The majority of studies suggest older inmates are less mentally stable, while some studies document that older inmates psychologically adjust to prison better than their younger counterparts. Overall, it is not clear whether the psychological characteristics of older inmates are due to the effects of prison life or reflect pre-existing conditions.<sup>16</sup>

**Psychological Grade by Age as of June 30, 2000**

<i>Psycho-logical Grade</i>	<b>14 &amp; under</b>	<b>15-29</b>	<b>30-49</b>	<b>50-59</b>	<b>60-69</b>	<b>70+</b>	<b>Un-known age</b>	<b>TOTAL</b>
<b>1</b>	3	21,980	33,277	3,677	994	227	2	<b>60,160</b>
<b>2</b>	1	1,074	1,555	121	23	12	0	<b>2,786</b>
<b>3</b>	0	2,295	4,606	386	70	16	0	<b>7,373</b>
<b>4</b>	0	67	137	23	5	4	0	<b>236</b>
<b>5</b>	0	72	86	14	4	0	0	<b>176</b>
<b>Missing</b>	0	215	257	22	7	0	0	<b>501</b>
<b>Un-graded</b>	0	1	0	0	0	0	0	<b>1</b>
<b>TOTAL</b>	<b>4</b>	<b>25,704</b>	<b>39,918</b>	<b>4,243</b>	<b>1,103</b>	<b>259</b>	<b>2</b>	<b>71,233</b>

\* Source: Florida Department of Corrections, Bureau of Research & Data Analysis

**c. Medical Service Utilization & Cost Data for Community Care Episodes**

The department's OBIS system contains cost data for health care delivered to inmates in community facilities. This includes inpatient hospitalization, emergency care, ambulatory surgery, outside consultations, and ancillary services. The following data was retrieved from OBIS on September 15, 2000. These data do not include the costs of hospitalization, emergency and surgical care provided within the department.

As reported above, those inmates 50 and over represented 7.8% of the total inmate population on June 30, 2000 yet were responsible for a disproportionate share of medical care delivered to inmates in community facilities. For example, the 50 and over population accounted for 29% of inpatient care costs (charts 1& 2); 13% of emergency room admission

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housed in the Corrections Mental Health Institution (CMHI) at Zephyrhills. These inmates are designated as S5s.

<sup>16</sup> Kerbs, John J., "The Older Prisoner: Social, Psychological, and Medical Considerations" in Max B. Rothman, Burton D. Dunlop, and Pamela Entzel, (Eds.), *Elders, crime, and the criminal justice system: myth, perceptions, and reality in the 21<sup>st</sup> century* (Springer Publishing Company, Inc., New York, NY, 2000) page 214-215.

costs (chart 3); 19% of ambulatory surgery costs (chart 4); 20% of specialty care costs (chart 5); and 30% of the costs for ancillary care (chart 6).

The 50-59 age group accounted for approximately 75% of the 50 and over population; those 60 and over represented approximately 25% of the 50 and over population.

**1. Inpatient Cost Per Case by Age**

<i>AGE</i>	<b>FY 94-95</b>	<b>FY 95-96</b>	<b>FY 96-97</b>
	<b>IPE/IPS*</b>	<b>IPE/IPS*</b>	<b>IPE/IPS*</b>
<b>15-29</b>	\$7,687/\$7,745	\$6,577/\$7,355	\$7,193/46,344
<b>30-49</b>	\$9,244/\$8,565	\$9,815/\$9,009	\$10,402/\$9,153
<b>50-59</b>	\$12,017/\$9,610	\$11,024/\$9,299	\$14,393/\$12,543
<b>60-69</b>	\$14,052/\$12,941	\$13,266/\$8,171	\$11,065/\$8,444
<b>70+</b>	\$7,749/\$11,274	\$11,110/\$5,354	\$8,594/\$15,619
	<b>FY 97-98</b>	<b>FY 98-99</b>	<b>FY 99-00</b>
<b>15-29</b>	\$8,170/\$6,023	\$7,140/\$5,901	\$8,873/\$11,606
<b>30-49</b>	\$8,885/\$7,719	\$8,990/\$8,027	\$10,897/\$9,694
<b>50-59</b>	\$10,731/\$9,732	\$12,951/\$10,097	\$10,676/\$12,846
<b>60-69</b>	\$10,840/\$9,040	\$13,150/\$11,914	\$16,395/\$8,560
<b>70+</b>	\$11,465/\$20,110	\$11,975/\$8,740	\$12,197/\$16,084

**\*Source: Florida Department of Corrections, Office of Health Services**

Inpatient Emergency (**IPE**) refers to an overnight admission of an inmate to a community hospital on an emergency basis. Inpatient Scheduled (**IPS**) refers to a non-emergency or scheduled admission of an inmate to a community hospital.

**2. Community Inpatient Care Episodes FY 1999-2000**

<b>AGE</b>	<b># OF PAID EPISODES</b>	<b>% OF TOTAL EPISODES</b>	<b>AVERAGE COST PER PAID EPISODE</b>	<b>% OF PAID TOTAL</b>	<b>AVERAGE LENGTH OF STAY (DAYS)</b>
<b>15-29</b>	347	19%	\$9,369	16%	3.94
<b>30-49</b>	1,028	55%	\$10,559	54%	4.2
<b>50-59</b>	287	16%	\$11,327	16%	4.46
<b>60-69</b>	148	8%	\$14,017	10%	4.72
<b>70+</b>	44	2%	\$12,815	3%	5.5

**\*Source: Florida Department of Corrections, Office of Health Services**

There were 1,855 inmate inpatient community care episodes in FY 1999-2000, with total paid costs of \$19,994,979. The average total length of stay was 4.26 days. Although less than 8% of the total population, inmates over the age of 50 accounted for 29% of the inpatient costs in community facilities. Those 60 and older accounted for 45% of the total costs of the over 50 population.

### 3. Community Emergency Room Episodes FY 1999-2000

AGE	# OF PAID EPISODES	% OF TOTAL EPISODES	AVERAGE COST PER PAID EPISODE	% OF PAID TOTAL
15-29	883	40%	\$1,016	34%
30-49	1,122	51%	\$1,248	53%
50-59	118	5%	\$1,665	7%
60-69	53	2%	\$1,753	4%
70+	24	1%	\$2,607	2%

**\*Source: Florida Department of Corrections, Office of Health Services**

There were 2,277 total inmate non-department emergency room visits in FY 1999-2000, with total paid costs of \$2,650,045. Although less than 8% of the total population, inmates over the age of 50 accounted for 13% of the total non-department emergency room costs. Those 60 and older accounted for 46% of the total costs for the over 50 population. Note: Some of the emergency room episodes resulted in hospitalization of the patient in the community setting.

### 4. Community Ambulatory Surgery Episodes FY 1999-2000

AGE	# OF PAID EPISODES	% OF TOTAL EPISODES	AVERAGE COST PER PAID EPISODE	% OF PAID TOTAL
15-29	629	20%	\$3,527	22%
30-49	1,890	61%	\$3,207	59%
50-59	372	12%	\$3,049	11%
60-69	177	6%	\$3,272	6%
70+	55	2%	\$3,666	2%

**\*Source: Florida Department of Corrections, Office of Health Services**

There were 3,123 outpatient single-day surgery episodes (no overnight stays) provided inmates in a community setting during FY 1999-2000. The total paid costs were \$10,194,770. Although less than 8% of the total population, inmates over the age of 50 accounted for 19% of the total ambulatory surgery costs in community facilities. Those 60 and older accounted for 42% of the total costs for the over 50 population.

**5. Community Specialty Care Episodes FY 1999-2000**

<b>AGE</b>	<b># OF PAID EPISODES</b>	<b>% OF TOTAL EPISODES</b>	<b>AVERAGE COST PER PAID EPISODE</b>	<b>% OF PAID TOTAL</b>
<b>15-29</b>	7,770	20%	\$77	18%
<b>30-49</b>	23,216	60%	\$90	62%
<b>50-59</b>	4,761	12%	\$87	12%
<b>60-69</b>	2,101	5%	\$89	6%
<b>70+</b>	703	2%	\$100	2%

**\*Source: Florida Department of Corrections, Office of Health Services**

There were 38,552 inmate specialty care (outside consultations) episodes in FY 1999-2000, at a total paid cost of \$3,360,744. Although less than 8% of the total population, inmates over the age of 50 accounted for 20% of outside consultations. Those 60 and older accounted for 40% of the total costs of the over 50 population.

**6. Community Ancillary Care Episodes FY 1999-2000**

<b>AGE</b>	<b># OF PAID EPISODES</b>	<b>% OF TOTAL EPISODES</b>	<b>AVERAGE COST PER PAID EPISODE</b>	<b>% OF PAID TOTAL</b>
<b>15-29</b>	2,923	14%	\$118	9%
<b>30-49</b>	13,332	64%	\$172	60%
<b>50-59</b>	2,722	13%	\$251	18%
<b>60-69</b>	1,626	8%	\$237	10%
<b>70+</b>	271	1%	\$315	2%

**\*Source: Florida Department of Corrections, Office of Health Services**

These services include laboratory, radiology, optometry, physical & respiratory therapy and are provided on-site by external providers under contract to the department. There were 20,877 inmate ancillary care episodes in FY 1999-2000, with a total paid cost of \$3,784,977. Although less than 8% of the total population, inmates over the age of 50 accounted for 30% of ancillary care costs. Those 60 and over accounted for 40% of the total costs of the over 50 population.

**d. Incidence of Depression, Alzheimer/Dementia, and Substance Abuse<sup>17</sup>**  
**Alzheimer, Dementia, Depression & Substance Abuse FY 1999-2000**

<b>AGE GROUP</b>	<b>INMATES DIAGNOSED WITH ALZHEIMER OR DEMENTIA</b>	<b>INMATES DIAGNOSED WITH DEPRESSION</b>	<b>INMATES DIAGNOSED WITH SUBSTANCE ABUSE</b>
	<b>% of total</b>	<b>% of total</b>	<b>% of total</b>
<b>15-29</b>	25%	50%	39%
<b>30-49</b>	25%	47%	56%
<b>50-59</b>	25%	2%	4%
<b>60-69</b>	0	<1%	2%
<b>70+</b>	25%	<1%	<1%
<b>TOTAL</b>	<b>4</b>	<b>1,757</b>	<b>903</b>

**\*Source: Florida Department of Corrections, Office of Health Services**

The low numbers for Alzheimer or Dementia and Substance Abuse may be due to the limitations of OBIS data previously described. The data were retrieved from OBIS on 9/15/00.

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<sup>17</sup> The OHS requested all the diagnostic data from OBIS based on the *International Classification of Diseases, 9<sup>th</sup> revision*, disease identifier codes. The above table reflects the status (current) population on September 15, 2000. Refer to earlier discussion on the limits of OBIS data.

## **VII. Elderly & Aging Inmate Typology**

As described in the Florida Corrections Commission 1999 Annual Report and the House Corrections Committee report on aging, much of the literature on elderly inmates identifies three main groups of inmates.<sup>18</sup> The first group comprises first-time offenders; those sent to prison for the first time when 60 or older. This group may be more likely to commit “crimes of passion.” Offenses committed late in life may reflect biological changes due to the aging process (chronic brain syndrome may be associated with loss of inhibitions leading to inappropriate sexual behavior). The second group comprises career or repeat offenders (prison recidivists), who will most likely become geriatric inmates. These inmates often have substance abuse and other chronic problems that make it hard for them to cope on the outside. The third group comprises those with a long-term history in the system and who are aging in place. These inmates may be the least volatile, have the least family ties, the most limited work history, and may be among the most fearful of leaving prison.

To provide a profile of these groups a purposeful sample was selected for review. This sample was not intended to be truly representative of the elderly and aging inmate population, but was nevertheless expected to provide a “snapshot” of the typical elderly and aging inmate as of June 30, 2000. Thus, the names of 40 inmates were requested from the department as of June 30, 2000. These were the last ten inmates admitted to the department who were first time inmates over the age of 60, the ten inmates over 60 admitted in FY 1999-00, with the most incarcerations in a Florida prison, and the ten longest serving inmates. Also requested were the names of the ten oldest inmates. The following information was requested for each of the 40 cases: age, race, gender, primary offense, medical level, psychological grade, dental grade, classification regarding impairment, institution, custody level, tentative release date, housing assignment, disciplinary history, and number of previous Florida incarcerations. The findings follow by group.

### **a. First-Time Inmates Over the Age of 60**

The ten first-time offenders reviewed were all in the 60-69 age group and were admitted to the department in June 2000. The charts below represent key characteristics of this group of inmates.

None of the inmates had prior Florida incarcerations. A review of their files indicated none had received a disciplinary report as of October 6, 2000. The inmates were housed in ten institutions including major institutions, female institutions with reception center functions and inpatient mental health services, a work release facility, and the River Junction Correctional Institution Work Camp.

Each of the first-time offenders was white and two were female (chart 1). The primary offenses were drug manufacturing and DUI (non-injury) (chart 2). There was one case each

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<sup>18</sup> Florida Corrections Commission 1999 Annual Report (pages 3-4), and *An Examination of Elder Inmates Services: An Aging Crisis*, Florida House of Representatives Criminal Justice & Corrections Council Committee on Corrections (pages 12-13).

of capital murder, 2<sup>nd</sup> degree murder, and lewd and lascivious behavior. The majority of the inmates received sentences less than five years; one received 26 years; and one received a life sentence (chart 3). Two of the inmates were close custody cases and the majority of the inmates were housed in the general population (chart 4). One inmate was assigned to a work release facility and two were in drug treatment programs. Five of the inmates were medical level 3, three were psychological grade 3, and six were dental grade 3 (none were assigned higher grades) (chart 5).

The two females were serving sentences of less than three years for drug related offenses. Both females were minimum custody inmates. One was assigned to general population and the other to a work release program. Both females were medical level and psychological grade 3. One received a dental grade of 3; the other was a dental grade 2.

**1. First-Time Offenders – Race & Gender**

<i>Race &amp; Gender</i>	<b>Male</b>	<b>Female</b>	<b>TOTALS</b>
<b>White</b>	8	2	<b>10</b>
<b>Black</b>			<b>0</b>
<b>Other</b>			<b>0</b>
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>

**2. First-Time Offenders – Primary Offense by Gender**

<i>Primary Offense</i>	<b>Male</b>	<b>Female</b>	<b>TOTALS</b>
<b>Drugs, Manufacturing</b>	2	1	<b>3</b>
<b>Drugs, Trafficking</b>		1	<b>1</b>
<b>Drugs, Possession</b>	1		<b>1</b>
<b>DUI Non-injury</b>	2		<b>2</b>
<b>Capital Murder</b>	1		<b>1</b>
<b>2<sup>nd</sup> Degree Murder</b>	1		<b>1</b>
<b>Lewd/Lascivious</b>	1		<b>1</b>
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>

### 3. First-Time Offenders – Tentative Release Date (TRD) by Gender

<i>TRD</i>	Male	Female	TOTALS
2000-2005	5	2	7
2006-2010	1		1
2011-2020			0
2021-2030	1		1
Life	1		1
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>

### 4. First-Time Offenders – Custody Level & Housing Assignments by Gender<sup>19</sup>

<i>Custody Level &amp; Housing Assignment</i>	Male	Female	TOTALS
<b>Custody Level</b>			
Close	2		2
Medium	5		5
Minimum	1	2	3
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>
<b>Housing</b>			
General Population	5	1	6
Close Management			0
Pre-Work Release		1	1
Confinement	1		1
Drug Treatment	2		2
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>

<sup>19</sup> General population inmates do not have restrictions on their housing location and are free to move around the compound within the rules of the institution. Close management & confinement inmates are secured in single or double cells for management purposes and are escorted out-of-cell for exercise, showers, and medical appointments.

**5. First-Time Offenders – Medical Level, Psychological & Dental Grades by Gender**

<i>Medical Level, Psychological Grade, &amp; Dental Grade</i>	<b>Male</b>	<b>Female</b>	<b>TOTALS</b>
<b>Medical Level</b>			
<b>1</b>	1		<b>1</b>
<b>2</b>	4		<b>4</b>
<b>3</b>	3	2	<b>5</b>
<b>4</b>			<b>0</b>
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>
<b>Psychological Grade</b>			
<b>1</b>	6		<b>6</b>
<b>2</b>	1		<b>1</b>
<b>3</b>	1	2	<b>3</b>
<b>4</b>			<b>0</b>
<b>5</b>			<b>0</b>
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>
<b>Dental Grade</b>			
<b>1</b>			<b>0</b>
<b>2</b>	3	1	<b>4</b>
<b>3</b>	5	1	<b>6</b>
<b>4</b>			<b>0</b>
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>

**b. Repeat Offenders Over the Age of 60**

The repeat offenders reviewed represent the ten inmates, 60 and older, who on June 30, 2000 had the most incarcerations in Florida (between five and 14) and were most recently admitted to the department in FY 1999-00 (chart 1). These ten inmates were all male, seven were black and three were white. Eight of these inmates were in the 60-69 age group; two were over 70 years of age. These repeat offenders were housed in eight major institutions including two reception centers. Four of the ten repeat offenders were close custody, four were medium custody, and two were minimum custody; all were housed in the general population. Drugs, burglary, and other theft charges were the most common primary offenses leading to the current incarceration (chart 1).

Previous crimes included burglary/theft/trafficking in stolen property, forgery, check fraud, drug offenses, witness retaliation (one inmate), possession of a firearm by a felon (one inmate), first degree murder or attempt (one inmate), lewd and lascivious behavior with a child under 16 (one inmate), and aggravated battery (one inmate). Some of these offenses occurred as long ago as 1967.

Two of the ten repeat offenders had received disciplinary reports for rule violations during the current incarceration (one for being in an unauthorized area, and the other for lying to staff). The inmate with the most previous disciplinary reports received 12 reports between 1967 and 1996. Three of the ten repeat offenders had never received a disciplinary report.

Seven of the repeat offenders were medical level 3 or higher and six had a dental grade of 3. Nine of the ten inmates were psychological grade 1 (chart 2).

**1. Repeat Offenders – Primary Offense & Previous Incarcerations by Age**

<i>Primary Offense, (Current) &amp; Number of Prior Incarcerations</i>	<b>60-69</b>	<b>70+</b>	<b>TOTALS</b>
<b>Primary Offense</b>			
<b>Burglary, structure</b>	1	1	<b>2</b>
<b>Other Theft</b>	2		<b>2</b>
<b>Weapons, Possession</b>		1	<b>1</b>
<b>Drugs, Manufacturing</b>	3		<b>3</b>
<b>2<sup>nd</sup> Degree Sexual Battery</b>	1		<b>1</b>
<b>Burglary, Dwelling</b>	1		<b>1</b>
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>
<b># of Priors</b>			
<b>1-5</b>		1	<b>1</b>
<b>6-10</b>	7	1	<b>8</b>
<b>11-15</b>	1		<b>1</b>
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>

**2. Repeat Offenders – Medical Level, Psychological Grade, & Dental Grade by Age**

<i>Medical Level, Psychological Grade, &amp; Dental Grade</i>	<b>60-69</b>	<b>70+</b>	<b>TOTALS</b>
<b>Medical Level</b>			
<b>1</b>			<b>0</b>
<b>2</b>	3		<b>3</b>
<b>3</b>	5	1	<b>6</b>
<b>4</b>		1	<b>1</b>
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>
<b>Psychological Grade</b>			
<b>1</b>	7	2	<b>9</b>
<b>2</b>	1		<b>1</b>
<b>3</b>			<b>0</b>
<b>4</b>			<b>0</b>
<b>5</b>			<b>0</b>
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>
<b>Dental Grade</b>			
<b>1</b>	1		<b>1</b>
<b>2</b>	2	1	<b>3</b>
<b>3</b>	5	1	<b>6</b>
<b>4</b>			<b>0</b>
<b>TOTALS</b>	<b>8</b>	<b>2</b>	<b>10</b>

**c. Longest Serving Inmates**

The ten longest serving inmates were admitted to the department between July 1960 and March 1968. They had served the longest number of consecutive years of any inmates in the system as of June 30, 2000. Each of these inmates has a life sentence. As of June 30, 2000, they were housed in nine institutions including major institutions, a reception center/staging facility, and a work camp.

Four of the ten inmates were white and six were black. All of these inmates were male. Six of the ten were in the 50-59 age group (chart 1). The majority of the offenses committed by this group were violent offenses (chart 2). The majority of the inmates were close custody inmates (chart 3) housed in the general population (chart 4). Four of the ten inmates received disciplinary reports in the past year (charts 5 & 6). Five of the ten inmates were medical level 3; three were psychological grade 3 and above; and six were dental grade 2 and above.

**1. Longest Serving - Race & Gender by Age**

<i>Race &amp; Gender</i>	<b>50-59</b>	<b>60-69</b>	<b>70+</b>	<b>TOTALS</b>
<b>White</b>	2	2		<b>4</b>
<b>Black</b>	4		2	<b>6</b>
<b>Male</b>	6	2	2	<b>10</b>
<b>Female</b>				<b>0</b>

**2. Longest Serving - Primary Offense by Age**

<i>Primary Offense</i>	<b>50-59</b>	<b>60-69</b>	<b>70+</b>	<b>TOTALS</b>
<b>Capital Murder</b>	5	1		<b>6</b>
<b>2<sup>nd</sup> Degree Murder</b>			1	<b>1</b>
<b>Sexual Assault</b>	1	1	1	<b>3</b>
<b>TOTALS</b>	<b>6</b>	<b>2</b>	<b>2</b>	<b>10</b>

**3. Longest Serving - Custody Level by Age**

<i>Custody Level</i>	<b>50-59</b>	<b>60-69</b>	<b>70+</b>	<b>TOTALS</b>
<b>Close</b>	4	2	2	<b>8</b>
<b>Medium</b>	1			<b>1</b>
<b>Minimum</b>	1			<b>1</b>
<b>TOTALS</b>	<b>6</b>	<b>2</b>	<b>2</b>	<b>10</b>

**4. Longest Serving – Housing Assignment by Age<sup>20</sup>**

<i>Housing Assignment</i>	<b>50-59</b>	<b>60-69</b>	<b>70+</b>	<b>TOTALS</b>
<b>General Population</b>	4	2	1	<b>7</b>
<b>Close Management</b>	1			<b>1</b>
<b>Transitional Care Unit</b>	1			<b>1</b>
<b>Medical Staging</b>			1	<b>1</b>
<b>TOTALS</b>	<b>6</b>	<b>2</b>	<b>2</b>	<b>10</b>

**5. Longest Serving – Number of Disciplinary Actions by Age**

<i>Number of Disciplinary Actions Since Admission</i>	<b>50-59</b>	<b>60-69</b>	<b>70+</b>	<b>TOTALS</b>
<b>None</b>			1	<b>1</b>
<b>0-5</b>	1			<b>1</b>
<b>6-10</b>	2	1		<b>3</b>
<b>11-15</b>	2		1	<b>3</b>
<b>16-20</b>				<b>0</b>
<b>21-25</b>				<b>0</b>
<b>26-30</b>	1	1		<b>2</b>
<b>TOTALS</b>	<b>6</b>	<b>2</b>	<b>2</b>	<b>10</b>

<sup>20</sup> Medical staging refers to a limited number of facilities, typically reception centers, which house inmates waiting on complex medical care or referrals. These facilities also house medically complex inmates who cannot be managed effectively at the permanent institution. Elderly inmates with complex medical needs may also be housed at one of these facilities in the hospital setting.

**6. Longest Serving –Year of Last Disciplinary Action by Age<sup>21</sup>**

<b>Year of Last Disciplinary Action</b>	<b>50-59</b>	<b>60-69</b>	<b>70+</b>	<b>TOTALS</b>
<b>None</b>			1	<b>1</b>
<b>1965-1975</b>		1	1	<b>2</b>
<b>1976-1985</b>				<b>0</b>
<b>1986-1995</b>	1			<b>1</b>
<b>1996</b>				<b>0</b>
<b>1997</b>	1			<b>1</b>
<b>1998</b>	1			<b>1</b>
<b>1999</b>	1	1		<b>2</b>
<b>2000</b>	2			<b>2</b>
<b>TOTALS</b>	<b>6</b>	<b>2</b>	<b>2</b>	<b>10</b>

**7. Longest Serving – Medical Level, Psychological, & Dental Grades by Age**

<i>Medical Level, Psychological Grade, &amp; Dental Grade</i>	<b>50-59</b>	<b>60-69</b>	<b>70+</b>	<b>TOTALS</b>
<b>Medical Level</b>				
<b>1</b>	3			<b>3</b>
<b>2</b>	1	1		<b>2</b>
<b>3</b>	2	1	2	<b>5</b>
<b>4</b>				<b>0</b>
<b>TOTALS</b>	<b>6</b>	<b>2</b>	<b>2</b>	<b>10</b>
<b>Psychological Grade</b>				
<b>1</b>	4	2		<b>6</b>
<b>2</b>			1	<b>1</b>
<b>3</b>	1			<b>1</b>
<b>4</b>	1		1	<b>2</b>
<b>5</b>				<b>0</b>
<b>TOTALS</b>	<b>6</b>	<b>2</b>	<b>2</b>	<b>10</b>
<b>Dental Grade</b>				
<b>1</b>	3		1	<b>4</b>
<b>2</b>	2	2	1	<b>5</b>
<b>3</b>	1			<b>1</b>
<b>4</b>				<b>0</b>
<b>TOTALS</b>	<b>6</b>	<b>2</b>	<b>2</b>	<b>10</b>

<sup>21</sup> Four of the ten longest serving inmates received disciplinary reports in the last year. These were for defacing state property, possession of contraband, unarmed assault, and possession of stolen property.

#### **d. The Ten Oldest Inmates**

One final group was selected for review: the ten oldest inmates as of June 30, 2000. These inmates ranged in age from 82 to 88. Two of the ten were black and eight were white; all were male. Only one of the ten had a prior Florida incarceration.

Four of the ten committed their first offense when over the age of 80; three when over the age of 70; two when over the age of 60; and one when over the age of 50. The average sentence of this group was 16 years, with two life sentences. Five of the ten inmates entered the system within the last five years. Six of the ten inmates were close custody and four were medium custody. The inmates were housed in seven major institutions including a reception center. Five of the ten inmates were housemen, two were in medical staging, one worked with PRIDE (license tag plant), one was an infirmary orderly, and one was assigned to the inside grounds.

The primary offenses committed by this group included capital murder (2), 2<sup>nd</sup> degree murder (2), capital sexual assault (2), first degree sexual assault (1), lewd & lascivious behavior (2), and robbery with a firearm (1). Five of the inmates' crimes involved sex offenses; one involved sexual battery of a mentally retarded person; two involved child victims under the age of 12; and three involved child victims under the age of 16. The age and types of crimes of this group lend some support to the theory that biological changes due to the aging process may be associated with loss of inhibitions leading to inappropriate sexual behavior. This is an area that requires much study.

Two of the ten inmates had received disciplinary reports; one inmate received three; refusing a substance abuse test, disobeying an order, and fighting. The other inmate received a disciplinary report for disobeying a regulation. These reports were issued within the last two years.

Seven of the inmates were medical level 3 and above. The majority of the ten inmates were psychological grade 1; there was one psychological grade 3 inmate. There were four dental grade 3, three dental grade 2, and three dental grade 1 inmates. Four of the ten inmates had some form of physical/medical impairment.

#### **e. Program and/or Work Participation**

Of the 40 inmates profiled above, 19 (47.5%) worked as housemen, three (7.5%) maintained the inside grounds, two (5%) were in drug treatment programs, and two (5%) worked with PRIDE (mattresses & gloves, and license tag plant). Three (7.5%) inmates were housed in medical staging facilities, two (5%) were unassigned, one was in transit, one was assigned to a TCU, and one was in a pre-release work transition program. One close management inmate was assigned to a restricted labor squad and one inmate was in confinement. The remaining four inmates were assigned to the following jobs/programs: library clerk, infirmary orderly, academic student, and food service laborer.

## **VIII. CMA Survey Findings Related to Elderly and Aging Inmates**

During FY 1998-99 and FY 1999-00, the authority surveyed the physical and mental health care at 41 major institutions. Three of the 41 institutions were privately run facilities. In four, the department contracted with private providers to deliver health care services. Age is routinely collected on every case surveyed by the authority. Accordingly, survey findings for the past two years are summarized by age (50 and older, and age 49 and younger). However, the survey samples were selected by type of service (chronic illness, episodic care, use of psychiatric restraints, etc.) and not by age group. Therefore, the samples of inmates aged 50 and older for each type of service ranged from one case (use of psychiatric restraints and substance abuse) to 92 (hypertension clinic). Only those service types with a significant sample are presented below (the sample size for those 50 and older equals “N”). The data are presented by race and gender as a percentage of each sample population, and by a summary of the survey findings for that population. The age range for the over 50 population is also presented for each sample population. While these data are subject to the limits described above, the findings indicate areas for further study.

The survey findings for the two populations differed in certain areas. Black inmates were disproportionately represented in the hypertension, diabetes, immunity (HIV/AIDS), and TB chronic illness clinics in the 49 and younger population. Black inmates in the 50 and older population were disproportionately represented in the immunity clinic. Older women were also represented at a significantly higher rate in the immunity clinic than in any other area, and than younger women in any area (this may have been due in part to the small sample size, but is nevertheless an area for further study). The older population was more likely to have blood sugars controlled within range, but was less likely to be offered an HIV test in the TB clinic. The older males were more likely to receive a hemocult exam along with the rectal exam. With regard to sick call visits, the acuity level for the 50 and older population was described as “serious” at three times the rate of the younger population. The top two reasons for infirmary admissions in the younger population were asthma and HIV/AIDS complications. The older population was most often admitted for respiratory and circulatory complaints.

There was not sufficient data to meaningfully compare private and departmental provision of health care.

a. Chronic Illness Clinics

1. Chronic Illness Clinics, Inmates 50 Years & Older - 1998-2000

<i>Clinic, Race, &amp; Gender</i>	<b>Black</b>	<b>White</b>	<b>Male</b>	<b>Female</b>	<b>Survey Findings</b>
<b>Hypertension</b> N=92 Age range 50-82	57%	43%	93%	7%	Ninety-nine percent prescribed medications; 89% compliant.
<b>Diabetes</b> N=64 Age range 50-82	50%	50%	91%	9%	Eighty percent not insulin dependent. Ninety-four percent prescribed oral medications; 85% compliant with medications. Eighty percent had blood sugars controlled within range.
<b>Immunity HIV</b> N=10 Age range 52-62	80%	20%	70%	30%	All prescribed antiretrovirals, and all rated appropriate by surveyors
<b>Respiratory</b> N=38 Age range 50-100	24%	76%	89%	11%	Six percent non-compliant with medications
<b>TB</b> N=21 Age range 50-66	29%	71%	100%		PPD performed in 99% cases; Thirty-three percent NOT offered HIV test. Eighty-nine percent started treatment; of those, 99% monitored monthly for medications.
<b>Seizure</b> N=10 Age range 51-56	50%	50%	90%	10%	Eighty-six percent reported to have seizures controlled by medications.

## 2. Chronic Illness Clinics, Inmates 49 Years & Younger - 1998-2000

<i>Clinic, Race, &amp; Gender</i>	<b>Black</b>	<b>White</b>	<b>Male</b>	<b>Female</b>	<b>Survey Findings</b>
<b>HTN</b>	75%	25%	89%	11%	Ninety-eight percent prescribed medications; no data on compliance.
<b>Diabetes</b>	63%	37%	84%	16%	Seventy-eight percent not insulin dependent. Seventy-eight percent prescribed oral medications; 93% compliant with medications. Sixty-five percent had blood sugar controlled within range.
<b>Immunity HIV</b>	72%	28%	84%	16%	Eighty-eight percent prescribed antiretrovirals and all rated appropriate by surveyors.
<b>Respiratory</b>	54%	46%	89%	11%	Three percent non-compliant with medications.
<b>TB</b>	62%	38%	88%	12%	PPD performed in 93% of sample. Thirteen percent NOT offered an HIV test. Ninety-five percent started treatment; of those, 99% monitored monthly for medications.
<b>Seizure</b>	44%	56%	84%	16%	Eighty-three percent had seizures controlled by medications. Ninety-one percent prescribed medications; of those, 27% non-compliant.

**b. Episodic Care**

**1. Emergency, Infirmary & Sick Call, Inmates 50 Years & Older - 1998-2000**

<i>Service</i>	<b>Black</b>	<b>White</b>	<b>Male</b>	<b>Female</b>	<b>Survey Findings</b>
<b>Emergency</b> N=28 Age range 50-73	32%	68%	93%	7%	Majority of complaints were injuries, shortness of breath/respiratory
<b>Sick Call</b> N=25 Age range 50-68	28%	72%	92%	8%	Acuity level reported as “serious” in 16% of sick call visits.
<b>Infirmary</b> N=39 Age range 50-79	33%	67%	92%	8%	Majority of complaints in descending order: respiratory; circulatory; and nervous system/brain.
<b>Male, Periodic Exam</b> N=44 Age range 50-95	25%	75%	100%		Twenty-six percent did NOT receive a rectal exam; while of those who did receive a rectal exam, 44% did NOT receive a hemoccult exam.

**2. Emergency, Infirmary & Sick Call, Inmates 49 Years & Younger –1998-2000**

<i>Service</i>	<b>Black</b>	<b>White</b>	<b>Male</b>	<b>Female</b>	<b>Survey Findings</b>
<b>Emergency</b>	51%	49%	87%	13%	Majority of complaints were asthma, injury/laceration, burns, seizures, and falls. Five percent of the cases indicated inadequate care.
<b>Sick Call</b>	47%	53%	90%	10%	Complaints in descending order: injury, back pain, abdominal pain, chest pain, hernia, respiratory, and Hepatitis. Acuity level was reported as “serious” 5% of the time.
<b>Infirmary</b>	56%	44%	90%	10%	Majority of complaints: asthma, HIV/AIDS complications, abdominal pain, and cellulitis.
<b>Male, Periodic Exam</b>					Forty-five percent did NOT receive a rectal exam; of those who did receive a rectal exam, NONE received a hemocult exam.

**c. Dental Care**

**1. Dental, Inmates 50 & Older – 1998-2000**

<i>Race &amp; Gender</i>	<b>Black</b>	<b>White</b>	<b>Male</b>	<b>Female</b>	<b>Survey Findings</b>
<b>Dental</b> <b>N=64</b> <b>Age range</b> <b>50-100</b>	50%	50%	94%	6%	Ninety-one percent requested treatment; 84% prescribed preventive treatment. Fourteen percent referred for outside consultation. Forty percent received prescriptions. Ninety-six percent oral health improved. Twenty-five percent received urgent care. Fifty-eight percent received an annual dental exam.

**2. Dental, Inmates 49 & Younger – 1998-2000**

<i>Race &amp; Gender</i>	<b>Black</b>	<b>White</b>	<b>Male</b>	<b>Female</b>	<b>Survey Findings</b>
<b>Dental</b>	53%	47%	88%	12%	Ninety-two percent requested treatment.

**d. Mental Health**

**1. Mental Health Outpatient (S1-3), Inmates 50 & Older – 1998-2000**

<i>Race &amp; Gender</i>	<b>Black</b>	<b>White</b>	<b>Male</b>	<b>Female</b>	<b>Survey Findings</b>
<b>Outpatient Services</b> N=29 Age range 50-80	17%	83%	93%	7%	Most common Axis 1 diagnosis was depression
<b>Sex Offenders</b> N=26 Age range 50-75	38%	62%	100%		Eighty-four percent met DSM-IV criteria for mentally disordered sex offender. Forty-three percent refused treatment; 56% completed treatment.

**2. Mental Health Outpatient, Inmates 49 & Younger– 1998-2000**

<i>Race &amp; Gender</i>	<b>Black</b>	<b>White</b>	<b>Male</b>	<b>Female</b>	<b>Survey Findings</b>
<b>Outpatient Services</b>	47%	53%	88%	12%	Primary diagnoses in descending order: adjustment disorder; depression; bipolar disorder; pedophilia; psychotic disorder; and schizophrenia.
<b>Sex Offenders</b>	43%	57%	96%	4%	Forty percent refused treatment; 25% were in treatment; 35% completed treatment.

**e. Mortality**

<i>Mortality by age, race &amp; gender</i> N=152 Age range 19-91	Black	White	Male	Female	Survey Findings
<b>49 &amp; Younger</b> N=93	55%	45%	79%	21%	Cause of death in descending order: circulatory (36%); HIV/AIDS (18%); digestive (15%); brain and nervous system (9%); respiratory (8%); cancer (6%); stabbing (2%); suicide (2%); & strangulation (2%).
<b>50 &amp; Older</b> N=59	40%	60%	85%	15%	Cause of death in descending order: circulatory (54%); digestive (15%); nervous system/brain (10%); cancer (5%); HIV/AIDS (5%); and respiratory (5%).

The 152 mortality cases selected for review by the authority regarding institutions surveyed in FY 1999-00 do not represent the total inmate deaths in FY 1999-00. The authority attempts to review all deaths of inmates housed at a particular institution since the previous survey of the institution. Therefore, these deaths may have occurred over a period of three years.

In contrast, the OHS mortality review process evaluated 189 deaths occurring in FY 1999-00, excluding executions. Eighty-five (45%) of the 189 deaths reviewed were inmates 50 years and older. The deaths among those 50 and older were due to (in descending order): cancers; cardiac/circulatory; liver disease; respiratory, HIV/AIDS (five cases); and suicide (two cases aged 56 and 62).

## **IX. River Junction Correctional Institution**

The River Junction Correctional Institution Work Camp, established by Senate Bill 2390 opened on June 23, 2000. The Florida Corrections Commission held its August 25, 2000, meeting at the institution. A summary of the information presented follows.

The mission of the institution is to provide work squads for Florida State Hospital, and deliver programs to elderly inmates housed at the facility. (Note: this is not a facility for seriously ill or impaired elderly inmates). As of August 25, 2000, there were 371 minimum or medium custody inmates with no major medical problems housed at the institution. None of the inmates had first degree murder, sex, or violent felony offenses. None of the inmates had serious escape histories, life without parole eligibility, or had been in close management within the last six months. Thirty-eight percent of the inmates had no prior incarcerations.

As noted above, on August 1, 2000, the majority of the inmates were aged 52 or younger with a population age range of 40 to 67 years. The majority of the inmates were from north and west of Alachua County to avoid negatively impacting family contact. The staffing consisted of 77 security positions, four classification positions, six food service positions, three health services positions, and one support position. Services offered included academic and special education, vocational education, wellness, substance abuse, betterment (family development, victim awareness, & stress/anger management), and chaplaincy programs.

The authority has not conducted its initial survey of the medical and mental health services provided to the inmate population. The survey will be scheduled once the institution has been operational for at least a year.

## **X. Other States**

Staff of the Florida Corrections Commission conducted a nation-wide survey of state correctional systems to determine promising policies, practices, and programs regarding the management of elderly inmates. This material is presented in detail in the Commission's 2000 report on aging. A brief summary of the Commission's findings follows.

States responding to the survey are characterized by varying demographics among the inmate populations and varying definitions of an "elderly" inmate; most considered 50 or 55 as elderly, while one state considered 65 as elderly. Many of the states had not defined an elderly inmate. Twelve states indicated that they had facilities devoted to elderly and/or infirm inmates. Twelve states indicated that they had programming for elderly inmates. Comparatively few states reported providing training for staff regarding geriatric inmates, or maintaining age-related data to help with planning purposes.

Depending upon the needs identified by the states, some house aged and medically impaired or disabled inmates together, and others operate hospice facilities, convalescent, or nursing homes. One state operates a licensed Skilled Nursing Facility. Another state has reduced its infirmary costs by developing an assisted living facility for elderly inmates. Some states enter into arrangements with community and educational organizations to provide training opportunities for social work and geriatric social work students in exchange for assisting institutional counselors with their caseloads. These arrangements help states manage increased workloads and costs associated with managing infirm inmates. Other states identify "special needs" inmates who may include the elderly, and develop programs accordingly. Some states contract with private providers who deliver programmatic and support services to elderly inmates. Transition programs for elderly inmates approaching end-of-sentence are emphasized in various states.

## **XI. Conclusions**

### **a. Background**

Population trends in the wider society will continue to impact state prison systems. The growth in the aging population in Florida is reflected in the growth of the aging population behind bars. Furthermore, the demographic trends are compounded by sentencing laws that place inmates in prison for longer mandatory minimum sentences or for life. In these circumstances, the physical health, psychological health, and social needs of inmates raise increasingly important management and budget decisions for prison administrators.

The debate continues regarding the definition of an “elderly” inmate, and what medical, mental health, and programmatic services best meet the needs of elderly inmates in a fiscally responsible manner. Based on the current literature on aging inmates, the information available on how various states manage this population (and its subgroups) and recent comprehensive reports by the Florida Corrections Commission and House Corrections Committee, and the department’s response to these reports, several points are clear.

However we choose to define the elderly inmate (and currently there is no conclusive research in this area), the boundary between younger and older inmates is artificial in the sense that preventive health care measures, and cost efficiency are based on a continuum of care that anticipates future as well as current needs. For example, those younger inmates who will age in prison should be the targets of preventive health measures now, if some of the problems of “aging in place” and associated costs are to be ameliorated. Also, qualifying for programs is not necessarily a strict function of age; infirmities and disabilities requiring special interventions currently impact all age groups. Additionally, the older first-time inmates who enter the system in poor health may require a unique approach.

Rather than debating the merits of mainstreaming versus segregation of elderly inmates, it is more likely that Florida will require a range of policy and program options to manage the inmate population as it will age. And these options should be explored for the best delivery alternatives, including private contracts, the use of volunteers, and collaboration with community health care programs and universities.

These policy and programmatic decisions cannot be made without good information. This leads to two significant points. First, the department does not currently have the capacity to collect average cost data, including operations, health services, and education services by age groups. Nor is certain key health care utilization and cost data collected for services provided within the department. While the cost of care provided to inmates in community facilities is collected, the OBIS is very limited regarding data retrieval and analysis. The Florida Corrections Commission, the House Corrections Committee, and OPAGGA have each addressed aspects of these concerns. As noted above, the department has suggested that an electronic medical record would address the health services data concerns, but would require additional expenditures for hardware, software, and staff training. Reliable cost data by age are needed now in order for Florida to make judicious, cost-effective plans for the aging inmate population.

Second, most existing research on older prisoners is based on small and non-random, potentially unrepresentative samples, and most existing research does not examine the relationships between age, ethnicity, gender, and race.<sup>22</sup>

#### **b. Research Needs**

The need for research has been recognized and recommended by the Florida Corrections Commission and the House Corrections Committee during the past year. The Florida Corrections Commission has recommended that the department, in conjunction with a state university, conduct a study to determine the current and long-term needs of older inmates. The House Corrections Committee has recommended that the department study the security risks posed by the elderly inmate population. The House has also recommended that the department, in conjunction with the Department of Elder Affairs, study elderly first-time inmates in order to assist in the development of community-based programs that would intervene before elders commit violent crimes against family members. The department has indicated that research on the long-term needs of the elderly inmate population would be desirable.

There is a need for methodologically sound research to inform policy choices regarding the management of elderly and aging inmates. Furthermore, due to its mission the authority is in a unique position to survey the health concerns of older inmates, and to work in collaboration with other state agencies to perform this task.

A model that may be adapted for such a study in Florida exists in research reported in a January 2000 article titled *The Health-Related Concerns of Older Prisoners: Implications for Policy*.<sup>23</sup> The authors studied the socio-demographic characteristics, health conditions, and problems in the activities of daily living of two groups of older Texas inmates (one group was selected for purposes of comparison). The authors developed an interview schedule for systematic data collection based on extensive fieldwork and several national data collection systems. The interview instrument was narrowed to seven areas which included socio-demographic characteristics; criminal history; lifestyle and patterns of drug, alcohol, and cigarette use; perceived health status, health condition, and attitudes to a co-payment system; mental health status; institutional living issues; and attitudes to living in the general prisoner population. Health care staff was also interviewed in order to elicit their views of the health issues and health-related problems of older inmates. (Similarly, security staff can be expected to provide useful information when asked to convey their perceptions of future trends in the management of elderly inmates).

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<sup>22</sup> Kerbs, John J., "The Older Prisoner: Social, Psychological, and Medical Considerations" in Max B. Rothman, Burton D. Dunlop, and Pamela Entzel, (Eds.), *Elders, crime, and the criminal justice system: myth, perceptions, and reality in the 21<sup>st</sup> century* (Springer Publishing Company, Inc., New York, NY, 2000) pages 211, 213, 215, 217, 219-20.

<sup>23</sup> Marquart, James W.; Merianos, Dorothy E.; Doucet, Geri *The Health Related Concerns of Older Prisoners: Implications for Policy*, Ageing and Society, Vol: 20 pt 1, January 2000, pages 79-96. Printed in the United Kingdom, 2000 Cambridge University Press.

The results of this particular study highlighted the need for separate facilities for some older inmates as their physical and mental condition declined. Additional questions for study were also raised. These included factors other than health needs that were motivating older inmates to access health care (e.g., boredom, the need for social stimulation, etc.), and the associated impact on health costs; the need to address boredom with constructive activities including work; staff training needs; the role of volunteers in providing social stimulation; the concept of mandatory mobility (exercise) programs; special staffing needs; diet compliance monitoring; and other issues.

Finally, the authors recommended that research begin to establish life expectancy in a penal setting. To this end, older as well as younger inmates with lengthy sentences, should be monitored regarding their health condition at admission and across their sentences.

This information is key to budgetary decisions and proactive decision-making in the management of Florida's elderly inmates.