# Bridging community and prison for older adults: invoking human rights and elder and intergenerational family justice

Tina Maschi, Deborah Viola, Mary T. Harrison, William Harrison, Lindsay Koskinen and Stephanie Bellusa

Dr Tina Maschi is an Associate Professor and Lindsay Koskinen is a Doctoral Student, both are based at Graduate School of Social Service, Fordham University, New York, New York, USA.
Dr Deborah Viola is an Associate Professor and the Director, based at Department of Health Policy & Management, New York Medical College, Valhalla, New York, USA.
Dr William Harrison and Dr Stephanie Bellusa are based at True Grit Program, Nevada Department of Corrections, Reno, Nevada, USA where Dr Mary T. Harrison is an Correctional Psychologist

The study was funded by the John A. Hartford Foundation and the Gerontological Society of America for a Geriatric Social Work Faculty Scholars Award (Principal Investigator: Dr Tina Maschi).

**Abstract**

**Purpose** – *Older adults in prison present a significant health and human rights challenge for the criminal justice system. To date, there is no known study that provides a comprehensive examination or portrait of older persons in prison. The purpose of this paper is to understand individual, family, system, and community vulnerabilities that can complicate successful community reintegration for these individuals.*

**Design/methodology/approach** – *This study provides a cross-sectional, descriptive analysis of biopsychosocial, spiritual, and prison use characteristics associated with a sample of 677 older prisoners, aged 50+, in a state-wide prison system.*

**Findings** – *Results indicate the extent of diversity within this population based on demographic, clinical, social, legal profiles, prison service use patterns, and professional and personal contacts.*

**Research limitations/implications** – *Due to the diversity within this population, an interdisciplinary approach is needed to address the complex social and health care needs of an aging prison population and to plan for their reentry.*

**Practical implications** – *These findings suggest the need for holistic prevention, assessment, and interventions to interrupt the social-structural disparities that foster and support pathways to incarceration and recidivism.*

**Originality/value** – *The human rights implications for the current treatment of older adults in prison include providing in-prison treatment that promotes safety, well-being, reconciliation, and seamless bridges between prison and community for older adults and their families. The True Grit Program is presented as an example of a humanistic and holistic approach of such an approach.*

**Keywords** *Criminal justice system, Prison, Correctional health care, Elderly and prison, Human rights, Social justice, Elder justice, Post-release care, Ageing in prison*

**Paper type** *Research paper*

## Introduction

The steady rise of the mass incarceration of the elderly is international in scope but is particularly problematic in the USA, which has the largest incarceration rate per capita (American Civil Liberties Union, 2012). As of 2009, prisoner population rates per 100,000 were 760 in the USA, 624 for the Russian Federation, 153 in the UK, 119 in China, and 116 in Canada (Organization for Economic Co-Operation and Development, 2010). Of the 2.3 million persons in custody in the USA, 16 percent ($n = 200{,}000$) are aged 50 and older (Guerino *et al.*, 2011). In global corrections, the number of incarcerated adults aged 50 and older varies and has been steadily increasing over the past two decades (Aday, 2003; Carstairs and Keon, 2009). Prisoners aged 50 and older represent about 20 percent (2,800) of Canada's total inmate population of 14,000 (Hale and Swiggum, 2011; Sapers, 2008). In Australia, of 19,082 general population of prisoners, 7.4 percent (1,412) are aged 50 and older (Grant, 1999); in England and Wales,

older prisoners aged 50 plus represent almost 11 percent (6,417) of the total prison population (Ministry of Justice, 2010).

Two major reasons have contributed to the global rise in aging prison populations: increases in the aging population coupled with the long-term aftermath of stricter sentencing policies from the 1980s (Gaydon and Miller, 2007). In the USA, for example, the number of aging prisoners is expected to continue to increase to 20 percent between 2010 and 2030 (US Census Bureau, 2010). In addition, conservative criminal justice policies that began in the 1980s resulted in stricter public and legislative policies, such as restrictive drug and habitual offenders laws (Aday, 2003). This conservative shift resulted in adjudicated offenders receiving longer mandatory minimum prison sentences including an increase in the number of life sentences without parole. Currently, the global prison system is not prepared to address the growing numbers of the incarcerated aging in prison, especially those aged 65 and older, which increases the likelihood that costs for specialized long-term care or palliative and end-of-life care will continue to strain budgets and resources (Davies, 2011).

A portrait of older adults in prison reveals a heterogeneous population. For example, in the US prison population aged 50 and older, the majority are men (96 percent) and are disproportionately racial ethnic minorities (black = 45 percent, Latino = 11 percent, other = 10 percent) compared to whites (43 percent; Guerino *et al.*, 2011). Goetting's (1984) classic typology describes four distinct types of older adults in prison based on time served: the long termer (a person with 20 or more years served), the lifer (life sentence), the chronic recidivist (two or more incarcerations), and the later life offender (first convicted in old age). Health status also varies; some individuals have functional capacity while others suffer from serious and terminal illnesses such as HIV/AIDs, cancer, and dementia or mental health and substance use problems (36 percent; James and Glaze, 2006). Many have histories of victimization prior to and during prison and varying levels of coping and social support (Sampson and Laub, 2003; Maschi *et al.*, 2013a, b).

When considering the important task of bridging older adults from prisons to their families and communities, issues of elder and intergenerational justice are invoked. The pathways to prison vary for older adults in prison and one or more cumulative disadvantages or inequalities, related to race, education, socioeconomic status, gender, disability, legal, or immigration status can influence their access to health and social services, economic resources, and justice. As the international human rights movement is gaining momentum in its efforts to advocate for the rights of older persons, the interdisciplinary practice community is challenged to think creatively and out of the concrete "prison" box on how to respond effectively. Based on recent documentation of the accelerated aging of incarcerated adults, which is attributed to their high-risk personal histories and the stressful conditions of confinement (Cooney and Braggins, 2010), a closer examination of this process and its implications is essential.

We assert that the poor social and environmental conditions of confinement, particularly for older persons, are in fact a type of elder abuse and neglect. Chronic victimization, medical neglect, lack of rehabilitation services, and discharge planning exacerbate physical and mental illnesses and are a violation of human rights, especially the right to health, well-being, social security, family, culture, and safety, including protection from torture or cruel and unusual punishment or elder abuse (American Civil Liberties Union, 2012; Human Rights Watch, 2012; United Nations (UN), 1948, 2012). The World Health Organization (2012) defines elder abuse as a "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" (p. 1). Elder abuse may take many forms and consists of physical, sexual, psychological, emotional, financial exploitation, and intentional or unintentional neglect, including medical neglect (UN, 2012; Stojkovic, 2007). The existence of abuse invokes arguments for a more pronounced human rights consideration when addressing the aging prisoner crisis.

### *Human rights considerations*

Existing United Nations documents, such as the *Standard Minimum Rules on the Treatment of Prisoners* (United Nations, 1977) and the *Handbook of Special Needs Prisoners* (United Nations

Office on Drugs and Crime (UNODC), 2009), provide non-enforceable guidelines that address the needs of older prisoners which include access to prison rehabilitation, physical and mental health care, geriatric-specific care, and family programming and community linkages to services. The community reintegration or resettlement of older people with their families is a critical issue requiring attention, since it invokes a sense of intergenerational family justice. The collateral consequences of incarceration, such as lack of access to family contact, housing, health care, employment, and social security and benefits, make it challenging for older adults to readjust, especially those with longer or life prison terms (Aday, 2005; Dawes, 2009; Higgins and Severson, 2009).

The recent "Report of the United Nations high commissioner for human rights" (UN, 2012) urges that special consideration be given to older adults in prison due to the accumulated or aggravated disadvantages inherent in their status and grave human rights conditions. Fundamental to human rights values are dignity and respect for all persons and the indivisible and interlocking holistic relationship of all human rights in civil, political, economic, social, and cultural domains (UN, 1948). In the Convention on the Rights of Older Persons, rights are framed by conceptions of equality, respect, autonomy, and dignity (UN, 2012). Areas of protections of older persons that are underscored for those in prison include: age discrimination, legal capacity and equal recognition before the law, conditions of institutional and home-based long-term care, violence and abuse, access to productive resources, work, food, and housing, social protection and the right to social security, right to health and palliative and end-of-life care, disabilities in old age, access to justice and legal rights. The United Nations classifies "older prisoners" as a special needs population along with racial/ethnic minorities, persons with disabilities or terminal illnesses, homosexuals (GBLT), and death row inmates with specific non-binding guidelines for their treatment that include care transitions (Maschi *et al.*, 2012b; UNODC, 2009).

### *Older compared to younger prisoners*

Older people in prison differ from their younger counterparts. Because of older adults' growing age-related frailty, they are at increased risk of victimization and injury, medical and social care neglect, lack of access to human rights, loss of family and community relationships, and the lack of age appropriate discharge planning services (Human Rights Watch, 2012).

Older adults' health and well-being are generally compromised while serving prison sentences. Older adults in prison often do not benefit from prison programming targeting younger prisoners' needs, such as reducing offending behavior through education, vocational, and employment programs (Mesurier, 2011). Many international correctional facilities lack geriatric-specific programming or units (Thivierge-Rikard and Thompson, 2007). Palliative care and information and counseling about end-of-life options are needed in prison, especially since many older adults in prison are chronically ill, including with dementia, and a sizable number (e.g. 5,000 in the USA) die each year while in prison (Loeb *et al.*, 2008; Maschi *et al.*, 2012c; Williams and Abraldes, 2007).

Older adults have a more difficult psychological adjustment than younger prisoners to prison life and community reintegration. The reality of declining health often places older adults in a state of high alert to victimization and/or a fear of dying in prison. Social well-being is an important concern for older adults, who are also more than likely to have elderly spouses and other family members that make the prison experience (and reentry process) more problematic (Crawley and Sparks, 2005). Some scholars document the "institutional thoughtlessness" of staff in the treatment of older prisoners (Crawley and Sparks, 2005). In prisons, older adults often are less of a problem for staff, which, ironically, may lead to them being neglected or forgotten. Staff may not provide older adults with supports such as wheelchairs or assistance climbing stairs. Sometimes they assign volunteer prisoners responsibilities for caregiving of aging prisoners, without providing these volunteers adequate training (Mesurier, 2011).

Upon community reentry, the health and well-being of older adults often are challenged. Compared to their younger counterparts, older adults are often more difficult to resettle in the community, especially when they have longer sentences that result in institutionalization

which challenge their ability to survive and thrive successfully outside of prison (Davies, 2011). Resettlement success for older adults may be hindered by limited financial resources, health and/or mental health problems, lack of family and peer support, ongoing substance use, lack of available health care and substance abuse services, and a paucity of suitable housing options, shelter services, and transportation. Many older adults are in need of social services, health insurance or other income supports (e.g. Medicare and/or Medicaid, food assistance programs in the USA), or they are in need of financial or retirement assistance. Even assistance with everyday practical issues, such as taking public transportation, using a cell phone, obtaining dentures, eyeglasses, or hearing aids, and self-care needs related to activities of daily living (e.g. walking, self-feeding), become problematic. Enrollment and access take time, and if not started early enough in prison, older adults may enter the community without the assurance of adequate, age-specific discharge planning (Mesurier, 2011).

For able-bodied older adults, employment is another factor to consider for successful community reintegration. Dually stigmatized by their age and incarceration status, older adults exiting prison experience far more challenges in obtaining needed economic and employment opportunities, which put them at an increased risk of homelessness (UN, 2012). Older adults who have physical and/or mental disabilities require access to community-based or institutional long-term care. For individuals with terminal illnesses, hospice services may be needed either in-home with family caregivers or at a hospice facility with staff who are often not trained to work with formerly incarcerated persons and their families. More critically, many community service providers are resistant to accept clients or patients with criminal offense histories, such as violent or sex offenses. Sadly, this leaves many incarcerated individuals, including with severe dementia, and families few options to provide a peaceful death for an individual who has served his or her time (Maschi *et al.*, 2012c).

More research is needed to better understand the experiences of older adults while in prison and after their release. Research on prison, care transitions, and community reintegration has important implications for practice and policy initiatives aimed at bridging individuals to their families and communities during and after release from prison. Providing a holistic portrait of older adults in prison is particularly critical given their complex needs and the burden for families and providers who must attend to these needs as part of the incarceration and discharge planning process. Creating adequate bridges can help to foster and maintain the health and well-being of intergenerational family members, including children and grandchildren. Without a comprehensive portrait of who these individuals are who make up the older adult prison population, it will be impossible to achieve not only elder, but intergenerational justice, for older adults and their families.

### *Study objectives*

The current study attempts to fill a gap in the literature by providing a holistic analysis of a US statewide prison system of adults aged 50 and older in prison. The objectives of this study are to: first, examine the biopsychosocial, spiritual, and legal factors associated with these prisoners; second, explore the influence of these personal and social structural factors on recidivism; and third, examine the role of family and sentence length in bridging older adults to their families and communities while in prison and post-prison release. An in-depth case study analysis of the True Grit Program, a rehabilitation program for older adults in the Nevada state prison system, is presented as an example of how these programs can promote elder and intergeneration family justice by providing effective bridges to community services and supports.

## Methods

### *Research design*

The current study is a cross-sectional analysis of a sample of 677 older adult prisoners aged 50 and older (40 percent response rate) housed in the New Jersey Department of Corrections in September 2010 who completed an anonymous, self-administered mail survey. Data were

collected using a modified version of the Dillman *et al.* (2009) four-step mail methods strategy. On week 1, a study announcement and invitation were mailed to all eligible participants; on week 2 the survey was mailed with a self-addressed stamped envelope for return; and on weeks 3 and 4 a one page reminder that included a request for a survey replacement with a self-addressed envelope. Participants completed a battery of survey instruments, including the Personal and Professional Contact Scale (see Tables II and III for scale items; Maschi, 2010), in which participants described and rated their degree of contact with different services, personal (i.e. family and peers from the community) and professional contacts. Descriptive analysis was used to generate a holistic portrait of older adults in prison. This data were supplemented with case study vignettes based on qualitative data gathered from participants based on their life histories and their experiences of the current conditions of confinement.

### *Results*

*Demographic profile*. As shown in Table I, participants' ages were evenly distributed between young-old and old; 9 percent of the sample are among the older and oldest-old, aged 65 +. Approximately two-thirds of the sample are racial/ethnic minorities; two-thirds describe themselves as Christians; and the sample is overwhelmingly male (96 percent).

*Clinical profile*. Roughly 41 percent reported one or more physical health problems, including serious and chronic illness (e.g. HIV/AIDS, cancer, heart problems and hypertension, lung and breathing problems) and other health issues, such as hearing and vision problems and difficulty walking. Some participants identified themselves as having a mental health problem and a history of alcohol problems (25 percent), drug problems (44 percent), or gambling problems (9 percent). The majority reported experiencing some type of trauma, grief, loss, or separation experience, such as being a victim of violence (24 percent), witness to violence (48 percent), or combat or war (15 percent). Many participants reported experiencing other life stressors, such as the unexpected or expected death of a loved one (70 percent), financial stress (53 percent), family caregiving stress (25 percent), and abuse or stress in prison (53 percent).

*Social and legal profiles*. Social and legal concerns also differed among participants, including family structure, income, occupational, and military status. Marital status included currently married (14 percent) or partnered (11 percent) while others reported being single (29 percent), divorced (29 percent) or separated (7 percent), and widowed (8 percent). Most participants reported being a parent (80 percent) and grandparent (61 percent) with one or more children under age 18 (23 percent), or one or more grandchildren under age 18 (56 percent). The majority of respondents had a high school diploma (74 percent) or college degree (16 percent); 49 percent reported incomes of $20 K or less, 70 percent described themselves as unskilled; and 30 percent are veterans.

The length of time served in prison ranged from one to five years (38 percent), six to 19 years (28 percent), 20 or more years (24 percent); 5 percent will serve a sentence of 51 years to life. The number of days spent in solitary confinement in the past year ranged from one to ten days (2 percent), 11 to 150 days (3 percent), and 151 to 365 days (4 percent). About a third of the participants reported one incarceration while two out of three reported a history of two or more prior incarcerations, which included: delinquent offenses (35 percent), violent offenses (64 percent), sex offenses (25 percent), drug-related offenses (46 percent), violation of probation (44 percent), and parole violations (42 percent). Many of the participants expected to be released from prison within one year (22 percent) or two to five years (37 percent). Others reported being released in six to ten years (13 percent) and 11-50 years (12 percent). Over two-thirds expected to be released to communities within an urban/suburban setting.

*Prison service use profile*. Participants also provided information pertaining to their prison service use patterns (see Table II). Most participants reported using medical services (86 percent) in the past three months and about three-quarters found these services helpful. Approximately one-fifth of the respondents reported using inpatient and/or outpatient mental health services and two-thirds found these services helpful. Only 25 percent reported participating in substance abuse services but for those who did, most (74.1 percent) found these services helpful. Slightly more participants (32 percent) reported participating in Alcoholics or Narcotics Anonymous and again,

**Table I** Biopsychosocial, spiritual, and demographic profile

| *Characteristics* | *%* | *n* |
|---|---|---|
| *Chronological age* | | |
| Young old (aged 50-54) | 44.7 | 288 |
| Middle old (aged 55-64) | 44.0 | 284 |
| Oldest old (aged 65-100) | 9.3 | 60 |
| *Race/ethnicity* | | |
| White | 35.0 | 227 |
| African -American | 44.9 | 291 |
| Hispanic/Latino | 11.0 | 71 |
| Other | 9.1 | 59 |
| *Gender* | | |
| Male | 96.0 | 626 |
| Female | 4.0 | 26 |
| *LGBT* | 2.2 | 15 |
| *Education* | | |
| No high school diploma | 10.0 | 65 |
| High school diploma | 74.3 | 481 |
| College degree or above | 15.6 | 101 |
| *Religion* | | |
| Christian | 62.2 | 335 |
| Islamic/Muslim | 13.2 | 71 |
| Atheist/Agnostic | 13.2 | 71 |
| Other | 11.5 | 62 |
| *Military history* | 30.3 | 196 |
| *Mental health/substance use* | | |
| Mental health DX | 28.2 | 183 |
| Alcohol problem | 25.4 | 165 |
| Drug problem | 43.5 | 283 |
| Gambling problem | 9.2 | 60 |
| Drugs at time of offense | 42.8 | 272 |
| Alcohol time of offense | 33.1 | 209 |
| Suicide history | 4.5 | 30 |
| Medication history | 28.2 | 183 |
| *Trauma, grief, loss history* | | |
| Victim of violence $<16$ | 24.4 | 211 |
| Witness to violence $<16$ | 47.7 | 293 |
| Been in combat or war | 15.2 | 92 |
| Death of someone close (expected) | 69.9 | 446 |
| *Financial stress* | 53.0 | 324 |
| Caregiving stress (family member) | 25.3 | 159 |
| Abuse/stress in prison | 52.5 | 321 |
| *Physical health (any)* | 41.0 | 256 |
| Eye/vision problem | 20.0 | 132 |
| Back or neck problem | 19.7 | 130 |
| Arthritis/rheumatism | 17.0 | 112 |
| Hypertension | 15.3 | 101 |
| Walking problem | 10.9 | 72 |
| Fractures, bone/joint injury | 10.8 | 71 |
| Heart problem | 9.9 | 65 |
| Lung/breathing problem | 9.6 | 63 |
| Diabetes | 9.6 | 63 |
| HIV/AIDS | 4.2 | 28 |
| Hearing problem | 5.0 | 33 |
| Cancer | 2.4 | 16 |
| Stroke | 1.5 | 10 |
| Other impairment | 8.0 | 53 |
| *Mental health (MSD)* | | |
| Depression | 8.4 | 56 |
| Bipolar disorder | 4.5 | 30 |

*(continued)*

**Table I**

| *Characteristics* | % | *n* |
|---|---|---|
| Post-traumatic stress disorder (PTSD) | 2.7 | 18 |
| Schizophrenia/schizoaffective disorder | 2.2 | 15 |
| Other | 3.9 | 26 |
| *Family relations* | | |
| *Marital status* | | |
| Never married | 28.6 | 182 |
| Married | 14.3 | 91 |
| Partnered-not married | 10.8 | 69 |
| Divorced | 29.4 | 187 |
| Separated | 7.2 | 46 |
| Widowed | 7.9 | 50 |
| Other | 1.7 | 11 |
| *Children and family* | | |
| One or more children | 79.9 | 504 |
| One or more children $<18$ | 22.7 | 129 |
| One or more grandchildren | 61.3 | 365 |
| One or more grandchildren $<18$ | 56.4 | 324 |
| Incarcerated family member | 47.7 | 306 |
| *Homelessness History* | 10.1 | 65 |
| *Income $20,000 or less* | 48.8 | 306 |
| *Benefits history (SSI, MC, MC, other)* | 15.8 | 99 |
| *Occupation* | | |
| Skilled | 28.6 | 191 |
| Unskilled | 70.0 | 467 |
| Retired | 1.3 | 9 |
| *Offense history* | | |
| Delinquent offense | 35.3 | 226 |
| Violent offense | 63.5 | 413 |
| Sex offense | 25.2 | 163 |
| Drug offense | 45.5 | 294 |
| Violation of probation | 44.0 | 285 |
| Parole violation | 41.9 | 271 |
| *Expected release date* | | |
| 0-1 year | 21.7 | 145 |
| 2-5 years | 36.7 | 245 |
| 6-10 years | 12.6 | 84 |
| 11-50 years | 12.3 | 82 |
| 51 years-life | 4.5 | 30 |
| *Time served* | | |
| 1-5 years | 37.5 | 250 |
| 6-19 years | 27.7 | 185 |
| 20 or more | 23.8 | 159 |
| *Solitary confinement (days past year)* | | |
| 1-10 | 1.7 | 12 |
| 11-150 | 3.2 | 22 |
| 151-365 | 3.7 | 25 |
| *Number of incarcerations* | | |
| 1 | 32.0 | 208 |
| 2 or more | 66.3 | 442 |
| *County of release* | | |
| Rural | 33.0 | 209 |
| Urban/suburban | 67.0 | 448 |
| *Services used (in prison)* | | |
| Prison religious participation | 71.7 | 463 |
| Prison MH TX | 32.8 | 212 |

the majority (83 percent) found these programs to be helpful. As for other activities, most participants (65 percent) reported attending religious services and almost all (94 percent) reported those as helpful. Close to three-quarters of the respondents participated in recreational activities and of those, 89 percent found them helpful.

| **Table II** Service use in the last three months and helpfulness of services | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | *Services used* | | | | *Helpfulness of services* | | | | |
| | | *Yes* | | *No* | | *Yes* | | *No* | | |
| *Services* | *Total n* | *%* | *n* | *%* | *n* | *%* | *n* | *%* | *n* |
| Medical services | 641 | 86.1 | 552 | 13.9 | 89 | 76.2 | 409 | 23.8 | 128 |
| Mental health – inpatient | 565 | 20.5 | 116 | 79.5 | 449 | 65.6 | 80 | 34.4 | 42 |
| Mental health – outpatient | 563 | 21.0 | 118 | 79.0 | 445 | 66.4 | 75 | 33.6 | 38 |
| Alcohol or drug treatment | 567 | 25.0 | 142 | 75.0 | 425 | 74.1 | 100 | 25.9 | 35 |
| Religious services | 608 | 65.1 | 396 | 34.9 | 212 | 93.9 | 354 | 6.1 | 23 |
| Recreational activities | 603 | 72.6 | 438 | 27.4 | 165 | 88.5 | 362 | 11.5 | 47 |
| AA/NA | 566 | 32.2 | 182 | 67.8 | 384 | 83.1 | 147 | 16.9 | 30 |

*Professional and personal contact*. Contact with professionals and volunteers varied among participants (see Table III). Most participants reported having contact with medical staff (66 percent), religious volunteers (43 percent), and other inmates (43 percent). Less common was contact with social workers (37 percent), psychologists (32 percent), psychiatrists (26 percent), probation or parole officers (10 percent), and teachers (8 percent). Many participants reported minimal contact with family or friends during the past three months (see Table III). Over two-thirds had no contact with their marital or life partner (67 percent) or parents (69 percent). The majority reported no contact with their children (60 percent) or their grandchildren (77 percent). Almost half (49 percent) reported they had no contact with siblings.

Participants' experiences of service use and patterns of personal and professional contact were further explored using the responses from the open-end survey questions (see Table IV). Approximately 200 participants' responses were thematically analyzed and revealed themes related to trauma and stress about service provider mistreatment and medical neglect, isolation from family, and resiliency despite adversity. Participants also described coping with the stressful conditions of confinement by engaging in seven types of well-being practice behaviors, consisting of root (basic needs), cognitive, emotional, physical, social, spiritual, and participatory (empowerment) behaviors or activities (see Table V). Strategies that include visual arts, listening to or making music, yoga, reading, writing, and peer leadership suggest avenues for prison and

| **Table III** Professional and personal contacts within the last three months | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | *Method of contact* | | | | | | | | | |
| | | *No contact* | | *Phone contact* | | *Visits* | | *Phone contact and visits* | | *Letters* | |
| | *Total n* | *%* | *n* | *%* | *n* | *%* | *n* | *%* | *n* | *%* | *n* |
| *Personal contact* | | | | | | | | | | | |
| Marital or life partner | 600 | 67.8 | 407 | 13.8 | 83 | 9.3 | 56 | 8.5 | 51 | 0.5 | 3 |
| Children | 611 | 59.9 | 366 | 17.8 | 109 | 12.4 | 76 | 8.2 | 50 | 1.6 | 10 |
| Grandchildren | 569 | 77.0 | 438 | 10.5 | 60 | 7.7 | 44 | 3.9 | 22 | 0.9 | 5 |
| Siblings | 625 | 49.0 | 306 | 27.7 | 173 | 13.3 | 83 | 7.7 | 48 | 2.4 | 15 |
| Parents | 591 | 69.2 | 409 | 15.7 | 93 | 9.0 | 53 | 5.4 | 32 | 0.7 | 4 |
| Friends | 612 | 64.5 | 395 | 19.3 | 118 | 10.1 | 62 | 3.8 | 23 | 2.3 | 14 |
| *Professional contact* | | | | | | | | | | | |
| Teachers | 587 | 91.8 | 539 | 1.2 | 7 | 6.6 | 39 | 0.3 | 2 | – | – |
| Social workers | 603 | 63.3 | 382 | 2.5 | 15 | 33.7 | 203 | 0.5 | 3 | – | – |
| Medical staff | 607 | 33.6 | 204 | 2.8 | 17 | 62.9 | 382 | 0.7 | 4 | – | – |
| Psychologists | 592 | 68.2 | 404 | 1.2 | 7 | 30.6 | 181 | – | – | – | – |
| Psychiatrists | 587 | 73.9 | 434 | 1.0 | 6 | 25.0 | 147 | – | – | – | – |
| Other inmates | 543 | 57.3 | 311 | 2.2 | 12 | 39.8 | 216 | 0.6 | 3 | 0.2 | 1 |
| Probation/parole officers | 591 | 89.5 | 529 | 1.0 | 6 | 9.1 | 54 | 0.3 | 2 | – | – |
| Religious volunteers | 604 | 56.6 | 342 | 1.0 | 6 | 41.7 | 252 | 0.5 | 3 | 0.2 | 1 |

| Table IV Types of stressors confinement |
| --- |
| *Health as a stressor* |
| Physical and mental pain/distress and receiving services (DISTRESS) |
| *Social cultural context* |
| Separation and loss (DISENFRANCHISED GRIEF) |
| Missing family and friends, too much time in cell (ISOLATION AND LONELINESS) |
| Safety: assault, gang members, witnessing assault, mean guards |
| Being a victim/witness of abuse (FEAR) |
| Administration-sudden changes (ANXIETY) |
| Loud noise, no peace, young people (ANNOYED) |
| *Anticipatory stress* |
| Dying in prison, life after prison, family wellness, work ability (WORRY) |

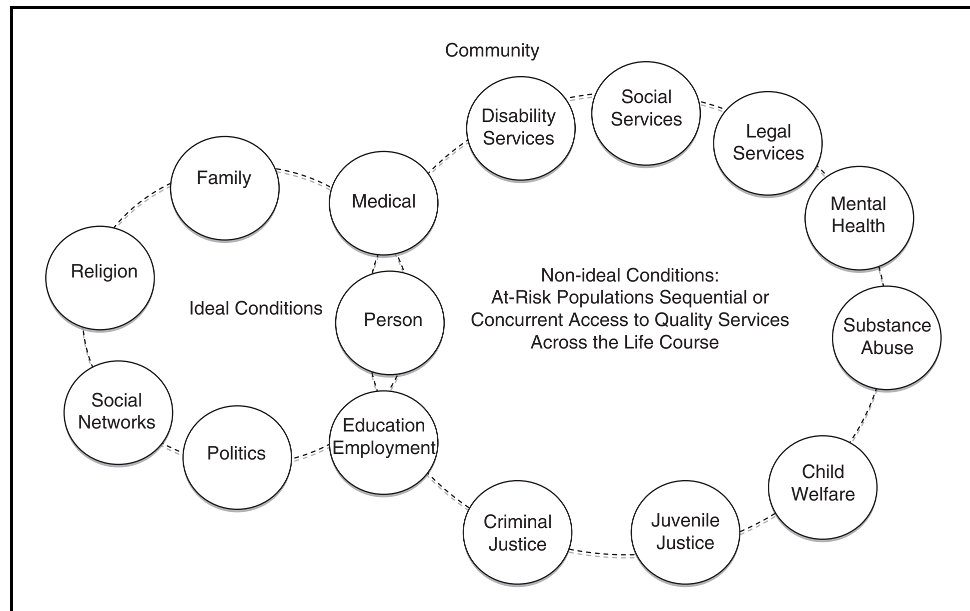
| Table V Types of psychosocial spiritual medicine used by older adults in prison |
| --- |
| *Coping and alternative medicine practices* |
| ROOT (basic needs/foundation: food, clothing, safety, grounded in love ad family) |
| PHYSICAL-exercise (yard, run/walk, yoga, sports), medication |
| COGNITIVE-find peace within, think positive, making healthy choices, puzzles, read |
| EMOTIONAL-supportive counseling, anger and stress management, music (listening) |
| SPIRITUAL-church, God, pray, service to others |
| SOCIAL/Cultural-interaction with family, friends, or peers in prison, program participation |
| PARTICIPATORY: (LEARNING/WORK/EMPOWERMENT): classes, vocational training, teaching, leading a book club, being a paralegal |
| MULTI-DIMENSIONAL: yoga, meditation, art-making, music-making |
| *Sample quotes* |
| "I pray. I try to meditate and read a great deal to take my mind off worries" |
| "I do yoga, Dr. Tina Maschi, yoga" |
| "I participate every Monday in group therapy. Cage Your Rage program 10 weeks" |
| "I became a jogger and sprinter at 56 years old. I run 5 miles per day and sprint 105 yd sprints every other day" |
| "Prayed to God, got in touch with family members and did a whole lot of jogging exercise" |
| "I love to work" |

community programming to provide "psychosocial spiritual medicine" that helps participants maintain a positive state of health and well-being.

## Discussion

The purpose of this study was to build upon the extant literature by providing a holistic examination of a statewide prison population aged 50 and older. The results show that older adults in prison represent a heterogeneous group who have been or continue to be exposed to social injustices as a result of limited access to health, education, and employment opportunities. Early family histories suggest most were at high risk for incarceration and often did not receive the specialized services or supports, e.g., child welfare, mental, or substance abuse, which may have prevented their entry to the criminal justice system (Figure 1). In the case of older adults in prison, high-risk factors continued to accumulate over time, especially while aging in prison (e.g. declining physical or mental health status, victimization experiences). Figure 2 illustrates the multiple risk factors or vulnerabilities identified in the sample that may have had an influence on these prisoners' lack of access to services and identifies possible trajectories to prison. As described, these factors contribute to a holistic assessment of prisoner needs while incarcerated and should contribute to discharge planning to help mitigate potential community bridging barriers that contribute to increased risk of recidivism.

**Figure 1** The life cycle and circle of oppression and injustice: prevention, assessment, and intervention planning



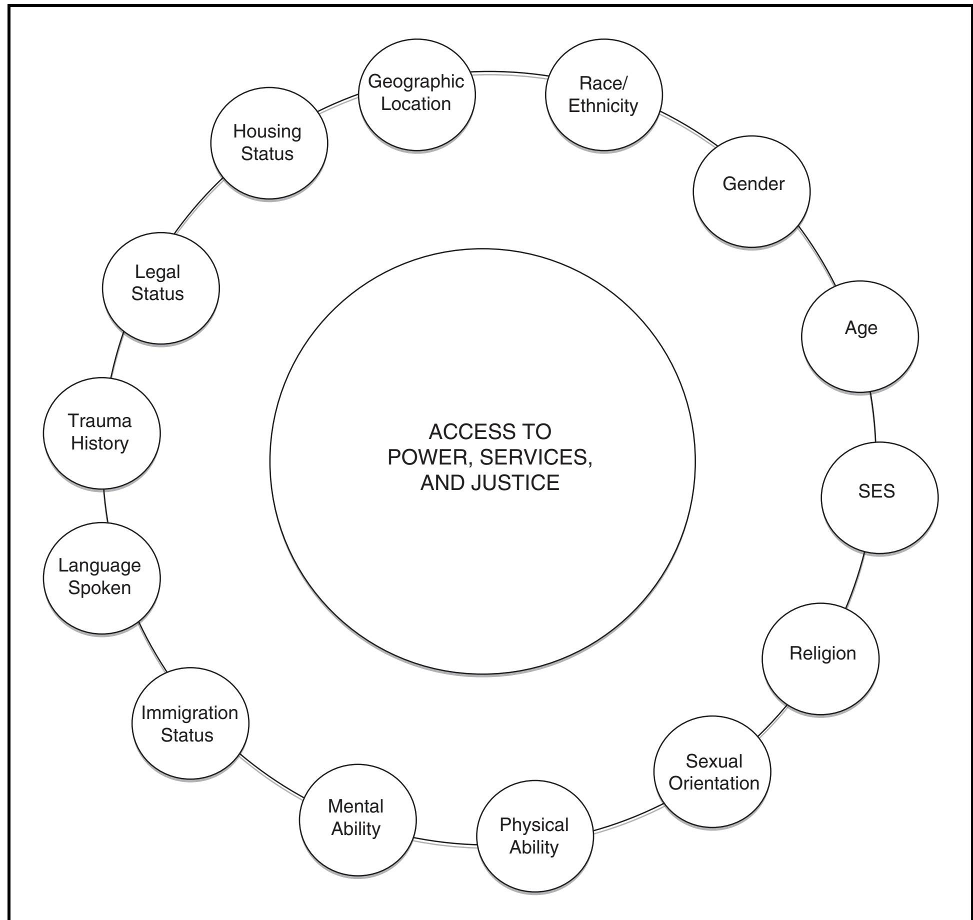

*Building bridges*

Using a human rights framework, older adults and their families and communities have the right to care transitions that foster health and well-being, safety, and maintaining their family bonds. Yet, a combination of individual, family, and community vulnerabilities often complicate the building of bridges between prison and community for older adults and their families. As our findings indicate most prisoners had no contact with family or community members which suggests that prisoners have little external supports to assist them through the challenges of every day prison experiences, let alone provide for any re-integration within families and communities. The context with which prisoners experience their reentry is critical: income, employment and potential for employment, housing, safety, and the availability of health and social service providers influence the likelihood for successful reintegration within communities (La Vigne and Cowan, 2005; Urban Institute, 2012). While incarcerated, the ability to be employed and contribute to partners and children, and to provide for the health and welfare of families, impacts anticipatory stress (Maschi *et al.*, 2012b). Released prisoners can expect to earn no more than half of what they made before incarcerated and the impact on families cannot be overstated; research shows that family income is a major indicator of future success for children, and combined with the associated school problems children with an incarcerated parent experience, the intergenerational costs become incalculable (Pew Charitable Trusts, 2010).

Thus, for older prisoners who still have responsibility for children $<18$, moving from prison to work takes on even more import than it might otherwise, whether they reside with the children or not. Over 10 percent of those returning to prison for violations are sent back because of the inability to pay child support (Pew Charitable Trusts, 2010). Despite this, even for those prisoners who would normally be approaching "retirement age," work takes on increased significance since they often have no other income or family support for retirement. Therefore, programs and policies that support work initiatives and training, or provide support from community-based coalitions that bridge returning prisoners and employers, are critical to securing and sustaining employment opportunities.

Within the prison population there are those who are at greater risk for recidivism, especially those who were homeless, suffer from physical and/or mental health issues, or present with alcohol or drug use at time of offense. Programs that combine rehabilitation services with

**Figure 2** Intersectional social locations that influence access to power, services, and justice: key considerations for assessment, prevention, intervention




employment and housing demonstrate higher levels of reentry success and lower levels of drug relapse (Pew Charitable Trusts, 2010). Providing disease prevention programs and consistent medical care while incarcerated and anticipating transitions to community-based care, including health homes designed for vulnerable Medicaid beneficiaries, or Accountable Care Organizations for elderly who suffer from chronic conditions, are critical for removing health barriers that prevent newly released prisoners from seeking employment, housing, or renewing family and community relationships. Improving care while incarcerated is an important step toward reducing overall costs of incarceration and reentry; costs for care while incarcerated are two to eight times higher for those between the ages of 55 and 80 (Maschi *et al.*, 2012a, b). Policy changes are also required at the federal and state level if we are to truly have any success at reintegrating the formerly incarcerated. Existing laws prohibit employment opportunities, receipt of government benefits that provide housing, education, and even food stamps, as well as limited to no opportunity for removing criminal records and histories after a period of time (Western, 2008; Pager, 2006).

## Case study: True Grit as a prison and community reintegration program

We present an in-depth case study of the True Grit Program that has had promising results in bridging older adults from prison to the community. True Grit infuses principles of human rights and social justice, such as dignity and worth of the person, and fosters biopsychosocial well-being among older adults in prison (Harrison *et al.*, 2012). The original program was

established for men but an additional program site has been added for women. A description of the program and practical lessons learned in bridging prison and community for older adults and their families are discussed next.

Similar to New Jersey, Nevada is a state with a rapidly aging prison population; between 2006 and 2012 Nevada's older adult prisoner population over age 55 increased from 366 to 1,299 (Livingston, 2010). Recognizing this potential problem as early as 2003, the Nevada Department of Corrections began to explore ways to address the issue of older adult prisoners (D. Nash Holmes, personal communication, December 11, 2011). A small pilot program involving 15 prisoners was established at High Desert State Prison. This proved to be successful in meeting the mental health needs of the cohort, but it was clear that the program needed to be expanded in both size and scope. In 2004, the program was moved to northern Nevada, to be co-located with the Department's Regional Medical Facility. Since there was no template on which to build a program, a number of different resources were evaluated, including prison hospices and other eldercare facilities (Harrison, 2006; Harrison and Benedetti, 2009).

During the ten years the program has been in existence, it has been a work in progress. The formal name of the program is the Senior Structured Living Program (SSLP). Once SSLP was established, its members opted to choose a shorter nickname, similar to other correctional programs. They decided on the name True Grit, to reflect their obstinate refusal to simply be warehoused until release or death, and designed a logo, *a la* John Wayne in the movie of the same name. There are 15 women in the structured living program ($<10$ percent – which is about the same ratio as women-to-men overall in the Nevada Department of Corrections). They are housed at the Florence McClure Correctional Center for Women near Las Vegas, in southern Nevada. The discussion that follows will focus on the men's True Grit Program, but conceptually the same program supports are available at the women's center.

Beginning with a dozen older prisoners, True Grit currently has more than 200 active participants. Approximately 265 additional prisoners have been in the program for various periods of time. Of this latter number, 47 died in prison and 111 have paroled or finished their sentences. The others left the program at their own request or were dismissed for violations of prison regulations. Not as many incarcerated seniors are participating in the program as might have been expected because some of them do not wish to become involved in a therapeutic community and others do not qualify because of their security level or other correctional or geographic factors.

The current ethnic composition of True Grit is: 71 percent Caucasian, 16 percent African-American, 9 percent Hispanic, and 4 percent Native American, Asian, or Pacific Islander members. These percentages are slightly more skewed toward Caucasian males than the general Nevada prison population. These figures are also somewhat different from national demographics, wherein Caucasian males comprise only 50 percent of those in prison, African-Americans, 32 percent, and Hispanics, 14 percent (Sabol and Couture, 2008). The mean age of the group is 68.2 years. Most are serving sentences of 21-24 years. The mean age of first incarceration is 53 (Livingston, 2010).

As the program developed, it became apparent that rather than just providing a safe and healthy environment within the prison for these older adults, True Grit could become a mechanism for bridging the chasm between prison and the community. It gradually became a program of rehabilitation and community reintegration to society.

### *Definition and program criteria*

Since its inception, True Grit has been a work in progress. With no formal guidelines to follow, it has evolved gradually. The present definition of structured living is "a comprehensive program of structured physical, mental, emotional and spiritual activities with a set routine and within which each member is required to participate, to the best of his abilities, on a regular basis" (Harrison, 2011).

Age is a core criterion for acceptance to the program. The definition of "geriatric prisoner" varies among US state jurisdictions, ranging from 50 to 60. Nevada unofficially designates prisoners as "elderly" at the age of 50 (Livingston, 2010). There is general consensus that people in prison

age more rapidly than their community counterparts. The reasons for this can be ascribed to chronically unhealthy lifestyle, lack of access to medical care, socioeconomic inequality, the stresses of prison life, and substance abuse (Maschi *et al.*, 2012b, d). As a consequence older adult prisoners are physiologically and mentally ten to 12 years older than their chronologic age (Aday, 2003). Because of these common characteristics, associated with aging in place in prison, the True Grit Program has participants who may experience physical disabilities, chronic health problems, substance abuse; sexually deviant behavior, post-traumatic stress disorder, depression, terminal illness, chronic pain, and end-of-life issues, and/or concerns with community reintegration, especially for those with long prison terms.

In addition to being age 55 or over (with no upper age limit), prisoners must meet certain prerequisites, including:

- no full-time work or school (part-time school is acceptable);
- willingness to participate in all program activities, including correctional programs that target individual criminogenic factors; and
- compliance with a signed formal contract that specifies the rules and regulations governing behavior and grooming standards.

The primary objective of SSLP is to assist elderly offenders in their physical, mental, emotional, and spiritual growth, including rehabilitation and eventual reentry into society. The mission statement of True Grit is "no more victims."

Secondary objectives include:

- providing structured treatment programs for rehabilitation designed specifically for older adult prisoners;
- providing for the physical, emotional, and spiritual needs of men undergoing end-of-life by assisting them in maintaining their dignity and inner peace; and
- maximizing limited resources.

*The True Grit Program components*. The SSLP is comprised of 11 interactive modules. An important facet of the program is that all members are housed together in a separate unit; younger inmates are excluded. When medically necessary, program members may be transferred to the Regional Medical Facility; upon medical discharge they return to the SSLP unit. As necessary, dying inmates are afforded end-of-life care in the infirmary, provided by staff, volunteers, and compassionate care visits from other SSLP members.

*Diversion activities*. Diversion activities are a major segment of the program. Crocheting, knitting, beading, and latch-hook rug-making provide activity that is not only cognitively stimulating, but affords excellent physical therapy for arthritic hands and fingers. Beginning with no resources, the program's musical activities have expanded to include five vocal ensembles and four instrumental groups. Recent donation of guitars and sound amplification equipment by a prisoner-rehabilitation organization (Jail Guitar Doors) allows former professional musicians in the program to enable amateurs to improve their skills. The Do-Wop Band, True Grit Choir, Spanish ensemble, True Grit Pops, and Country/Western groups rehearse regularly, and perform whenever the opportunity presents itself.

*Cognitive therapy*. Because a busy mind may not decline as rapidly as an idle one (Rubin, 2009, pp. 3-5), True Grit has many cognitive therapy activities, including an ethnodrama theater arts group; a creative writing group; a cultural arts group; and a Spanish language study group. Literary skills are enhanced by production of True Grit Notes, written and edited by members, and an extensive microwave cookbook featuring meals that can be prepared using limited supplies available in prison. Most of the performances by the ethnodrama group deal with problems unique to aging in place in prison. Unchained Verse is an on-going anthology of poetry created by the members and mentored by a volunteer retired college professor. This exercise enables men to express thoughts and emotions that they might otherwise never verbalize. A Navy veteran volunteer works with inmate veterans to write memoirs or produce artwork relating to their military experiences.

*Substance abuse/addictions groups*. Traditional 12-step groups including Alcoholics Anonymous, Narcotics Anonymous, and Sexual Compulsives Anonymous meet regularly, facilitated by volunteer sponsors. Recent studies suggest that from one-half to two-thirds of male prisoners have diagnosable substance abuse or dependence (Maschi *et al.*, 2012b). Therefore it is important to address this factor in order to prepare individuals for repatriation into the community (Mumola and Karberg, 2006).

*Wellness and life skills/activities of daily living*. Once each week SSLP members gather for seminars on various aspects of health and wellness, life skills such as cooking, menu-planning and healthy life choices, or other relevant activities. Group members present a layperson's view of a medical condition or discuss topics such as human sexuality and the aging process.

*Pet therapy/end-of-life care*. Pet therapy plays an extensive role within True Grit. Volunteers from Intermountain Therapy Animals visit the prison on a weekly basis, providing the members with the opportunity to experience unconditional affection. The volunteers from this organization provide animal-assisted therapy in the areas of physical, occupational, speech and psychotherapies, as well as special education. The dogs assist regularly in the pain management group; several have been in the infirmary with dying inmates during their last days.

*Physical fitness*. The men assemble regularly in the gymnasium or ball field for group and individual physical activities. Depending on the weather these may include wheelchair softball, basketball, or volleyball; aerobics, tennis, measured-distance walking, weight lifting, stationary bicycle, billiards, Ping-Pong, horseshoes, or dancing. The latter is usually combined with one or more musical sessions. Although no credentialed music or dance therapist conducts these sessions, they achieve the desired goal of enhancing the men's physical and mental fitness.

*Peer support groups/Vet-to-Vet*. Approximately 55 percent of True Grit's members are veterans, which is a high proportion in correctional systems (Noonan and Mumola, 2007). Volunteers from chapters of the Vietnam Veterans Association, both within and outside the prison, conduct weekly peer support groups with elderly veterans, modeled on the Department of Veterans Affairs Vet-to-Vet program. Volunteers assist members with writing their combat-related memoirs, and a number are producing sketches and paintings related to their military experience.

*Spiritual activities*. In addition to institutional religious activities conducted by prison staff and volunteers, there are a number of lay leaders within True Grit. They carry out various spiritual rituals on a regular basis. One particularly moving ceremony is the memorial service conducted after an SSLP member dies in prison.

*Correctional mental health activities*. Formal correctional programs facilitated by both staff and community volunteers are available to members of True Grit. These programs include victim awareness, stress management, anger management, conflict resolution, relationship skills, health-related recovery, commitment to change, trauma and recovery, addictions prevention education, sex offender treatment of prisoners (STOP) (Harrison and DeFrancesco, 2010), Inside/Outside Dads, and special populations programs. Many of these programs, when completed successfully, provide the members with meritorious credit toward reducing the length of their sentence.

*Discharge planning*. Volunteers provide members with information and referrals concerning their eventual release from prison. This includes collaboration with non-profit organizations, halfway houses, resources for potential employment, and other assistance. Organizations such as the Department of Veterans Affairs have also been helpful in preparing SSLP members for release and successful return to the community.

### *Maintaining True Grit in the face of diminishing resources*

In Nevada, the Department of Corrections continues to face a significant budget crisis, resulting in the reduction of non-correctional staff, such as mental health professionals, as well as lack of funding for new projects. Despite this, True Grit has grown and been successful because the costs for the state have been minimal. This is due primarily to extensive use of volunteers and generous donations of supplies and material from community organizations. The first volunteers were a group of dogs and their handlers, part of the Intermountain Therapy Animal organization.

Volunteers now include college professors and other educators, psychologists, nurses, and retired military personnel. Community organizations and private donors also enable diversion activities, cognitive-behavioral interventions, musical activities, the library, the physical fitness program, and the wheelchair repair program to operate successfully. As an example, a community service organization in Reno regularly donates used durable medical equipment, including wheelchairs, to True Grit.

*Preliminary evaluation results*

The program is currently being evaluated for its impact. Preliminary analysis of the qualitative data from True Grit participants suggests that they view the program as an invaluable part of their lives, helping them cope with daily prison stress while allowing them to offer restitution for their crimes. Preliminary quantitative analysis suggests that participants who released from prison have a 0 percent recidivism rate.

*Caveats and pitfalls*. As described, True Grit is a multi-faceted, multi-disciplinary programmatic approach to the biopsychosocial and spiritual needs of older adult prisoners, with the primary goal of rehabilitation of the individual and assistance with reentry into society. However, True Grit has not been without problems. First and foremost, not all security or correctional officers or professional staff support or agree with the program. There has been resistance in some quarters to fully implementing True Grit. Uninformed members of the general public tend to resist what some have labeled “coddling” of prisoners. Unless a cadre of volunteers and an outside support system of donors are organized, funding for older adult prisoner programs may be difficult to implement. With support from administration and continued educational efforts, both inside and outside prison, however, most resistance has been diminished.

*Recommendations on overcoming challenges*

As illustrated in this study and the True Grit case example, the biggest challenges for interdisciplinary professionals and programs to foster health and well-being among incarcerated older adults are developing competencies in working at the practice intersection of aging, health/mental health, and criminal justice sectors of care. Although the extent to which some skills are used depends upon where a professional is “positioned” in the system (e.g. clinical social worker in prison, reentry program administrator), it involves having competencies in aging (gerontological practice), physical and mental health assessment and intervention, case management, interdisciplinary collaboration, discharge planning, and legal and policy issues.

Due to the complex nature of individual and social-structural level factors impacting the pathways to prison, prison conditions, and transitional planning, an interdisciplinary response that includes doctors, nurses, psychologists, social workers, peer companions, family, and communities is critical. The grassroots, multiple stakeholder perspectives, as demonstrated in True Grit, are critical to foster health and well-being among older adults and to help them maintain family and community bonds while in the criminal justice system. Professionals, such as social workers or nurses, who conduct needs assessments, can identify the potential barriers in their local communities and identify community-based organizations and members who can help address them.

The best case scenario for older adults reentering the community is to provide them with services that match their complexity of needs. Providing needed resources early enough in the process, such as obtaining social security benefits or housing, may make a significant difference toward successful reintegration (Higgins and Severson, 2009). Lawyers can provide services for many older adults in prison who need legal representation, such as in the case of disabilities or victimization or medical neglect while in prison. Human rights and legislative advocates can assist with ongoing policy and system reform efforts.

Providing a seamless bridge between prison and community is not only a key component of providing individual, family, and community cohesion, health, and well-being (Higgins and Severson, 2009; Snyder *et al.*, 2009), it may also be key to reducing the $60 billion in reentry costs that are positioned to increase as more prisoners age with complex health and social care needs (Nunez-Neto, 2008). Coupled with society’s increased recognition of the elderly as a

vulnerable population, as demonstrated by the proposed Convention of the Rights of Older Persons and the growing elder and intergenerational and family justice movements, there is now the potential for older prisoners to achieve access to justice. True Grit is an example of a promising program that illustrates that even correctional staff can triumph over attitudinal and systemic barriers to treat incarcerated older adults and their families with dignity and respect and help make communities safer.

## References


Aday, R.H. (2003), *Aging Prisoners: Crisis in American Corrections*, Praeger, Westport, CT.

Aday, R.H. (2005), "Aging prisoners' concerns toward dying in prison", *OMEGA-Journal of Death and Dying*, Vol. 52 No. 3, pp. 199-216.

American Civil Liberties Union (2012), "The mass incarceration of the elderly", available at: www.American Civil Liberties Union.org/files/assets/elderlyprisonreport_20120613_1.pdf (accessed January 6, 2013).

Carstairs, B. and Keon, D. (2009), *Canada's Aging Population: Seizing the Opportunity Report*, Special Senate Committee on Aging, Ottawa, available at: www.parl.gc.ca/Content/SEN/Committee/402/agei/rep/AgingFinalReport-e.pdf (accessed September 1, 2011).

Cooney, F. and Braggins, J. (2010), *Doing Time: Good Practice with Older People in Prison – The Views of Prison Staff*, Prison Reform Trust, London.

Crawley, E. and Sparks, R. (2005), "Hidden injuries? Researching the experiences of older men in English prisons", *The Howard Journal of Criminal Justice*, Vol. 44 No. 4, pp. 345-56.

Davies, M. (2011), "The integration of elderly prisoners: an exploration of services provided in England and Wales", *International Journal of Criminology*, pp. 1-32, available at: www.internetjournalofcriminology.com/DaviesTheReintegrationofElderlyPrisone.p.pdf (accessed September 1, 2011).

Dawes, J. (2009), "Ageing prisoners: issues for social work", *Australian Social Work*, Vol. 62 No. 2, pp. 258-71.

Dillman, D.A., Smyth, J.D. and Christian, L.M. (2009), *Internet, Mail, and Mixed-Mode Surveys: The Tailored Design Method*, 3rd ed., John Wiley and Sons Inc, Hoboken, NJ.

Gaydon, L. and Miller, M. (2007), "Elders in the justice system: how the system treats elders in trials, during imprisonment, and on death row", *Behavioral Sciences & the Law*, Vol. 25 No. 5, pp. 677-99.

Goetting, A. (1984), "The elderly in prison: a profile", *Criminal Justice Review*, Vol. 9 No. 14, pp. 14-24.

Grant, A. (1999), "Elderly Inmates: Issues for Australia", *Trends & Issues in Crime & Criminal Justice*, Vol. 115, pp. 1-6.

Guerino, P., Harrison, P. and Sabol, W. (2011), "US Department of Justice, Bureau of Justice Statistics", Prisoners in 2010, available at: http://bjs.ojp.usdoj.gov/content/pub/pdf/p10.pdf (accessed January 6, 2013).

Hale, L. and Swiggum, C. (2011), "Older prisoners pose new challenges for Canada's prisons", *UBC Journalism News Service*, March, available at: http://thethunderbird.ca/2011/03/31/older-prisoners-pose-new-challenges-for-canadas-correctional-service/ (accessed October 1, 2011).

Harrison, M.T. (2006), "True Grit: an innovative structured living program for elderly inmates", *Corrections Today*, Vol. 68 No. 7, pp. 46-9.

Harrison, M.T. (2011), "A promising practice – True Grit: a structured living program for older adults in prison", paper presented at the Public Forum Aging Prisoners: A Crisis in Need of Intervention, Fordham University, New York, NY, November.

Harrison, M.T. and Benedetti, J. (2009), "Comprehensive geriatric programs in a time of shrinking resources: true grit revisited", *Corrections Today*, Vol. 71 No. 5, pp. 44-7.

Harrison, M.T. and DeFrancesco, D. (2010), *STOP – Sexual Treatment of Offenders in Prison: A Multiphase Cognitive-Behavioral Treatment Protocol for Sexual Offenders*, National Institute of Corrections Information Center, US Department of Justice, Aurora, CO.

Harrison, M.T., Kopera-Frye, K. and Harrison, W.O. (2012), "A promising practice – true grit: a structured living program for older adults in prison", in Maschi, T., Morrissey, M., Immagieron, R. and Sutfin, S. (Eds), *Aging*

*Prisoners: A Crisis in Need of Intervention*, New York, NY, pp. 99-109, available at: https://sites.google.com/site/betheevidenceproject/white-paper-agingprisoner-forum (accessed May 9, 2012).

Higgins, D. and Severson, M.E. (2009), "Community reentry and older adult offenders: redefining social work roles", *Journal of Gerontological Social Work Roles*, Vol. 52 No. 8, pp. 784-802.

Human Rights Watch (2012), "Old behind bars: the aging prison population in the United States", available at: www.Human Rights Watch.org/reports/2012/01/27/old-behind-bars (accessed January 6, 2013).

James, D.J. and Glaze, L.E. (2006), *Mental Health Problems of Prison and Jail Inmates (NCJ Publication No. 213600)*, Department of Justice, Rockville, MD.

La Vigne, N.G. and Cowan, J. (2005), *Mapping Prisoner Reentry: An Action Research Guidebook*, Urban Institute, Justice Policy Center, New York, NY.

Livingston, A. (2010), *A Brief Description of Age Characteristics of Select Populations*, Statistics and Planning Section, Nevada Department of Corrections, Carson City, NV.

Loeb, S.J., Steffensmeier, D. and Lawrence, F. (2008), "Comparing incarcerated and community – dwelling older men's health", *Western Journal of Nursing Research*, Vol. 30 No. 2, pp. 234-49.

Maschi, T. (2010), *Personal and Professional Contact Survey*, Be the Evidence Project, Fordham University, New York, NY.

Maschi, T., Suftin, S. and O'Connell, B. (2012a), "Aging, mental health, and the criminal justice system: a content analysis of the literature", *Journal of Forensic Social Work*, Vol. 2 Nos 2/3, pp. 162-85.

Maschi, T., Viola, D. and Sun, F. (2012b), "The high cost of the international aging prisoner crisis: well-being as the common denominator for action", *The Gerontologist*, October 4, doi 10.1093/geront/gns12.

Maschi, T., Kwak, J., Ko, E.J. and Morrissey, M. (2012c), "Forget me not: dementia in prisons", *The Gerontologist*, Vol. 52 No. 4, pp. 441-51.

Maschi, T., Morrissey, M., Immagieron, R. and Sutfin, S. (2012d), "Aging prisoners: a crisis in need of intervention", New York, NY, available at: https://sites.google.com/site/betheevidenceproject/white-paper-agingprisonerforum (accessed May 9, 2012).

Maschi, T., Viola, D. and Morgen, K. (2013a), "Trauma and coping among older adults in prison: linking empirical evidence to practice", *Gerontologist*, doi: 10.1093/geront/gnt069.

Maschi, T., Viola, D., Morgen, K. and Koskinen, L. (2013b), "Trauma, stress, grief, loss, and separation among older adults in prison: the protective role of coping resources on physical and mental wellbeing", *Journal of Crime and Justice*, DOI 10.1080/0735648X.2013.808853.

Mesurier, R. (2011), "Supporting older people in prison: ideas for practice", available at: www.ageuk.org.uk/documents/en-gb/for-professionals/government-and-society/older%20prisoners%20guide_pro.pdf?dtrk=true (accessed September 1, 2011).

Ministry of Justice (2010), *Offender Management Caseload Statistics 2009*, Ministry of Justice, London, available at: www.justice.gov.uk/publications/statistics-and-data/prisons-and- probation/omcs-annual.htm (accessed September 28, 2011).

Mumola, C. and Karberg, J. (2006), *Drug Use and Dependence, State and Federal Prisoners, 2004*, Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice, Washington, DC.

Noonan, M.E. and Mumola, C.J. (2007), *Veterans in State and Federal Prison, 2004*, Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice, Washington, DC.

Nunez-Neto, B. (2008), "Offender reentry: correctional statistics, reintegration into the community, and recidivism: a CRS report for congress", available at: http://lieberman.senate.gov/assets/pdf/crs/offenderreentry.pdf (accessed January 6, 2013).

Organization for Economic Co-Operation and Development (2010), "Factbook", available at: www.oecdlibrary.org/economics/oecd-factbook-2010_factbook-2010-en (accessed January 6, 2013).

Pager, D. (2006), "Reaction essay", *Criminology and Public Policy*, Vol. 5 No. 3, pp. 505-14.

Pew Charitable Trusts (2010), *Collateral Costs: Incarceration's Effect on Economic Mobility*, Pew Charitable Trusts, Washington, DC.

Rubin, S. (2009), *Autumn LEAVES: Aging, with and without Dementia*, SER Publishing, Reno, NV.

Sabol, W.J. and Couture, H. (2008), *Prison Inmates at Midyear 2007*, U.S. Department of Justice, Rockville, MD, pp. 1-24.

Sampson, R.J. and Laub, J.H. (2003), "Life-course disasters? Trajectories of crime among delinquent boys followed to age 70", *Criminology*, Vol. 41 No. 3, pp. 555-92.

Sapers, H. (2008), "Speaking notes for Mr. Howard Sapers, correctional investigator of Canada", from the Office of the Correctional Investigator, February 4, available at: www.oci-bec.gc.ca/comm/sp-all/sp-all20080204-eng.aspx (accessed October 1, 2011).

Snyder, C., Van Wormer, K. and Chadha, J. (2009), "Older adult inmates: the challenges for social work", *Social Work*, Vol. 54 No. 2, pp. 117-24.

Stojkovic, S. (2007), "Elderly prisoners: a growing and forgotten group within correctional systems vulnerable to elder abuse", *Journal of Elder Abuse and Neglect*, Vol. 19 Nos 3/4, pp. 97-117.

Thivierge-Rikard, V. and Thompson, M.S. (2007), "The association between aging inmate housing management models and non-geriatric health services in state correctional institutions", *Journal of Aging and Social Policy*, Vol. 19 No. 4, pp. 39-56.

United Nations (UN) (1948), *The Universal Declaration of Human Right*, United Nations, available at: www.un.org/en/documents/udhr/ (accessed January 6, 2013).

United Nations (1977), *Standard Minimum Rules for the Treatment of Prisoner*, United Nations, available at: www2.ohchr.org/english/law/treatmentprisoners.htm (accessed January 6, 2013).

United Nations (UN) (2012), "Report of the United Nations high commissioner for human right", Substantive session, July 23-27, Geneva.

United Nations Office on Drugs and Crime (UNODC) (2009), *Handbook for Prisoners with Special Needs*, UNODC, available at: www.unhcr.org/refworld/docid/4a0969d42.html (accessed January 6, 2013).

Urban Institute (2012), "Reentry roundtable series", available at: www.urban.org/projects/reentry-portfolio (accessed January 6, 2013).

US Census Bureau (2010), "US popclock projection", available at: www.census.gov/main/www/popclock.html (accessed January 6, 2013).

Western, B. (2008), *From Prison to Work: A Proposal for a National Prisoner Reentry Program*, The Brookings Institution, Washington, DC, available at: http://scholar.harvard.edu/brucewestern/files/12_prison_to_work_western.pdf (accessed January 6, 2013).

Williams, B. and Abraldes, R. (2007), "Growing older: challenges of prison and re-entry for the elderly", in Greifinger, R. (Ed.), *Public Health Behind Bars: From Prisons to Communities*, Springer, New York, NY, pp. 56-72.

World Health Organization (2012), "Ageing and life course", available at: www.who.int/ageing/projects/elder_abuse/en/ (accessed January 6, 2013).

## About the authors

Dr Tina Maschi, PhD, LCSW, ACSW, is an Associate Professor at the Graduate School of Social Service, Fordham University. Her research and scholarly interests are at the intersection of trauma and mental health, aging, and the criminal justice system. She has over 70 peer reviewed publications mostly published life course trauma and resilience among older adults in the correctional system. She is the 2010 recipient of the Gerontological Society of American and John A. Hartford funded Geriatric Social Work Faculty Scholars Award for a study on trauma, coping resources, and well-being among older adults in prison. She is the President of the National Organization of Forensic Social Work and the Executive Director of the Fordham University "Be the Evidence Project". Dr Tina Maschi is the corresponding author and can be contacted at: tmaschi@fordham.edu

Dr Deborah Viola, PhD, is an Associate Professor and the Director, Doctoral Program, in the Department of Health Policy & Management at the New York Medical College, School of Health Sciences & Practice, and a Research Scholar at the Center for Long Term Care Research & Policy. Dr Viola is an economist whose current research includes the effects of home-delivered

meals programs among frail, isolated NYC residents; a study of the relationship between income support programs and health among children and communities; the development of medical residency training that emphasizes the non-medical determinants of health; and the long-term care needs of children with intellectual and developmental disabilities.

Dr Mary T. Harrison is a Correctional Psychologist who has developed and refined an innovative humane, humanistic, rehabilitation, and reintegration program for older adult prisoners in Nevada. She has been active in correctional programs for a number of years, specializing in substance abuse and sex offender treatment. She has published a number of articles about "True Grit," the structured living program for older adults in prison.

Dr William Harrison is Fully Trained and Board-Certified in Preventive Medicine and Public Health. He has published more than 75 articles and book chapters including such topics as medical ethics, infectious diseases, geographic and travel medicine, and geriatrics. He is currently involved with True Grit, an innovative rehabilitation and reentry program for older adult prisoners in Nevada.

Lindsay Koskinen, LMSW, is a Doctoral Student at the Graduate School of Social Service, Fordham University and a Research Assistant for the Aging in the Criminal Justice System Project. She has over ten years of experience as a licensed clinical social work and trauma treatment with children and adults.

Dr Stephanie Bellusa, PsyD, is a Recent Graduate at the Argosy University, San Francisco Bay Area campus and is completing her Post-Doctoral Training in the True Grit Program. Dr Bellusa has a wide range of clinical experience that is being utilized within True Grit as she is facilitating several rehabilitation programs with geriatric and justice involved prisoners as well as conducting weekly individual psychotherapy sessions.

To purchase reprints of this article please e-mail: reprints@emeraldinsight.com
Or visit our web site for further details: www.emeraldinsight.com/reprints