Health Self-management Among Older Prisoners: Current Understandings and Directions for Policy, Practice, and Research

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ABSTRACT
The population of aging prisoners has increased significantly over the past several decades, resulting in concerns about the criminal justice system’s ability to address the needs of prisoners and parolees with chronic health conditions. This is troubling, given the health disparities among incarcerated populations. Health self-management has become a strategy within the community-based health care industry to improve health services and outcomes while reducing health care costs for nonincarcerated individuals with chronic conditions. However, to date little research has focused on the practice or promotion of health self-management among current and former incarcerated populations. This article highlights current understandings about chronic health self-management among older prisoners and parolees, with an emphasis on the potential benefits and current challenges in promoting their health self-management practices. Finally, specific recommendations are made for promoting health self-management for these populations through social work practice, policy advocacy, and research to achieve goals in improving health outcomes and reducing healthcare costs.

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Over the past several decades, the general aging of the U.S. prison population has raised concerns about the American correctional system’s ability to address the medical needs for the increasing number of prisoners with chronic conditions. Among nonincarcerated populations, there has been a general movement in the health and long-term care systems to promote patients’ ability to self-manage their chronic conditions, such as diabetes, heart disease, HIV/AIDS, and disabilities (Ruggiano & Edvardsson, 2013). Health self-management promotion is associated with improved physical and mental health outcomes, as well as health care cost savings (Lorig, Ritter, Laurent, & Plant, 2006), though little is known about prisoners’ experience with health self-management. This article analyzes current policy, practice,
and research pertaining to health self-management among prisoners. Implications and future directions for social work will be discussed.

The growing need for chronic care among prisoners

Chronic care for U.S. prisoners has become an increasing concern, mainly fueled by the growth and aging of the prison population. Many factors contribute to the rise in prison populations, such as the overall increase in our country’s population after World War II when the baby boomer generation was established (Yamamoto, 2009). Criminal justice trends also contribute to increases in the older inmate population, such as increases in first-time aging offenders, the elimination of parole, increased sentence lengths, and mandatory minimum sentencing (Office of the Inspector General, 2015). For instance, between 1992 and 2003 there was an 83% increase in the number of inmates serving life sentences (Gross, 2007). As a result of these trends, a growing number of prisoners are experiencing chronic conditions that are normally associated with age, such as vision and hearing problems, arthritis, hypertension, diabetes, digestive disorders, and heart disease (Loeb, Steffensmeier, & Lawrence, 2008; Wilper et al., 2009). In addition, inmates generally are 5 to 10 years older physiologically than persons of the same chronological age who are not in prison, often due to substance abuse, the stress of prison life, lack of appropriate health care services, and transmission of diseases within prisons (Aday, 2003). Older prisoners also have an increased risk for most chronic conditions, compared to the overall population (Anno, Graham, Lawrence, & Shansky, 2004; Binswanger, Krueger, & Steiner, 2009; Linder, 2014).

Sterns and colleagues (2008) report that when compared to their nonincarcerated counterparts, prisoners aged 65 and older are more likely to report having at least one disability and attribute such disparities to issues such as lower socioeconomic status, lower levels of education, greater instances of substance abuse, and limited access to health care during their younger years. Reporting the average incident rate found across numerous studies, Aday (2006) found a number of chronic conditions experienced by aging inmates, including arthritis (41%), menopause problems (33%), heart disease (26%), emphysema (20%), prostate problems (18%), diabetes (12%), stroke (8%), and cancer (6%). Such conditions are also prevalent to older prisoners postrelease, with Williams and colleagues (2010) reporting high rates of hypertension (51.8%), arthritis (43.6%), heart problems (34.1%), and disability (30.7%) among a sample of older prisoners awaiting release. As a result, older inmates may have a variety of specialized health and disability-related needs compared to their younger counterparts, including: facilities, recreational activities, and work assignments that accommodate physical disabilities; expensive medications and medical care; increased supervision due to Alzheimer’s
disease and other forms of dementia; special diets; and supportive aids for disability, such as walkers, glasses, and Velcro clothing (Ornduff, 1996).

Prisoners’ rights to medical treatment

The U.S. Supreme Court has repeatedly held that correctional agencies must provide adequate health care for inmates. The Eighth Amendment of the U.S. Constitution protects citizens against cruel and unusual punishment and the courts have held that the Eighth Amendment mandates that correctional institutions provide reasonable health care to its inmates. In Estelle v. Gamble (1976), the U.S. Supreme Court concluded that “deliberate indifference to serious medical needs” was the “unnecessary and wanton infliction of pain, (par 12)” and thereby violated the Eighth Amendment. The Court ruled that prisoners were entitled to: (a) access to care for diagnosis and treatment, (b) a professional medical judgment, and (c) administration of the treatment prescribed by the physician. In 1998, the U.S. Supreme Court also ruled that the American’s with Disabilities Act (ADA) applies in the prison context and that prisoners are entitled to reasonable accommodations for their disabilities under Title II of the ADA (Griefinger, 2012). The ADA mandates that disabled inmates should be given equal access to facilities, equal participation in programs and proceedings, and to accommodations within a facility. Older prisoners are not necessarily disabled, but because they are more likely to be disabled, to become disabled, or to develop conditions that require special accommodation, disability legislation is important when determining whether their rights are being violated.

Although it is clear that inmates retain the right to adequate medical care, the courts have been reluctant to clarify issues of adequacy (Linder, 2014). Further, as stated in the Estelle case, the courts have held that Eighth Amendment violations regarding health care can happen only in limited circumstances. To be successful in litigation, the prisoner must establish (a) the presence of a serious medical need and (b) the prison administration’s deliberate indifference to such need. Although numerous court cases have attempted to more clearly specify the standards of inmates’ constitutional right to health care, considerable ambiguity still exists, especially as it pertains to the rights of aging prisoners.

Health self-management in chronic care

One issue related to prisoners’ medical care is their ability to engage in health self-management. Among the noninstitutionalized population, there has been a growing shift in health care away from a paternalistic model where providers assume primary control and responsibility over patient care to one that promotes patients’ involvement in the decision making and management of their condition (Hughes, Bamford, & May, 2008). This has resulted in a
growing interest in patient chronic health self-management, which refers to the “day to day tasks that individuals must undertake to control or reduce the impact of disease on physical health status” (Clark et al., 1991, p. 5) and may involve a number of psychosocial and behavioral tasks, such as problem solving, decision-making, researching, forming partnerships with healthcare providers, and taking action (Lorig & Holman, 2003).

It is unclear whether the legal definition of access to treatment includes the prisoner’s right to self-manage chronic health conditions or disabilities and to date, little research has focused on the experiences of aging prisoners with health self-management. In their study of older prisoners, Loeb and Steffensmeier (2006) found that almost two-thirds of respondents were very confident in their ability to manage their health during their current incarceration and about the same number were confident about their ability to manage their health concerns after their release. The same study indicated that respondents who reported greater self-efficacy in health self-management were more likely to report pro-health behaviors, which suggests that health self-management interventions may lead to prisoners taking a more active and positive role in managing their care. However, such a conclusion requires further investigation given the limitations to their study, including the small sample size (\(N = 51\)), use of modified and newly constructed measures, and self-efficacy was measured based on participants’ confidence in engaging in self-management behaviors, rather than actual ability to self-manage. In fact, 41% of the sample indicated a decline in their condition since being incarcerated.

Health self-management programs may involve health literacy education, support in decision-making about health, and/or skills development in pro-health behaviors. Among non-incarcerated older adults, studies have identified a number of benefits of health self-management programs, including better health outcomes (Lachman, 2006), improved clinical outcomes for specific conditions (see review by Chodosh et al., 2005), increased likelihood of receiving health screenings (Kfahana et al., 2010), and greater likelihood to receive diagnoses and/or needed health services (Kahana et al., 2011). The growing prevalence of chronic conditions, the high healthcare costs associated with these conditions, and the benefits of evidence-based self-management interventions have resulted in the Institute of Medicine identifying health self-management as a priority area for improving healthcare quality (Adams & Corrigan, 2003).

**The role of social work in health self-management**

The concept and principles of health self-management align well with a number of social work professional tenets. For instance, health self-management contributes to social work’s ethical principle of *dignity and worth of the person* (National Association of Social Workers [NASW],
by promoting patients’ responsible and informed self-determination and enhancing their ability to address their own chronic care needs. Health self-management also promotes the importance of human relationships, by helping patients develop better relationships with their providers and family members for the purpose of chronic care (NASW, 2008). Indeed, health self-management commonly involves social workers (Enguidanos, Coulourides Kogan, Keefe, Geron, & Katz, 2011; Faul et al., 2009). In fact, in the case of kidney dialysis, federal law mandates that a Master’s-level social worker be available at all U.S. dialysis centers and kidney transplant centers to provide support with health self-management issues (Browne, 2012).

Promoting health self-management among prisoners

Given the established benefits of health self-management promotion among nonincarcerated populations, there is a potential for cost savings and improved health outcomes for prisoners by facilitating their ability to self-manage their chronic care needs during and after their incarceration. To promote the health of prisoners, a number of programs have been implemented that address issues of health self-management for prisoners with chronic conditions. One example has been the True Grit program, which was founded in Nevada in 2004. True Grit was designed to address the physical, mental, emotional, and spiritual needs of elderly and infirmed inmates housed in the Northern Nevada Correctional Center (NNCC). The program promotes structured living where prisoners engage in activity and aims for overall better health rather than a hospice model of care (Harrison, 2006); its rules and regulations were designed to “empower elderly inmates to live as healthfully as possible” (Harrison & Benedetti, 2009, p. 45). Following the principles of chronic health self-management, True Grit supports older inmates’ ability to make positive contributions towards their own health (Harrison & Benedetti, 2009) through programs such as pedometer and wheelchair basketball programs to encourage and accommodate physical exercise and structured crafting activities to help with arthritis (Harrison, 2006). Although findings are based on descriptive data and more statistical analyses are needed to fully assess outcomes of the program for participants, True Grit has been attributed to a decline in infirmary visits by elderly inmates, an increase in the general feelings of well-being by participants, and a growth in social support among elderly participants (Harrison, 2006).

Not specific to aging inmates, another program that promotes health self-management is Project Wall Talk, a community-based, peer-led, HIV/AIDS prevention education program implemented in 36 Texas state prison units (Ross, Harzke, Scott, McCann, & Kelley, 2006). The program provides intensive 40-hr trainings to peer educators on HIV education, who upon completion would provide peer support and education to other inmates. In
2004, 590 inmates were trained as peer-educators and 2,506 additional inmates received peer education. Follow-up data of peer-students revealed that: knowledge about HIV/AIDS improved among participants; students sought information about HIV/AIDS outside of the classroom setting; and more participants received HIV tests, compared to a comparison group (Ross et al., 2006). Project Wall Talk follows the principles of health self-management by empowering prisoners with knowledge needed to assess their risk, engage in pro-health behaviors, and seek out needed health screenings.

Also not specific to older inmates, in 2009 the Federal Bureau of Prisons started to distribute self-monitoring blood glucose meters to diabetic prisoners who were insulin-dependent (Buskey, Mathieson, Leafman, & Feinglos, 2015). Ideally, distributing blood glucose monitors may promote health self-management by providing the diabetic prisoner with health-related information (blood glucose) that can be used to modify behaviors in an effort to avoid hyperglycemia or hypoglycemia. Unfortunately, Buskey et al. (2015) reported mixed results of the program’s effects on participants’ HbA1c blood glucose levels, and suggested that this was due to environmental constraints on self-management strategies and limited health education offered to prisoners. For instance, because prisoners have dietary, exercise, and health services restrictions while incarcerated, they are limited in the pro-health behaviors they may need to engage in to adjust their blood sugar.

**Barriers to health self-management for prisoners**

**Barriers stemming from prisoners**

Prisoners may be at a disadvantage when managing their chronic care, due to limits in their human and social capital. For instance, lack of social support (Gallant, 2003) and low educational attainment (Clark et al., 2008) may complicate one’s ability to self-manage health. Prisoners are disproportionately drawn from groups that have the poorest health status in free society, such as low-income urban minorities (Marquart, Merianos, Hebert, & Carroll, 1997). Prisoners are also more likely to have engaged in risky health behaviors, such as drug and alcohol use (Anno et al., 2004; Marquart et al., 1997; Maruschak & Beck, 2001) and the health status of older inmates is far worse than that of the general inmate population (Auerhahn, 2002; Fazel, Hope, O’Donnell, Piper, & Jacoby, 2001).

Given the disadvantaged background of many inmates, the incidence of health problems among older inmates appears to be higher, compared with the health needs of older adult populations at large (Anno et al., 2004; Binswanger et al., 2009; Fazel et al., 2001). In addition, processes prior to incarceration such as arrest, arraignment, trial, conviction, and sentencing
are likely to produce a high level of anxiety in the older adults, with outcomes that may be very detrimental to their health. In their small ($N = 23$), qualitative study, Marquart and colleagues (2000) found that the majority of the participants reported excellent or good health while on the streets in the years before their incarceration, but now reported declining health as inmates in prison facilities. A critical factor in their worsening health was found to be a lack of preventive care while in wider society. In the same study, health care providers agreed that the lack of preventive care had implications for correctional health care. Most of the inmates smoked, had poor diets, and had little or no routine or preventive medical care. Also, those who did see a physician tended to be noncompliant with the doctor’s instructions.

Loeb et al. (2008) explored the most commonly reported perceived barriers to health behaviors among older male prison inmates and a community-dwelling sample of older men. Only 20% of the older inmates reported no barriers to health behaviors, compared to 52% of community-dwelling older men. The most commonly perceived barrier to health behaviors in the inmate group was “didn’t know that any programs or screenings were available” (Loeb et al., 2008, p. 242), in contrast to a lack of interest for the community-dwelling participants. In addition, inmates also attended fewer health promotion programs than men in the community. This lack of awareness regarding programs is concerning, but overall may reflect a shortage or absence of health programs in general, rather than a specific lack of knowledge or communication about actual available programs.

**Environmental barriers within the correctional system**

Prisons have several purposes. Among these are separation from society and confinement for the safety of society, punishment for crime, and correction and rehabilitation to the community (Watson, Stimpson, & Hostick, 2004). Prisons are not, primarily, concerned with the health of the prison population and, indeed, “the need for security and discipline can cut across the perception of individuals (prisoners) as patients” (Her Majesty’s Inspector of Prisons, 1996, p. 1). Overall, incarceration results in aging in place, challenges to self-care abilities, and the possibility that prisoners will leave prison with serious health problems (Beckett, Peternelj-Taylor, & Johnson, 2003). However, Trotter and Baidawi (2015) emphasized that potential health/disability-related goals may directly conflict with goals of safety and security, citing examples where canes or walkers needed for mobility may potentially become a weapon. Prisoners may also refuse treatment if they believe that by seeking care they may be at risk of disciplinary action (National Commission on Correctional Health Care Board of Directors, 2015).

There has been criticism regarding correctional facilities’ ability to meet chronic care needs, including prisoners’ physiological/functional needs, such
as loss of mobility and strength, as well as mental and emotional needs, resulting from dementia and short-term memory loss (Aday, 2003). In a nationwide sample of correctional facilities, Wilper and colleagues (2009) found that among inmates with a persistent medical problem, 13.9% of federal inmates, 20.1% of state inmates, and 68.4% of local jail inmates did not receive a medical examination since they became incarcerated. In addition, of those inmates who were taking prescription medication at the time of their incarceration for a condition, 26.3% of those in federal prison, 28.9% of state prisoners, and 41.8% of local jail prisoners had stopped their medication regimen. The study also found that 60% of jail inmates who had conditions that normally require routine blood tests did not receive any. Hence, prisoners’ ability to self-manage health may be greatly compromised by lack of availability in services. Even when self-management programs are available, waiting lists may pose constraints on participation (Condon, Hek, & Harris, 2008).

Buskey and colleagues’ (2015) found other environmental constraints that are posed upon older prisoners that may create barriers to health self-management. For instance, dietary restrictions, such as fixed meal times, limited food choices, and inability to access food outside of dining facilities may complicate management of certain chronic conditions, such as diabetes (Buskey et al., 2015). Also, many prisons are poorly designed to meet the needs of prisoners with conditions that may limit mobility. For instance, many prisons lack wheelchair accessibility, handrails, or grab bars (Mara, 2002). In addition, a study of health-related decisions among prisoners across age groups found that many participants viewed smoking as a way of coping with prison life (Condon et al., 2008), suggesting that the stress of living in prison may thwart health self-management.

Research by Williams and colleagues (2006) examined the prevalence and nature of functional impairment in a sample of older female prisoners in California. According to their research, functional impairment qualifies as needing help with daily and prison activities such as getting to meals, hearing orders from guards, standing for count, and dropping to the floor for alarms. Overall, they found that 16% of women aged 55 and older reported needing help with one or more daily activities, about twice the rate of the general population in the U.S. over the age of 65 (Williams et al., 2006). They also found that 69% of women in their study reported needing assistance with activities unique to the prison environment and that women who needed help with daily and prison activities were more likely to report adverse experiences, including falls, feeling depressed, feeling unsafe, and physical violence. Hence, lack of support for functional needs within prison environments may lead to situations where existing medical or psychological conditions decline or new conditions develop.
**Barriers experienced post-release**

Although incarcerated people have a right to access medical care, there is no legal right to medical care for prisoners after they are released back into the community. Many prisoners go without health care after release (Wang et al., 2010), which is troubling, given one study’s findings that 80% of older prereleased prisoners reported at least one medical condition, and an average of 2.1 conditions (Williams et al., 2010). Binswanger and colleagues (2007) found that prisoners in Washington State were 12.7 times more likely to die within the 2-week period following their release, compared to their nonincarcerated counterparts. They also reported that older prisoners were more likely than those under the age of 45 to die from cardiovascular disease (the second leading cause of death after drug overdose) or cancer after release. Critics have asserted that correctional facilities may reduce inmates’ risks of certain chronic conditions by providing health services inside and outside of correctional facilities and partnering with community-based facilities (Ross et al., 2006).

Community reintegration is challenging for all inmates but particularly complicated for older prisoners (Blevins & Blowers, 2014). Recent research has documented that longer incarceration times and serious drug use histories negatively affect optimism about life after incarceration (Visher & O’Connell, 2012). This is likely to be exacerbated as most prisoners return to urban disadvantaged communities characterized by low levels of formal resources. Holistic service needs of chronically or terminally ill offenders may not be readily available in the community and the seriousness of their criminal offense may make it difficult to find housing or nursing home placement (Nowotny, Cepeda, James-Hawkins, & Boardman, 2016). Furthermore, prisoners serving long sentences may have become institutionalized, and as a result, changes in the key institutions during their absence may make it difficult to reintegrate seamlessly, and some of their work connections, family support systems, and social networks may simply not exist anymore.

**Ways forward: Overcoming barriers to health self-management for older prisoners**

**The role of social work practice**

Social workers are well-positioned to promote health self-management among older prisoners. First, social workers are often involved in the care and support of older inmates, providing services such as case management, recommendations for mercy parole, counseling services, and nursing home or hospice placement (Aday, 2006). Also, social workers may be involved with prisoners during discharge planning, which is when they may be able to identify support for health self-management during postrelease (Snyder, Van Wormer, Chadha, & Jaggers, 2009). Wheeler and Patterson (2008) emphasized the importance of
social work in addressing the health of prisoners, both during inmates’ incarceration and around the time of release, because of the significant social stressors and disadvantages that compound physical and mental health problems they experience. They argued that community-based health providers are not prepared to meet the complex needs of this stigmatized population and that social workers can play a role as part of the health care team, both pre- and postrelease, to make health care transitions more seamless.

In addition to providing and linking inmates to direct services, social workers may also help facilitate health literacy education and emotional support for coping with chronic health problems. For instance, social workers may facilitate group counseling sessions that focus on helping inmates cope with chronic health conditions, understanding how to deal with family relationships in regards to their health issues, and exploring their concerns about daily living with chronic conditions both inside and outside of the prison setting (Aday, 2006). Curd, Ohlmann, and Bush’s (2013) findings suggest that health literacy education may benefit prisoners. In their small study ($N = 87$), prisoners ($n = 50$) who participated in nutritional workshops demonstrated improved nutritional practices and improved general health overall, compared to controls ($n = 37$).

The role of policy practice

Social work’s long history of client and policy advocacy will also benefit aging prisoners with chronic conditions, given that there is little public support or awareness for the special health needs of prisoners (Snyder et al., 2009). There are a number of specific policy responses that would be beneficial for this population. For instance, in 2011 a group of experts with knowledge about and experience with prison health care, geriatrics, or palliative medicine convened to identify special considerations for the care of older prisoners and to propose a set of priority areas for a new policy agenda (Williams, Stern, Mellow, Safer, & Greifinger, 2012). Among the nine priority areas established by this roundtable, several are particularly relevant to health-related needs of prisoners, including screening for dementia, creating uniform policies for geriatric housing units, identifying release and reentry challenges for older adults, and improving medical release policies.

The role of social work research

Finally, social work researchers may play a significant role in facilitating health self-management practices among incarcerated and paroled population. Given the limited research on the topic, social work researchers must identify if and what strategies these populations may already rely on for
managing their health inside correctional facilities and within the community. Given older prisoners’ social and environmental constraints, it is assumed that their health self-management decisions and behaviors may look different than from what investigations have found in nonincarcerated populations. For instance, researchers should examine the informal social networks or unique strategies prisoners rely on to manage their health or gain health information while in prison.

There is also a significant need for research on health self-management interventions for this population. For instance, the Chronic Disease Self-management Program developed at Stanford University has demonstrated success in improving health outcomes and reducing healthcare costs for older adults with a variety of chronic conditions (Lorig et al., 2006). It is also available online and has been adapted for use with Spanish-speaking and veteran populations. Researchers should explore how such programs could be adapted to currently and formerly incarcerated populations to improve health. Also, Buskey and colleagues’ (2015) evaluation of the federal program that distributed self-monitoring blood glucose levels was able to identify specific environmental and policy-related barriers to success. Similarly, researchers should examine the implementation of policies that promote health self-management and identify ways that the structures and policies within the correctional system may safely be changed to improve outcomes of such health promotion efforts.

**Conclusion**

To date, there has been minimal research on the health self-management of older prisoners and the limited number of studies focused on the health of older prisoners has primarily involved small samples and descriptive data. Although research from the nonincarcerated population suggests that there would be health- and cost-related benefits to promoting health self-management among older prisoner populations, if and how that should be done is not fully clear. There is a moral and legal obligation for society to meet the health needs of the growing number of older prisoners. Some correctional systems have made progress in addressing the health care of their prisoners in general, though there remains ample evidence that older prisoners continue to be at risk of medical and social care neglect, lack of access to human rights, loss of relationships, and lack of age appropriate discharge planning (Maschi, Viola, Morgen, & Koskinen, 2015). Too often, correctional health care is compromised by strained resources, isolation, and pressures to conform to the punitive aspects of command control environments (Griefinger, 2012). Strategies that correctional systems are beginning to consider include developing separate geriatric prisons, use of telemedicine, and greater use of early-release mechanisms, such as compassionate release.
It is also imperative that older inmates have the opportunity to learn how to care for their medical needs before they are released from prison to ensure greater success upon reentry to general society.

To shift the mission and services of correctional health care from acute care only to health promotion will require leadership from correctional managers, public health officials, and advocacy organizations (Ramaswamy & Freudenberg, 2012). Correctional administrators and policy-makers need to integrate theory, research, and practice to develop a more holistic approach to the care of aging prisoners (Hurley, 2014; Kerbs & Jolley, 2014). Additionally, there needs to be more coordinated linkages between service providers in the prison and those who can assist the offender after their release from prison (Blevins & Blowers, 2014; Griefinger, 2012). Regardless of the strategies employed, correctional systems need to be more intentional about recognizing the unique challenges faced by aging prisoners and need to partner with those in the fields of social work, gerontology, health, and public policy to ensure that prisoners be provided with adequate and humane care.

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