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Spotlight July/August 2008 - Prison Gray

New York Tackles Inmate Dementia with Special-Needs Facility



Photos courtesy of NYDOCS

FISHKILL, N.Y. — From coast to coast and border to border, corrections officials must face the prospect of housing ever-growing numbers of older inmates and providing for their special needs.

The United States must deal with the looming reality of an en masse graying of society, as approximately 76 million baby boomers begin to

turn 65 years old. Boomers — born between the mid 1940s and mid 1960s — account for almost 30 percent of the U.S. population.

Driven predominantly by longer, tougher sentencing laws and exacerbated by the boomer effect, the proportion of elderly inmates in federal and state prisons is projected to reach its zenith during the next 10 to 20 years, experts say.

The average age of inmates and the relative proportion of elderly inmates housed in federal and state prisons have steadily increased during the last several decades. In the 1980s, inmates 50 years and older accounted for about 3 percent of the state prison population, compared to more than 10 percent in 2006.

The accommodations and burdens associated with the graying of the inmate population — from the medical to the social and the psychological to the nutritional — are myriad, complex and almost invariably costly.

“The inmate population in the state of New York is growing older, getting sicker and staying longer,” says William J. Connolly, superintendent at Fishkill state prison.

The New York Department of Correctional Services embraced the challenge of aging inmates with the development of a pilot special-needs facility at a 1,700-bed, medium-security facility, 70 miles north of New York City.

“The DOCS is constantly evolving to meet emerging challenges in corrections,” Connolly says. “This unit is unique to New York and the first of its kind anywhere in the United States. We’re in the people business and we have a duty to treat these people humanely.”



Bathroom facilities are designed for special-needs inmates.

Safe Harbor for Special Needs

Fishkill’s 30-bed Unit for the Cognitively Impaired opened in 2006 to provide a calm, comforting and safe environment for inmates. It specializes in the treatment of inmates with dementia-related conditions such as Alzheimer’s disease. The average age of inmates housed in the unit is 62 — 25 years older than the average age systemwide.

“The principle behind the unit is simple: Train staff to understand how cognitive impairment affects decision-making and behavior so they can respond to inmates’ actions accordingly and appropriately,” says Fishkill Medical Director Dr. Edward B. Sottile.

Fishkill also operates as the regional medical hub for the state prison system and the UCI occupies the entire third floor of the prison’s four-story medical center. The unit is akin to a maximum-security environment inside a medium-security prison, allowing it to accept inmates of any security classification from any facility throughout the state system.

Fishkill Regional Medical Center

The 30-bed Unit for the Cognitively Impaired was integrated into Fishkill's medical center in 2006.

The four-story medical center opened in 2001 as a DOCS regional medical hub that provides approximately 133,000 square feet of multidisciplinary medical space. It houses a central medical clinic and general examination rooms on the first floor.

The center's pharmacy, emergency and X-Ray departments, and a specialty clinic serviced by approximately 30 physicians in specialties from cardiology to oncology also occupy first-floor.

A 20-bed infirmary for Fishkill inmates is located on the second floor. The unit features 10 isolation rooms, both positive and negative pressure, and 10 post-operative recovery rooms.

The second floor also incorporates a 30-bed long-term care unit for inmates systemwide. The unit features 10 isolation beds dedicated to inmates with various conditions including cancer and lung and liver diseases.

"You need to create a safe, nonthreatening environment for cognitively impaired inmates with dementia who may still be functioning to a degree and ambulatory, but who also have potential for poor decision-making, problematic behavior and victimization in the general population setting," says Meg Boyce, director of programs and services for the Alzheimer's Association Hudson Valley Chapter.

Staff trained in cognitive impairment and dementia-related conditions are better able to recognize inmate actions as a symptom of the disease rather than an act of hostility, aggression or unruliness and are more capable of providing appropriate care for older inmates afflicted by a variety of age-related conditions, Boyce says.

The brainchild of Dr. Lester N. Wright, DOCS deputy commissioner and chief

medical officer, UCI takes an interdisciplinary approach to tackling one of the major emerging challenges facing state corrections and New York policy-makers.

Wright recognized that increasing numbers of older inmates serving longer sentences creates a growing need for long-term care and specialized facilities, and collaboration between health and security staff.

The DOCS established a task force — composed of healthcare professionals, social workers, representatives of the Office of Mental Health, corrections officials and Fishkill's deputy superintendent for health — that worked for more than 12 months to plan and develop the special unit.

"The level of care is second to none and, in terms of outside-the-box concepts for dealing with cognitively impaired inmates," Connolly says. "This type of special unit is certainly the way to go because it's cheaper, safer and smarter to provide the required level of service and care in-house."

Officials from other states have toured the facility to take a first-hand look at the unit and Fishkill's approach to managing inmates with dementia-related conditions. However, many have balked at the intensive staffing levels and operational costs.

"My response is always, 'Pay me now or pay me later,' because if you don't take care of these inmates in a dedicated unit like this, you'll pay a premium for their care in an outside healthcare facility," Connolly says.



Staff engages cognitively impaired inmates with games and activities.

Paradigm Shift

The secure facility is more Spartan and clinical than draconian and correctional in character, with the "white-walled" feel of a nursing home rather than the steel and concrete finish of a prison.

Lighting in the unit is designed to maximize brightness to elevate and stabilize mood, while a light, subdued color palette of mocha, taupe and ecru engenders a calming influence.

Inmates are free to walk around the secure unit, which also helps to reduce agitation. A fenced balcony area that allows inmates to go outside and they can exercise in a secure outdoor recreation area adjacent to the medical center.

"An inmate is sent to prison as punishment, not for punishment, so a prison doesn't have to look like a prison to serve its function," Connolly says. "From a humanitarian perspective, you don't have to remind these people that they're in jail."

In addition to Alzheimer's disease, the unit is designed to accommodate inmates with other degenerative diseases such as Huntington's and Parkinson's, which often exhibit a dementia component, and the more sudden on-set dementias that can result from cardio-vascular episodes or traumatic brain injury.

In the general population setting, dementia-related conditions and cognitive impairment often go unrecognized and undiagnosed, according to reports. Cognitively impaired inmates have great difficulty functioning in the general population due to poor decision-making and behaviors that inhibit the ability to follow instructions.



Inmates receive frequent visits from special-needs dogs trained by Fishkill inmates.

The behavior of cognitively impaired inmates can easily be misinterpreted as problematic or unruly and result in disciplinary action.

“A lot of times the actions of these inmates would be construed as bad behavior but they have no idea what they’re doing,” Sottile says.

Cognitively impaired inmates also have higher victim potential in general population settings with other inmates able to sense or see dysfunction and take advantage of

any weakness.

When confined in the general population, inmates with these types of conditions and impairments tend to stay in their cells, becoming more and more isolated as they retreat from the world around them, Connolly says.

Problems continue after release, and inmates have difficulty surviving in the real world without appropriate support networks in the community.

“We’ve experienced great difficulty in placing inmates in appropriate settings after release because of the complex multi-issue nature of their conditions,” Sottile says.

In contrast to a general population setting, the UCI focuses on the management and mitigation of behavioral problems associated with dementia-related conditions and cognitive impairments. Staff and programming strive to keep inmates as mentally stimulated and physically active as possible in order to optimize their psychological state, emotional well-being and behavior.

“Inmates with dementia-related cognitive impairment don’t make good decisions, so staff are trained to recognize, understand and deal with inmates and their behaviors,” Sottile says.

UCI inmates participate in indoor-adapted activities, art programs, bingo, board games and puzzles and have access to an audio-video library. They enjoy regular live performances by visiting musicians and also receive visits from special-needs dogs three times per week — Fishkill operates a Puppy-Behind-Bars program that allows general population inmates to train dogs for the vision-impaired, disabled veterans and children with autism.

“When they’re not occupied, their mind starts to wander; they hallucinate, become paranoid and agitated, and act out,” Boyce says. “Failure-free activities help prevent agitation, which is critical to reducing behavioral problems.”

Inmates with low levels of cognitive impairment are permitted to attend more

comprehensive service programming and workshops located on the second floor, such as computer skills, transitional services and alternatives to violence.

Case History

Inmates throughout the state are screened for placement in the 30-bed unit and are initially considered on the basis of information collected by the officials at one of the state's prisons. Criminal history is not a factor in the screening process, although an inmate's conduct during incarceration is considered.

"Many of these older inmates don't even remember their crimes," Sottile says.

During the placement/intake process, inmates are evaluated with a variety of methods and tools including IQ testing and Mini-Mental State Evaluations for recognized markers for dementia.



Many components are similar to a skilled-nursing facility.

Setting UCI parameters for inmate eligibility and appropriate levels of cognitive impairment and functionality for placement presented one of the major challenges in developing the unit and defining its objectives.

Officials decided UCI would not accommodate inmates with advanced dementia who would be more suited to a traditional nursing-home setting. Inmates with extreme behavioral problems are ineligible for placement in the unit.

The UCI program and staff take a comprehensive approach to assessing inmates from a holistic perspective for various types of dementia-related cognitive impairment.

In addition to a clinical/medical staff composed of a psychiatrist, a psychologist, a clinical social worker, two counselors, a recreational therapist, a family practitioner and 19 nurses, more than 20 correctional officers are assigned to the unit. The unit's entire team discusses every aspect of an inmate and their dementia, from the psychiatric to the medical, the correctional to the social, during weekly meetings.

"We are focused on generating specific diagnoses for inmates placed on the unit, not only regarding their dementia but also in terms of any psychiatric issues that may be present," Sottile says.

Staff also put an emphasis on the post-release placement of inmates and establishing connections with healthcare, criminal justice and support networks in

the community.

The collaborative approach is designed to yield a more comprehensive understanding of issues and problems and to generate more effective responses and solutions.

“We really stressed the importance of open communication in which staff have to discuss and agree on how to deal with inmates on the unit,” Boyce says. “It’s a team approach where corrections, nursing and medical staff are involved in managing inmate care.”

Staff Training

In 2005, during the early planning stages for the unit, Angela Maume, director of nursing at Fishkill, approached Boyce to develop a program to provide training to educate staff about conditions such as Alzheimer’s, cognitive impairments and patient behaviors and care.

“My responsibility was to provide staff with the appropriate techniques to deal with potential situations and handle characteristic behaviors,” Boyce says. “If you have good communication, you decrease behavioral problems.”

Boyce adapted an existing Alzheimer’s Association staff training program for use in Fishkill’s correctional setting to help correctional officers be better prepared to interact, understand and communicate with cognitively impaired inmates.

“Staff and other inmates in the general population setting generally don’t understand that cognitively impaired inmates are unable to control what they do or say,” Boyce says.

“Essentially, you’re retraining correctional officers to work with a completely different inmate population,” she says.

The mandatory 40-hour training program includes DVD lectures from experts in the field of cognitive disease and dysfunction. A component of the training program employs role-play exercises and mock interactions to convey essential ideas and demonstrate basic methods.

Correctional staff also toured a special-care unit in a skilled-nursing facility to observe how staffs deal with agitated, cognitively impaired patients.

The program helps staff understand conditions, recognize the linkage between inmate conditions and behaviors, and make informed judgments about how to approach and interact with inmates.

“It’s an evolving process because this kind of training or unit have never been implemented before,” says Boyce, who attends monthly progress meetings at the unit.

Rules of Engagement

Adapting to the rules of engagement of a special-needs environment where clinical objectives are as important as correctional imperatives presented perhaps the most significant challenge for corrections staff. Some officers that transferred to UCI from Fishkill's S-Block maximum-security unit were accustomed to interacting with inmates a completely different corrections environment.

In the special-needs environment of the UCI, staffs routinely interact with inmates in their rooms, dayrooms, hallways and the outdoor balcony and recreation areas — environments more conducive to inmates' emotional comfort and psychological well-being than staff safety and security.

At a tangible level, a number of the older, cognitively impaired inmates had difficulty moving around freely because of the weight of the traditional security doors incorporated into the unit.

Unit staff and DOCS officials also had to contend with general population inmates faking dementia symptoms in order to serve their sentence in a more appealing, safer and comfortable environment.

The management and care of sundowners — those who become active in the evening and during night time hours — also presented some operational problems uncommon to the correctional setting.

Initially there was a blurred area for corrections staff in terms of appropriate interactions with cognitively impaired inmates and standard corrections protocols of inmate and facility management.

There was a question of whether cognitively impaired inmates should be put in lock-down for problematic behavior, when five minutes later they might not even remember the incident, Boyce says.

Conducting traditional head counts proved impractical with cognitively impaired inmates suffering from poor concentration or confabulation. Being in close proximity to inmates and having to sometimes get their attention via touch represented a difficult adjustment for officers accustomed to facing down problematic inmates or filling out a report with every physical interaction.

"Normally correctional officers are taught not to retreat from a situation but rather to get up in the face of inmates who are being difficult, unruly or acting out," Connolly says. "Here, contact comes with the territory."

Training for UCI assignment — in New York state correctional officers are allowed to bid for job assignments — is focused on understanding behaviors and communicating with inmates so staff will pause to assess situations in the context of cognitive impairment before acting.

"The officers on this unit wanted to be involved with this program and chose to work with inmates with these types of issues." Connolly says. "You can train and

educate all you like, but you can't instill decency, and these guys have it in spades."