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Older Inmates' Pursuit of Good Health: A Focus Group Study

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Abstract

A multitude of intersecting factors including the graying of the broader society, a paradigm shift away from rehabilitation, fewer opportunities for parole, and retrospective prosecutions contribute to an exponential increase in number of geriatric inmates. Elderly prisoners are likely to live in small tight quarters with other inmates, have two or more chronic health conditions, and encounter multiple barriers impeding health promotion while incarcerated. The purpose of this study was to identify perceived challenges to the health of older male inmates and to explore their self-care strategies. Focus group methodology was used. Data were collected from 42 male inmates age 50 and over who were aging in place and living with comorbidity. Cost issues, prison personnel and policies, food concerns, fellow inmates, and personal barriers all challenged older inmates' abilities to maintain their health in prison. However, these older inmates engaged in a variety of self-care strategies, including: accessing resources and support; staying positive; managing diet and weight; engaging in physical activity; and protecting self. A key motivator for pursuing good health was to be respected and perceived as healthy and strong by fellow inmates. Looking to the future, development and testing of programs to enhance inmates' self-management of chronic conditions and to facilitate health promotion are in order.

The cohort of geriatric inmates are special needs offenders (Wright & Bronstein, 2007; Rikard & Rosenberg, 2007) that are growing exponentially. At the end of 2008, there were 158,600 inmates age 50 and older in state and federal prisons in the US; accounting for 10–11% of the total inmate population (Bureau of Justice Statistics, 2009). However, by 2030 it is estimated that inmates age 50 and older will account for approximately one third of the U.S. prison population (Enders, Paterniti, & Meyers, 2005). The shift toward an older prison population has been accurately described in the subtitle of Aday's (2003) book as *A Crisis in American Corrections*. This group is particularly vulnerable if one considers that society tends to devalue older adults in general and even more so older inmates (Wahidin & Aday, 2005).

Since older inmates typically have two or more chronic health conditions (Loeb & Steffensmeier, 2006), chronic disease management is a major day-to-day effort (Stojkovic, 2007) that leads to consumption of considerably more health care resources than used by younger inmates. This high utilization of costly health resources contributes to ever growing strains on already stretched budgets of correctional systems in the United States (US)

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(Feldmeyer & Steffensmeier, 2007; Sterns, Lax, Sed, Keohane, & Sterns, 2008). Researchers who conducted a national survey of prison facilities and services for older inmates suggest that the demographic shift toward an older inmate population may require a twentyfold increase in prison medical services within the next decade (Sterns et al.). The phenomenon of an aging prison population is not limited to the US, but in fact is being experienced similarly in the United Kingdom (UK) (Carlisle, 2006; Fazel, Hope, O'Donnell, & Jacoby, 2004) and throughout the world (D'Souza, Butler, & Petrovsky 2005; Fazel & Grann 2002; Gallagher 2001; McGrath 2002).

Reports in the research literature and mass media alike acknowledge how impoverished lives, inadequate healthcare prior to incarceration, histories of drug and/or alcohol abuse, and the general stress of prison life contribute to premature aging among inmates (Green, 2009; Sterns et al., 2008). In fact, 50 is the most commonly used lower limit age criterion when referring to older inmates (Loeb & AbuDagga, 2006; Stojkovic, 2007). In this paper we present data collected from late 2007 to mid-2008 through six focus group (FG) discussions (and one individual interview) with 42 men age 50 and older who were incarcerated at either a medium or a close (designation between medium and maximum) security state correctional institution in a Mid-Atlantic US state. Strategies used by these older inmates to manage their health, as well as challenges to their health management efforts are examined.

Background

Although there is a scarcity of research on the topics of older inmate health behaviors and barriers to their pursuit of health, key observations from the available extant literature follow. Loeb, Steffensmeier, and Myco's (2007) survey study of 51 older inmates found that health programming interests included a desire for: age appropriate exercise classes; information on medications and specific diseases; and healthy diets. Some similar findings emerged from semi-structured interviews with English and Welsh inmates (Condon, Hek, & Harris, 2008). For those who wished to eat low fat, high fiber, and low sugar foods, the opportunity to do so varied widely across 12 prison settings. Older inmate participants were particularly distressed with their inability to access healthy food and worried about the long term effects of a poor diet (Condon et al.). Despite concerns regarding availability of healthy foods by some, the majority of participants reported accessing the canteen (store parallel to US prison commissary) to purchase fizzy drinks (sodas), crisps (potato chips), and chocolate bars. Older inmates also were described as being disadvantaged in regard to opportunities for exercise. Last, Condon and colleagues report that older inmates expressed a need for more accessible smoking cessation programs and non-smokers expressed concerns regarding exposure to second-hand smoke.

Risk of violence and actual violence, along with social isolation from and loss of family and friends may add to inmates' mental anguish and stress, all of which can impact health. Older inmates are also at risk for suffering from more indignities, neglect, and abuse than do other groups within prison (Stojkovic, 2007). Distrust of prison health care providers occurs; specifically perceptions on the part of inmates that correctional medical personnel are not acting with their patients' best interests at heart (Tillman, 2000). If confidence in the quality of correctional health-care is lacking, (Stojkovic, 2007) older inmates may then question diagnoses and treatment regimens, thus putting their health further in jeopardy.

Rationale for This Study

Despite the commonly acknowledged health disparities experienced by older inmates, we still know little about the specific health choices that older inmates make while in prison and thusly their health promotion needs. Condon and colleagues (2008) attribute this gap in

knowledge regarding inmates' health practices and health promotion needs to the limited number of qualitative studies conducted in correctional settings. This assessment is confirmed by Patenaude (2004) who reports that anthropological journals offer little in the way of firsthand experiences of prison inmates and that the criminology literature is predominantly quantitative.

Caraher, Dixon, Hayton, Carr-Hill, McGough, and Bird (2002) point to an exigent need to address important health issues of inmates and the broader determinants that affect their health. The inmate perspective is one that is imprudent to overlook, because inmates are well able to express their needs and experiences. In fact, Stojkovic (2007) asserts that we need to learn more about older prisoners experiences (e.g., in regard to health care) during incarceration. As Loeb and colleagues (2007) found in a study of older male prisoners' health beliefs and concerns for the future, the words of older inmates reveal successful strategies within the confines of prison. As well, the older inmates can elucidate the barriers and challenges encountered when attempting to promote their health and better manage their chronic health conditions within the context of prison. Increased knowledge regarding health program needs and barriers to health promotion allow us to achieve what Sterns and colleagues (2008) describe as the most crucial step toward stemming the tide of ever growing needs for health resources. Controlling health resource demand should lessen the burden on the prison health care system and the taxpaying public. Finally, since approximately 98% of inmates are eventually paroled or max out on their sentences and reenter the broader community (Ruddell & Tomita, 2005), their health impacts the health of their friends, families, and the broader community where they eventually settle (Loeb, 2009). Therefore, the aim of this study was to give voice to older inmates through FG discussions in order to identify (a) barriers that challenged their pursuit of good health and (b) self-care strategies used by older inmates to manage their health in prison.

Method

Design and Sample

The research reported here is the second phase (i.e., the focus group [FG] phase) of a broader two-phase study of factors influencing the health-promotion behaviors of older male inmates. FG methodology (Morgan, 1997) was selected because it enables an exploration of the daily challenges of health management in a prison setting from the perspective of older inmates who are aging in place with chronic health conditions. A wide range of experiences and feelings can be elicited efficiently, while allowing for a sharing of experiences that may uncover nuances of behaviors (Morgan, 1997). Researchers have found FGs are particularly valuable for understanding the collective experience of marginalized groups (Pollack, 2003).

A purposive sample of 42 male state prison inmates age 50 and older (range 50–68) were recruited to participate in this study. Inclusion criteria were: indicated during participation in prior research (conducted by these researchers) that they were interested in taking part in a FG discussion about managing their health in prison; reported two or more chronic health conditions; were incarcerated continuously for at least the past five years; spoke and understood English; and had adequate hearing to participate in a FG discussion. Those who were sentenced to life (because our long-term research goal is to promote the return of older inmates to the community in improved states of health) or death, or had behaviors or security infractions that resulted in them being in restrictive housing or having other limitations on privileges were excluded from participation.

Data Collection and Analysis

Institutional Review Board approval was obtained from the university where the researchers are employed and Research and Evaluation Committee approval was obtained from the state Department of Corrections. All participants received oral and written descriptions of the research and provided signed informed consent to participate in the FG study. FG size ranged from 6–8 participants in six of the seven sessions. One session had only one participant despite having two inmates attend and consent to participate--one was called away to the infirmary. The remaining participant was advised that he should not feel obligated to stay but he elected to meet with the researchers and respond to the focus group questions.

FGs were held in education rooms at the two prisons and were moderated by the first author, co-moderated by the second author, and written field notes were taken by a trained research assistant (audio recording was prohibited). A structured discussion guide (see Table 1 for questions posed) was used to maintain consistency across groups. FG sessions lasted for approximately 90 minutes each and continued to be scheduled until additional sessions ceased to increase understanding or provide new information on the topics of interest (Glaser & Strauss, 1967; Krueger, 1998). In addition to the written field notes, debriefing meetings among the research team were audio taped immediately after each session to provide insights. All field notes were transcribed verbatim by the research assistant who served as the note taker during the FGs. The accuracy of the transcript was later verified by a second research assistant who compared the field notes to the transcript.

The principal investigator and two trained research assistants met regularly as a team to analyze the FG transcripts through content analysis (Morse & Field, 1995) to develop a categorical schema of the discrete strategies used by these older male inmates to manage their health. In addition, challenges to their health management efforts were examined. First, each team member independently completed first-level coding of the transcripts. Next, during team meetings the individual codes were compared and contrasted in order to develop a coherent coding scheme. Through team analysis the number of categories was collapsed and category names were refined to best reflect what the older inmate participants had reported. After the categorization was fully developed, the transcripts were again analyzed by the team of three for the goodness of fit between the data and arrived upon categorizations. All categories were mutually exclusive with each unit of content assigned to only one category (Waltz, Strickland, & Lenz, 2005). As well, no negative units of content were discarded in the process. The team reached consensus on all categories. Final transcripts were cleaned of identifiers and stored in a locked file cabinet separate from the signed informed consents.

Findings/Results

Analysis of Demographic Data

The mean age of participants was nearly 56 years. Although the Department of Corrections data base classified all selected participants as being either White or Black, over 17% self-identified as being either of mixed race or American Indian, with 45% self-identifying as White and 37.5% self-identifying as Black. The most frequently reported marital status was divorced and the highest frequency for educational level was completion of high school or a general equivalency diploma. On average, inmates had been incarcerated for 12.5 years. See Table 2 for more detailed demographic information.

Overall Gestalt of Qualitative Findings

The older inmates who participated in this study reported perceptions of how their health had changed during their five or more years in prison. During the focus group discussions, examples of health losses, improvements, and maintenance of capabilities emerged from this group of men who were aging in place within the restrictive confines of a state correctional institution and simultaneously managing two or more chronic health conditions. Deteriorations in health were the most commonly reported change and evidenced in descriptions of health "going downhill," being less active since being "locked up," and negative health events such as having a heart attack. Health improvements during incarceration included getting blood pressure under control, integrating exercise as a part of one's life, eating better, and getting away from drugs and alcohol. Stable body weight and an ongoing ability to engage in sports were offered as evidence that their health had not changed much while in prison and indicated by reports that "jail preserves you" and "I'd imagine it's [my health is] about the same." Findings regarding the connection between incarceration and health are hard for inmates to sort out since many do not have a comparison point to health changes with increasing age outside of prison. Regardless, our attention focuses on what we can address, which is barriers and challenges to health in prison and self-care strategies to promote health.

Challenges to Health in Prison

Five categories of challenges were encountered that made it difficult for older inmates to maintain their health in prison. These challenges are: cost/money issues; prison personnel and policies; food concerns; fellow inmates; and personal challenges. In addition, barriers to information access and use are presented.

Cost/money issues—The cost of "medical keeps going up" summed up a group of issues including: a report by inmates that "multivitamins are about $13.00 a bottle" a considerable expense for men who are "economically strapped." Additional examples were the $1.20 cost per page to have medical records photocopied; and the $5.00 copay for sick call. An insightful assessment was "initiation of copays was to get rid of the malingering and have the providers focus on real health care issues, [the copay] has gotten rid of the goldbrickers [slackers attempting to avoid work] but they [older inmates] have not reaped the benefit of this in increased attention to their problems." One older inmate felt the added copay charge "…will keep someone who is hurting from getting care," while another participant similarly stated, "I don't bother going to medical because of the charge. I'll just ride it out." The lack of affordable options for smoking cessation was communicated when an inmate posed the question, "Who can afford $115.00 for [nicotine] patches?" and went on to share "there is no gum or lozenges or anything."

Prison personnel and policies—Health-related challenges extending beyond the financial were evident in the statement, "It's more than just money deterring people from sick call. I have complaints but they don't hear all of my complaints…they just give you medicine when there are tests that should be done." Other personnel related challenges included assigning "people in the dorm that don't get on"; putting a "higher percentage of older guys in the top bunks"; concerns about "never see[ing] the same person in medical" and that "there are no foot doctors." In addition, participants described some prison health care professionals as being impatient, unresponsive to inmates' needs, and "err[ing] on the side of someone seeking attention as opposed to genuine care and concern." One man described it as, "there is impatience, humanity is lacking." Another reported, "I have been put out of medical for asking questions…I told the doc I didn't really get an exam. The doc got mad and put me out." Fears of retribution were noted in the warning, "the PA [physician's assistant] will collaborate with the guard and get stuff [single cell or bottom

bunk] taken away from you." Some corrections officers challenged inmate health, particularly through causing stress, "you have to put up with the attitudes of the staff, if they have a bad day at home they take it out on us."

Prison policies that were perceived by the older inmates as negatively impacting their health included: a change to contracted prison health services; the discontinuation of the Services to Elderly Prisoners (STEP) program; and a perception at one institution that "the VA [Veteran's Administration] can't get okayed to get in here." Also, the policy regarding "if you sign a cell agreement it is good for six months, you can't get out of it" was stressful to them, since the implication is that you are stuck with an incompatible roommate for the duration of the six month period, no matter how bad they are. One participant articulated the opinion of others that "smoking should stop, they had nonsmoking blocks, having us in with smokers violates our contracts…this is no way to treat older people." Environmental issues included problems with the heating system, "it is usually too cold' and that "the beds are a slab of steel with a shabby mattress, my shoulder and hip and knee hurts in the morning on the side I was laying on."

Other concerns of the older inmates echoed health care consumers in the free society. For example, being prescribed generic medications and not getting all of the diagnostic tests that they felt were needed. Whereas others voiced dissatisfaction with their primary care provider, "it is hard to see the doctor, you have to go through the PA to see the doc and if the PA doesn't feel it is important, they can deny you seeing the doctor."

Food concerns—Although the official diet in the system is described as heart healthy, the older inmates repeatedly spoke of how challenging it was to maintain a healthy diet while in prison. One man stated "trying to maintain a good diet is impossible" and another shared "the food is horrible…I live off of the commissary." Specific concerns were: the prisons now "use a smaller tray"; "you walk up to the dining hall hungry and you leave hungry"; you can get "hooked on the flavor packs [from Ramon Noodles] to season food"; and "70% of the foods from the commissary have sodium…the food there drives your blood pressure up." Food management was called into question in the following statements, "the food itself coming in is not that bad but they cook out the goodness" and "they get fresh fruit and let it sit so it is no good." Finally, an inmate perceived injustice in the fact that although inmates and prison personnel eat the same basic meals, only the staff "get a soup and fresh salad every day."

Fellow inmates—Challenges to promoting health that relate to fellow inmates are captured concisely by one participant, "the young guys try and take over" and another recounting, "they don't got no respect." A third participant described the situation as "the weight rooms are not good; the young kids take everything up. They're ignorant. I'm country. I'm not used to being around these city kids: I'm not use to this constant aggravation; we [old guys] try and stay together." Beyond the issues in the weight rooms, another participant shared, "everyone just lays around. How can I go to the yard and compete with all those young guys? Stress levels are high."

A different challenge reported by two older inmates related to feeling responsibility for their younger counterparts—the first stated, "in this prison, older prisoners take more of a burden from younger prisoners, they look to the older prisoners which puts an extra stress burden on the older prisoner, there is no support system for the younger prisoners…" The second said, "sometimes we're [old guys are] supposed to be leaders…"

Finally, concerns regarding the hygiene of fellow inmates focused on those working in the chow hall. A representative quote was, “they are spitting and spraying over it [the food] while they are serving it. The staff and the guards are unmindful of it or just tolerate it."

Personal challenges—Participants described personal challenges that largely centered on a lack of motivation to engage in exercise or assume responsibility for one’s own health. One participant succinctly communicated, “I should be exercising but I don’t.” Common reasons given for not exercising included not having sufficient strength to engage in physical activity or fears that they would make their health problems worse. In addition, one participant boldly stated, “there’s too much moanin’ about what those people [prison staff] do or don’t do. You have to take some responsibility.” Another admitted, “they [medical] told me something but I didn’t follow up.”

Barriers to Health Information

Beyond the challenges to health in prison were barriers to either obtaining or applying health information, as well as distrust about the available sources of health information. Concerns regarding lack of privacy were evident in one man’s account that “sometimes I’m uncomfortable talking to the doctor ‘cause there are two corrections officers sitting there, but if I want to find out [information], I just ask.” Numerous participants spoke of difficulties in obtaining health information from corrections health care providers (e.g., did not have time to share information, would not write down information, and lack of literature or handouts). As well, participants indicated that information sharing was discouraged among inmates, which they perceived to be related to institutional concerns for security. Others attributed challenges in getting information to programming cuts.

Distrust of the information available to them was a concern. Some were “suspect of information provided by the prison…” and felt “they purposefully disinform (sic) you because an informed inmate is a dangerous inmate.” Others felt that “the information is not up to date.” Much of the information that was shared amongst inmates was not deemed as trustworthy, “once the information gets around the horn it can be pretty twisted.”

Day-to-Day Health Management

Despite the aforementioned challenges to inmate health, these older inmates did report engaging in a variety of self-care strategies to manage their health on a day-to-day basis within prison, including: accessing resources and support; staying positive; managing diet and weight; engaging in exercise and physical activity; and protecting self.

Accessing resources and support—Information from family or fellow inmates and program resources all contributed to inmates’ efforts toward good health. Examples of people who were perceived as resources included “the wife” as well as other family members including sisters, mothers, and even one grandmother. In regard to in-prison health care providers, one inmate shared with the group, “I have tried to partner with the health care providers on their level, you will be treated better if you are educated about your problem.” Additional references identified particular doctors and nurses as being helpful.

Inmates at one prison reported, “we confer with the doctor who is an inmate.” Beyond the physician inmate, other peers were mentioned, who were felt to be particularly knowledgeable. In addition to health care providers and family members, the block manager and corrections officers were viewed as a resource by two men, one of whom shared, “if you can’t stand a person and it is getting to the red point, I go to them [block manager or corrections officer] and tell them, they move me [to another cell].” Older inmate participants also reported relying on spiritual resources such as meditating or praying; one participant

shared, “I thank God everyday…” A number of programming related issues were raised across the groups, with insights provided regarding programs of interest, mode of program delivery, timing of programs, program deliverer, and ideas for targeting programs for older inmates (see Table 3).

A quote reflective of others in the group was “if you can’t educate yourself you are in trouble.” Information resources were largely in written form and obtained from “national health organizations,” or books and current magazine issues obtained from “the law library.” For example, one man reported, “I have a chart from a men’s health magazine that has food sources for vitamins, and other things; you need to know what you are eating and why.” Another proudly shared, “I have a PDR and Merck’s Manual…” and several others touted the affordability and helpfulness of the Merck Manual. Other media, such as the television and radio served as information sources. Also, inmates regularly accessed each prisons’ “chronic clinic.”

Staying positive—Staying positive entailed strategies that kept the older inmates busy with meaningful activities such as working, helping others, and engaging in pleasant activities. Being mentally tough, doing one’s own time also appeared to be important to remaining positive during incarceration. All four of the aforementioned strategies are noted in the following quotation, “it is important to feel useful, especially for guys who have been down a long time; that is good for your mental status. I sometimes feel like I am going to die. I feel better when I have a purpose. Do positive things and find a positive side.” Watching “a lot of comedy shows” and having “a sense of humor” were believed to be two important ways of staying healthy. Helping others also was viewed as important, one man proudly stated, “I’m an educational tutor…I will share things with others. I feel bad for guys who don’t have someone helping them from the outside. I’ll help them sometimes. It does help to relieve some of the stress. Older guys will do this and not the younger guys.” Another participant similarly stated, “I used to tithe my check outside, but I like to spread it around to the guys around me. I got $50 from my Dad and I can get what I need now. It lifts you up to help someone.” Mental toughness was evidenced in, “you can’t give up mentally. I have always been able to get myself up; you can overcome low points and not give up…I always tell myself that I’m not going to give up. Some of my friends did give up, [example given], he committed suicide.” Similarly, another man recounted, “the situation we are in is very depressing, [you] need to find something to bring you up, you can’t dwell on it.”

Managing diet and weight—Strategies for managing diet and weight included trying to avoid junk food, pork, and salt; being selective about what one eats off the meal tray; eating more at breakfast when foods like muffins, fruit, and cereal are offered and eating less at lunch and supper; “eat only one or two meals a day out of the chow hall;” and making lifestyle changes in “my diet to deal with my disease [diabetes].” The general phrase “I watch my diet” was uttered by many. Others reported getting their “weight under control” and deciding “to lose weight.”

Engaging in exercise and physical activity—Physical activities engaged in included running, walking, calisthenics (e.g., sit ups), basic body stretches, aerobics, yoga, Elite 50 weight lifting, playing ping-pong, working in a maintenance job, working seven days a week, and playing baseball or basketball. While some, as noted earlier, reported barriers to exercise, others reported “you can do it on your own in your cell” and “exercise wasn’t part of my life before [incarceration].” Motivations for exercise included that “weight training has an impact on decreasing high blood pressure,” “I walk for my [health] problem,” and the philosophy that “if you miss the daily exercise you’re gonna know it!” In contrast to reports that the younger inmates were a deterrent to their health, one man suggested he liked to “go

with different age groups at the gym" and pointed out "you can run *or* walk around the track."

Protecting self—The category protecting self is summed up best as "you need to portray yourself as strong." Numerous participants pointed out that a key way to convey strength was to "carry yourself with respect." The older men also emphasized the importance of staying: "away from young kids," "out of trouble," away from "chicken hawks [pedophiles]," and "in one's own group." It should be noted that one exemplar quote in the *protecting self* category had a much more aggressive tone to it, "people fear me; I'm the old silverback here."

Discussion

Our study extends prior research on health of older prison inmates in several key ways. First, we now know more about the specific health choices that older inmates make and the health strategies they undertake to promote their health while living in prison. Second, we have revealed diverse barriers that threaten older inmates' abilities to succeed in their health promotion efforts; barriers that may negatively impact their health. Finally, we identify health promotion programming needs expressed by this vulnerable group of elders, a contribution that was previously described as an exigent (Caraher et al., 2002) and a growing need toward achieving a healthier population of older offenders (Sterns et al., 2008).

For some older inmates, health improved during the course of their incarceration. Prison served as an interruption to prior unhealthy behaviors (e.g., drug and alcohol abuse) and provided an opportunity to proactively pursue good health in a setting where healthcare commensurate with that available in the community is required by law. A key motivator for pursuing good health was the importance of being respected and thus perceived by others as being healthy and strong. In addition, focusing on health promotion behaviors was a way to do *easy time*; an achievement that was actualized through staying focused on positive, purposeful activities. Taken together, accessing resources and support, staying positive, eating as healthy a diet as possible, engaging in physical activities, and protecting one's self all contributed to some older inmates maintaining a sense of control while living in prison.

Simultaneously, the prison environment was perceived as leading to poorer health by other inmate participants. Incarceration exposes individuals to stress, stigma, crowding, and violence (or its threat); all of which may produce negative health consequences. In addition, either out of personal challenges such as fears of making their health problems worse or due to insufficient motivation, and/or resourcefulness, some inmates failed to regularly pursue activities that contributed to good health. Instead, they succumbed to poor food choices both in the chow hall and the commissary, developed a sedentary prison life, and/or smoked throughout their waking hours. Additional barriers such as cost of services, prison personnel and policies, and fellow inmates also challenged older inmates' ability to achieve good health. The rising cost of copays for infirmary visits were similarly raised in Loeb and colleagues' (2007) study of older minimum security inmates and have been recently described by Williams (2007) as one of "several policy barriers that prevent inmates from receiving quality health care (p. 87). The presence of unresponsive or uncaring prison health care providers that were described by some in this study is an issue that might be addressed if we are to prevent vulnerable older inmates from being suspect of the quality of correctional health care. Questioning diagnoses and treatments are likely to negatively impact inmates' health, and have been previously noted by Tillman (2000).

The debate over whether or not to segregate old and infirm inmates, which has been raised by Aday (2003) and others, comes to the forefront when considering the perspectives of these elder inmates. Over and over again in this study the challenges of living amongst younger inmates were stated; however, it seemed that many older inmates successfully coexisted amongst their younger peers, particularly if they were able to maintain a strong and vigorous demeanor. As well, some felt needed by their younger peers, while yet another liked engaging in physical activity with inmates of different age groups. The competing demands—promoting the safety and security of older inmates, while focusing more exclusively on their specific needs versus the benefits (to inmates and corrections officials alike) of an intergenerational prison population—are difficult to resolve. If given the opportunity, some inmates would want to go to a facility for older inmates about as much as their free-living counterparts would want to go to a nursing home, while others would rest easier and be less stressed in an age segregated environment.

Setting this debate aside, there is a need for more elder specific programming for the approximately 11% of inmates who are 50 and older and live within the general population of US prisons. Our findings parallel and extend prior studies conducted with older inmates both in the US (Loeb et al., 2007) and the UK (Condon et al, 2008). Older inmates display a clear desire for more age-specific exercise opportunities and healthier dietary options, both in the chow hall and the commissary. As noted by Stojkovic (2007), as well as Sterns and colleagues (2008), if older inmates' desires for more age-specific exercise programs, healthier food, and more up to date and readily accessible health information resources were met, better management of the myriad chronic diseases experienced by older inmates could be achieved, thus keeping older inmates in better states of physical and mental health. Similar to the findings of Condon et al. (2008), our analysis (see also Condon et al., 2008) indicates that providing affordable and accessible smoking cessation resources represents an important need for the smokers, while nonsmokers wished for cleaner air and were concerned about the effects of the second hand smoke that they had to breathe.

Limitations

Limitations of this study are that FG participants came from one of two state correctional institutions in one northeastern state. However, these institutions were of differing security levels and were vastly different in structure (i.e., posing different environmental facilitators and constraints to health). Also, while findings were shared with participants, no substantive feedback was solicited. A more directive protocol using member checks would have enhanced the likelihood of soliciting participant responses. We acknowledge that our inability to audio record within the state prisons is a limitation; however, our protocol of written field notes, in addition to audiotaping of post FG debriefing sessions outside of the prison walls maximized our ability to acheive precision/accuracy. Finally, our results are generalizable to the extent that our sample was representative of the broader US older inmate population in the most common two racial identifications and the mean age of our participants was 56 years.

Conclusion

The FG process promoted a sharing among participants that generated insights and contributed to the breadth of our study findings regarding older prison inmates' health self-care behaviors and barriers to such behaviors. Our study findings confirm and extend previous research in the US and UK in regard to the specific health choices that older inmates make, the health strategies that they undertake to promote their health, the diverse barriers that threaten their ability to achieve good health, and their health promotion programming needs.

Later, as former offenders return to their communities and families (if available and welcoming) they also return to health risks faced prior to incarceration. The high potential for a negative trajectory upon release is ample justification for researchers to develop and test prerelease health-interventions in prisons so that practitioners have research based programs that are aimed at building older inmates' health self-management capabilities.

Although many of the findings emerging from this study are likely also relevant to older inmates who are sentenced to life in prison, replication of this study with inmates of all ages who are serving life sentences would add important insights to further inform the development of humane and cost-effective prison health programming. Intervention studies should also work toward enhancing health promotion and chronic illness program delivery in prison. Armed with research findings and knowledge of the correctional health system, health care professionals can take steps to safely mitigate barriers to older inmate health self-management. Such efforts hold potential for decreasing the budgetary drain on prison health systems and lowering inmate stress. Concomitantly, these measures can help security, for if older inmates see humanity and caring within the prison context they likely will perceive the system as working for them. Finally, enhanced chronic disease management in prison would better prepare soon to be released inmates for a healthier lifestyle upon their reentry to the general society.

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Table 1

Focus Group Discussion Questions

1	Please tell us your first name and little bit about the types of health conditions that you are experiencing. You don't need to share your whole medical history, but rather a bit on your health conditions and how long you've had them…
2	Can you explain to us how your health has changed during your incarceration?
	a. Why do you feel your health has changed that way?
3	Can you describe for us any ways that being in prison (or having access to prison resources) has helped you to improve your health?
4	Can you describe for us any challenges you have faced when trying to improve or even maintain your health while you've been in prison?
5	Please explain any things you currently do to try to improve your health.
6	How is information important in managing your health?
7	Where do you typically get your health information from?
8	Are your current sources of health information are accurate/up-to-date? Why/why not?
9	Can you describe any types of health instruction or programs at the prison that you have found to be helpful?
10	Can you tell us how programs were helpful and/or how they were not helpful?
11	If new health instruction or programs were to be offered, what types of programs do you think would be most helpful to you in managing and improving your health?
12	Of all of the things that we talked about today, what is it that has been most helpful to you in managing your health while in prison?

Table 2

Demographic Characteristics of Focus Group Participants (n=42)

Variable	Number	Valid Percentage
Age (n=42)		
50–54	18	42.9%
55–59	15	25.7%
60–64	7	16.6%
65–68	2	4.8%
Total	42	100%
Mean (Median)		55.8 (56.0)
Standard Deviation		4.54
Race/Ethnic Status (n=40)		
White (not of Hispanic origin)	18	45.0%
Black (not of Hispanic origin)	15	37.5%
American Indian/Alaskan Native	2	5%
Mixed Race	5	12.5%
Total (missing data=2)	40	100%
Marital Status (n=42)		
Single (never married)	10	23.8%
Married	9	21.4%
Divorced	19	45.2%
Widowed	4	9.5%
Total	42	100%
Education (n=41)		
Some high school	3	7.3%
High school graduate or completion of GED	18	43.9%
Some college or technical school	11	26.8%
Completion of technical school	8	19.5%
Completion of 4-year college degree	1	2.4%
Total (missing data=1)	41	100%
Years Incarcerated (n=42)		
Mean (Median)		12.5 (10.0)
Standard Deviation		7.39

Table 3

Older inmate insights regarding health programming

Programs of Interest

- Bring back the Services to Elderly Prisoners (STEP) Program
- Provide yard time for older inmates without the young guys
- Assist with smoking cessation
- Offer healthy food items in the commissary
- Provide assistance and guidance in self-care strategies
- More stress and anger management programming
- Provide meetings about health problems a couple of times a month
- A program to teach you how to manage your own health upon transition out of prison

Mode Program Delivery

- Channel information through the in house cable system
- Pipeline information directly into cells
- Videos and discussions
- Postings on the bulletin boards
- Distribute more printed materials

Timing of programs

- Provide for access to exercise equipment after work hours
- Provide in-service classes after work
- Stick to posted schedules for programs and classes
- Provide a transition program or hose approaching release

Program Deliverer

- Independent people from the outside
- Someone serious about helping the older inmates
- Intelligent and talented inmates (i.e., inmates okay only if qualified and monitored)
- Staff

Targeting the Older Inmates

- Annual physicals for guys 50 and older
- An athletic program for guys 50+
- More jobs for guys 50+ to keep them busy and active
- A specialist on diseases of older guys
- Offer a 3rd day of Elite 50 weight lifting