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Administrators' Perspectives on Changing Practice in End-of-Life Care in a State Prison System

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Abstract

Objective—Sentencing trends have created a demographic shift in prison populations. Greater numbers of inmates are aging and dying in prison, creating a demand for enhanced end-of-life care. Changing practice to meet escalating care demands in corrections settings is complicated by economic constraints, attitudinal barriers, and organizational features. This study explored perspectives of end-of-life care held by administrators in a state prison system to reveal challenges to changing practice to meet the needs of inmates suffering advanced illness and dying in prison.

Design and Sample—Qualitative interviews were conducted with 12 administrators from the central office of a state department of corrections.

Results—Key influences impacting end-of-life care services included: local prison culture; treatment versus security focus; case-by-case consideration; public sentiment; budget neutral approaches; and conflicting views of service targets.

Conclusions—These findings revealed the organizational structures, attitudes, and beliefs held by the administrative echelon of a state prison system and were used to guide the derivation of discrete approaches to changing practice in this complex system. Contextual evaluation permitted a much deeper understanding of the influences on changing practice in this hierarchical bureaucracy. This type of preliminary evaluation is crucial to infusing new practice initiatives in complex organizations caring for stigmatized, at-risk populations.

Each year correctional institutions across the United States house larger numbers of inmates, who are older and have more chronic and serious illnesses than prior years (Bureau of Justice Statistics, 2009). Longer prison sentences in a 'get tough on crime' environment are common across the United States, keeping offenders in prison into their later years of life (Abner, 2006). In 2009, approximately 10% of all inmates were serving a life sentence (Moore, 2009). The number of sentences for life without parole issued in the United States increased by 600% from 1972–2009 (Nellis & King, 2009). Six states (i.e., Maine, Pennsylvania, Louisiana, Illinois, Iowa, and South Dakota) now have policies that interpret the sentence of life as excluding any option for early release or parole; or, as commonly stated, *life is life* (Mauer, King, & Young, 2004).

While life sentences have increased dramatically, the number of death sentences issued from 1998–2007 decreased by 62% (Death Penalty Information Center, 2010); however, this decrease in sentencing is somewhat misleading. The death penalty was reinstated by the US Supreme Court in 1976 and executions resumed in 1977 (Snell, 2011). Following a peak in executions in 1998, there has been a downward trend in completed executions (from 99 executions in 1998 to 43 executions in 2011) (Criminal Justice Project, 2012). During that same period, the total number of inmates housed on death row decreased by only 7%: from

3492 in 1998 to 3199 in 2011. (Death Penalty Information Center, 2012a). Even among those whose death sentences are carried out, a death sentence equates with long-term incarceration. The average time between sentencing and execution has been on an upward trend for decades; in 2011, death row inmates spent 178 months (almost 15 years) aging in the highly restrictive setting of death row before execution (Death Penalty Information Center, 2012b). In 2005, a record 137 inmates on death row were 60 years or older, an increase by 351% since 1996. (Death Penalty Information Center, 2012c).

Collectively, these trends have created a demographic shift in prison populations. Once incarcerated, a continually growing number of inmates can be expected to live out a large portion of their lives and eventually die in prison. The significance of this trend is amplified since inmates are thought to have physiologic ages 10-15 years older than their chronological ages (Mitka, 2004). Compounding the scope of concern, this demographic shift has occurred during a time of economic restraint. In sum, prison administrators are challenged to do more with less during a time when care demands posed by older, sicker inmates are escalating. In particular, the provision of humane end-of-life (EOL) care for aging inmates is a need that has reached a level of concern that is only expected to increase in the years to come (National Institute of Corrections, 2010).

Prison administrators are obligated to lead the implementation of improved standards in prison health care to “ensure the most basic of human rights for prisoners, including access to care” (Stern, Greifinger, & Mellow, 2010, p. 2103). Prisons are hierarchical, bureaucratic organizations; staff members are accustomed to decision-making that requires approval through a chain of command. In sum, nurses and other health care providers who value EOL care and believe it should be implemented in their State Correctional Institution (SCI) need the support of administration to change protocol in one case or for all cases. In this organizational climate, implementation of new practices or a change in protocol without administrative approval places frontline staff at risk (e.g., reprimand or the potential for injury/harm). Compounding this dilemma, unsupportive attitudes held by security personnel, healthcare staff, other prison staff, and the public can influence the administrator’s prioritization of the need to address EOL care. A deeper understanding of the contextual backdrop of end-of-life care in a statewide prison system exposes challenges to changing practice in this area.

Administrative Characteristics of Prison Systems

State correctional institutions (SCIs), commonly termed prisons, are complex hierarchical organizations, with designated lines of authority. The state prison system is administered by a Department of Corrections (DOC). Executive leadership of the state-wide system is the responsibility of the Secretary (who reports to the Governor). Varied configurations of executive office positions oversee operations in specific segments of the statewide network in support of the Secretary. The upper echelons of the organizational structure are political appointments; thus, some degree of organizational change is typical with election cycles. The term central administrator refers to the executive officers responsible for statewide aspects of the operation.

On a more local level, each SCI has a similar hierarchical organizational structure. A superintendent or warden is directly responsible for the administration and operations of that SCI. Superintendents typically report up the chain through a regional deputy officer of the state-level DOC or executive officers responsible for discreet operational units (e.g., healthcare). Moving down the chain of command, the superintendents lead an internal hierarchy of administrators, supervisors and managers that oversee daily operations of the SCI. Typically, healthcare operations are managed by an administrator (i.e., Correctional

Health Care Administrator) who reports up the organizational chain to a senior administrator (e.g., Deputy Superintendent of Centralized Services) who then reports to the Superintendent. Communications are not tightly restricted to the chain of command; for example, it is not uncommon for a superintendent to make walking rounds interacting with middle managers, staff and inmates. However, formal communications regarding operations are of paramount concern within the chain of command; keeping the supervisory channels open and informed, which mitigates risk through approval.

The prison system organization is structured to accomplish specific goals supported by formal DOC policies that are expected to guide decisions across all levels of the system in order to achieve desired outcomes. Influences outside the system, such as interest groups, may stimulate administrative response or legislative regulation to change prison policies. Alternatively, issues identified from inside the system by staff or management could warrant policy change to enhance resolution. Policy changes in prison systems may involve layers of activity by multiple individuals including: state and federal legislators, registered voters, concerned citizen groups, news media reporters, prison rights activists, legal consultants, prison administration, prison staff, families or friends of inmates, or even the inmates themselves. While each of these stakeholder groups may have a vested interest in an issue, their power base and sphere of influence affects their ultimate impact on shaping policy change.

The nexus of these organizational influences can be quite complex. Upon incarceration, inmates become wards of the state and no longer eligible for privately-funded health care. Inmates have a constitutional right to taxpayer funded healthcare that is inclusive of *access to care*, and *professional medical judgment* (Rold, 2008, p. 11). Given the demographic trends of today's prisons, the expanding health care needs of the aging inmate population pose a significant challenge to the economic concerns of prison administrators. However, equally, or perhaps even more challenging for administrators, are the values and beliefs that permeate the system. For example, with a fixed budget, increased health care services for aging inmates may be perceived to threaten security and safety standards creating conflict between security and health care personnel. These internal conflicts may be compounded by community values. Often there is little community support for expanding the health care of inmates, and a public sentiment of "why should we care" subsequently influences state legislators in generating initiatives and funds needed by prisons to meet this growing problem (NPR, 2010).

Research Question

The extent of influence posed by administrative characteristics of a state prison system on the potential for change in practice is not known. The purpose of this article is to describe perspectives of EOL care held by prison administrators in a state prison system in order to reveal challenges to changing practice in this area. The findings reported herein are the result of a preliminary contextual evaluation completed during the initial phase of a larger study designed to enhance EOL care within the complex prison system organization.

Method

Design and Sample

This qualitative descriptive study was conducted as part of the contextual evaluation of a statewide DOC in preparation for a larger project aimed at enhancing EOL care in the complex organizations of prisons [NIH/ NINR 1R01 NR011874]. In this initial phase of the larger study, contextual features (e.g., structures, attitudes, beliefs) were investigated in preparation for subsequent participatory action research. Using findings from the

preliminary investigation of the contextual features, a collaborative research team consisting of the sponsored researchers (four senior researchers and two research assistants) and representatives from key stakeholder groups in six SCIs was established (n=24). The collaborative research team then prioritized needs, developed the “Toolkit for Enhancing End-of-Life Care in Prisons”, and launched initiatives to implement a system of managed change in end-of-life care (reported elsewhere).

The study was reviewed and approved by a university-based institutional review board (IRB) and by the state Department of Corrections (DOC) research review committee. All participants provided written informed consent under principles of full disclosure prior to involvement. This article reports the findings of the administrative arm of that contextual evaluation.

In the administrator segment of the contextual evaluation, face-to-face interviews were conducted with DOC central administrators from a DOC in the United States (n=12), many of whom had served in numerous positions in the DOC prior to their current appointment. Central administrator officers are responsible for system-wide services, such as chaplaincy, health care services, community transitions, and legislative affairs. A semi-structured interview was used to explore the current status of end-of-life care from the perspective of the senior leaders of the prison system. Experienced researchers on the research team conducted the interviews; research assistants observed, managed taping equipment (when permitted by participant and institution), and assisted with hand written field notes. All team members were trained in interviewing techniques and familiarized with the interview guide prior to data collection.

Measures

Interviews were conducted at sites most convenient to the participants. A semi-structured discussion guide was used. The majority of the interviews were conducted in administrative office locations, though some interviews were conducted inside the prison fences. The location of interviews impacted data collection procedures, since carrying audio-recording devices into the prison was forbidden. Therefore, participant interviews were either audio-recorded or recorded as field notes at the time of the interview. In cases where field notes were required, interviewers used the handwritten notes to dictate a full account of the interview immediately following their regress from prison grounds. All recorded data were transcribed verbatim and verified prior to analysis.

Analytic Strategy

Techniques of content and thematic analysis were applied by the research team during analysis. Content analysis was used to develop taxonomies or types of responses to each query in the interview. Thematic analysis was used to interpret the dominant conceptual patterns across the data set. Analytic processes included individual analysis by team members, followed by group analysis. During group analysis, analytic insights were discussed with emphasis on the evidence (i.e., data) supporting the interpretation. Categories and themes were collapsed until a final interpretive schema reached group consensus. These processes were used to enhance the credibility of the findings and resulted in the interpretive findings reported herein.

Results

Despite the highly organized hierarchical organization of the DOC, the interviews revealed the extent of variation across the system. Administrators described dealing with tension between what is perceived to be ‘right’ for a given prison, at a given time versus a more

centralized approach to end-of-life care. This tension was revealed in six key themes: centralized policy versus local prison culture; treatment versus security-focus; case-by-case versus system-wide perspectives; needs versus public sentiment; budget neutral approaches versus demands on the system; and inmate versus staff services.

Centralized Policy versus Local Prison Culture

Organizationally, the state prison system has clear lines of authority with a formal central administration designated to oversee all elements of operation of the individual SCIs in the state. Operationally, policies are centralized; however, each SCI operates under a separate management team that shapes priorities, values, and practices. The SCI leadership's heavy influence on the contextual background of a given SCI is clearly recognized by central administrators: "You know there is a culture . . . you can write policies and procedures but in each institution, there is a culture." Despite the tightly organized hierarchical organization, cultural variation pervades the system, "They [the SCIs] have separate superintendents. We are functioning under the same policies and procedures, but they are very different, most of the institutions are quite different . . ." Recent prison construction produced proto-typical prisons in which the physical plant characteristics are standardized. Despite this uniformity in physical context, cultural variation prevails:

We had a group of facilities . . . that were built in 1993. If I took you to them, other than flipping them in the order around the areas, they look virtually the same. So they physically have a strong resemblance. Culturally they don't.

Centralized policy was not the driving force behind EOL care offered to inmates at individual SCIs; ". . . whether you make a policy or not . . . Everybody is going to interpret that mission differently." One central administrator summarized,

Centrally we have a hospice policy . . . But we don't have a formal structure where we have designated individual sites, nor are we out driving programming in any one institution . . . it's based on need or interest of the facility . . . there is not a formal initiative to say we have X number of hospice programs here or there. If, or when, there are initiatives going on at various institutions, there is not standardization from one to the other.

Local prison culture was highly influential in the decision to offer formalized EOL care to inmates in a given setting. Perceived need and the perception that EOL care fits the mission of that SCI were the most significant considerations of the leaders; however, the influence of passionate, motivated frontline staff was evident. For example, one participant noted, "We have a couple of individuals who either came from backgrounds such as . . . long term care or who have been exposed to it [EOL care] before, who have a greater interest." This expressed that interest was a motivating factor in providing EOL care in that setting.

The extent of variation in the provision of EOL care was acceptable to the administrators and further explained by the intent of centralized policies on EOL care. These policies were described as "permissive" in that initiatives needed at the local level may be implemented (under extant policy); however, the policy "does not require a (formal) program." Local variations in application of central policies were expected and distinct SCIs were free to develop and provide whatever type of EOL care deemed necessary by the leadership of that prison.

Treatment versus Security Focus

Since the healthcare of inmates is federally mandated, all SCIs have a system of care delivery for housed inmates. The comprehensive care delivery system of the DOC includes internal (i.e., care offered within the system by SCI staff) and external (i.e., community-

based referrals for specialized care) services. Administrators concurred that medical care was of “high quality” across the system and had “improved greatly over the years.” Uniformly, the participants asserted that the actual costs of increased medical care associated with the aging inmates and increased demand for the treatment of chronic illnesses was adequately addressed in the allocated budget.

Security of the inmates receiving care and the staff (internal or external) is of paramount concern. One administrator was forthright: “. . . within the system of the DOC, I mean, the mission of the institution is to provide a safe and secure environment. It is not to provide health care.” The emphasis on security permeates decision-making, “We often have greater fears of security than what’s really likely to happen. But—that’s how the DOC has to think, you know.” This notion was further described in the context of end-of-life care as follows:

Security plays such a major role. And rightfully so in what we do in corrections. I mean don’t forget, don’t lose sight of what is our mission in terms of being a department of corrections. That sometimes can blur the line and what you would normally expect to happen in a community, in a regular community, in a real world, so to speak, for someone who is dying, and for death, doesn’t necessarily have a place in the prison system that is...basically focused on security and public safety . . .

Despite the standardization of medical care, the decision to implement EOL services is further influenced by cultural variation in the perceived mission of a given SCI. Data on providing humane care at end of life focused on the balance of care, custody and control in the prison system, “The motto of the DOC is care, custody, and control, and the DOC tends to slide toward custody and control. Care is often viewed with some suspicion.”

Differing values and beliefs regarding the balance of treatment and security were recognized by administrators as influential to the provision of EOL care,

Many institutions are very treatment oriented. They allow treatment programs. There are institutions that are less involved in that and I think those differences, the kind of (EOL) services . . . , lend themselves as an extension of a very treatment-oriented and very involved facility. Of course, if you take a facility that is more strongly security-oriented, maybe because it just has a large population of high-risk inmates or something, their level of involvement in that may be quite a bit different.

Treatment versus security orientation is a cultural variation that was neither directly related to the institution’s level of security (e.g., minimum, medium, close, or maximum) nor the age/health of the inmates. This variation is cultural, shaped by values, attitudes, and beliefs regarding the control and custody of inmates.

You have institutions that are much more therapeutically aligned and interested in providing those services. Then you have the old, we call them the ‘hard jails’, when you know in those days they didn’t do programming. So, they [central administration] still have them under the same policies and procedures but you would find dramatic differences . . . And that is simply more of a security issue than it might be medical.

The tension between treatment and security foci was further illustrated in the administrators’ insights on differing perspectives among staff in the same institution. It was commonly noted that healthcare providers held a different perspective on humane death/end-of-life care from their security-oriented colleagues. As one participant described, “. . . security staff aren’t caregivers, they’re—I wouldn’t say they are diametrically opposed—but their job is to provide security. They are not in general nurturers or caregivers.” Other participants noted

that compassionate behaviors by health care personnel had the potential to be misunderstood in the prison setting. One participant expressed the challenge of shifting this paradigm:

It has been a struggle to get it [EOL care] up and running because . . . [of] the culture of prison system. They [the prison system] are not here for healthcare, that's not their main mission. Their main mission is public safety and security. So, to kind of get the mindset changed that we [EOL care providers] are a part of the prison system as well, and we want to have our staff as well trained as they can be to care for our inmates . . . getting the paradigm shifted a little bit is . . . a challenge.

Few administrators expressed familiarity with national models in corrections hospice programs (e.g., Louisiana State Penitentiary at Angola). Among those who did, new potential for balancing security and care was perceived. Referencing a video program on the Angola program, one administrator noted, "Just seeing not only what is possible, but what does happen there and it's a wow! And I think, without threats to security, some of those models are something to learn from or at least experiment with."

Case-by-case versus System wide Perspectives

Administrators acknowledged the authority of SCI superintendents to make exceptions to policy or protocol under special circumstances. The most common example provided was superintendents who had granted special approval for family members of a dying inmate to visit outside of the prescribed visiting times or location. Decisions to waive policy were based on the facts available at the time of the decision (facts brought to attention through the chain of command). Responsibility for outcomes of special dispensation cases rested with the superintendent; these decisions were not taken lightly.

This case-by-case perspective was the most commonly reported effort to provide end-of-life care. The need for a case-by-case perspective was justified due to the degree of variation among: physical plants (e.g., feasibility of transporting very sick inmates to visiting areas or the privacy/security of the infirmary); level of security of prison inmate populations; and circumstances at a given point in time.

. . . you just couldn't write a policy and say because someone is at the end of their life that we will allow the visitation to be X. Because there would be too many things that you would not— that *medically* would make sense to you, but may not make sense to the operation of the institution.

Given this degree of autonomy, it was not surprising that central office administrators were unsure of the number or type of actual EOL services being provided in SCIs across the state. Pondering current end-of-life initiatives across the state-wide system, one administrator commented, "I just wish that I had a list of all the programs that are relative [sic] to this project." Other participants reinforced that there is no central source of information on case-by-case intervention or more formalized program offerings focused on end-of-life issues. As one participant responded, "Some SCIs are offering end-of-life services, but I'm not sure which ones are operating now." Exemplars of formalized end-of-life care initiatives referenced by participants were inconsistent (e.g., types of services offered, or SCIs offering the service); "SCI [name] has done some things, but I couldn't really say any of them." Despite emphasis on hierarchical communication along the chain of command, no mechanism for evaluating end-of-life care services within the system was established.

Needs versus Public Sentiment

Administrators acknowledged system-level needs surrounding the end-of-life care needs of inmates, including a need for more beds and updated space in some infirmaries; programming for inmates and staff; and, increased services and supplies. Beyond budgetary

concerns for capital improvements, public sentiment weighed heavily in the consideration of end-of-life care services. Several administrators acknowledged prevalent negative attitudes (i.e., “let them rot” or “who cares”) held by community residents, victims and family members toward inmates. This sentiment was especially relevant to those inmates at the end-of-life because they committed crimes serious enough to warrant long sentences that resulted in them aging/dying in place.

The nature of the crimes committed was a significant barrier to building community relations to support, or bridge end-of-life services. “The dying inmates are not incarcerated for drug and property crimes that people would feel a little more comfortable with . . .” Media releases regarding old, infirm inmates in the popular press or television were not perceived to be shifting community attitudes; rather, negative press reinforced attitudes. As one administrator lamented, “A lot of positive things [are] done day in and day out that nobody hears about. But the minute somebody screws up—it is all over the papers.”

Budget Neutral Approaches versus Demands on the System

The infusion of end-of-life care into the current system of medical care was overwhelmingly perceived to be budget-neutral. As a central administrative officer concluded, “I don’t think there really is a cost . . . the financial cost? It’s negligible. It entails no equipment. It entails no extra security.” As articulated by one administrator, the history of end-of-life care initiatives in the system reinforced this idea.

I am not really sure if there is a major cost involved because . . . the staff, they are doing it. They volunteer to do it—they do not get paid for it. Of course, the inmates—they are volunteering for it. They don’t get paid for it. And the folks that come in from the community hospice—they don’t get paid either. They are doing it on their own time because they believe in what they are doing. They believe in hospice care. They believe in the transition from you know a terminally ill person to that person that’s going to die.

Reliance on volunteer efforts fed off of the passion of the staff to make a difference. None of the participants questioned the sustainability of volunteer efforts. Discussing an end-of-life care initiative, a volunteer on that project expressed the depth of commitment to volunteer service in the DOC system:

. . . people bought into it, you know. It was supported by administrative staff . . . and the deputies—we would attend all these meetings. They were at 6:00 p.m. at night. I could have been sitting in boat fishing or something, but I always went with that group to listen to what they had to say.

Some administrators noted that while end-of-life initiatives may be budget neutral, there are concomitant demands placed on the system. The primary demand was staff time, summarized as, “It takes time to be very compassionate and an exceptional listener. It takes time.” From an administrator’s perspective, the question of enhancing end-of-life care activities hinged on consideration of available staff, not additional staff:

. . . do I have the staff time available to do what needs done for these end-of-life things? Because the underlying tone [is that] you have to be willing to have the time or take the time, you know, to make some of these happen. And I think a lot of times, . . . especially with the . . . way our budget is and . . . the state as a whole, the way it is—you just, you were doing more with less . . . Do the staff have the time to actually to go in and sit and talk to somebody, or spend an hour looking at a picture album . . .?

Inmate versus Staff Services

Reflecting on the impact of loss in the prison community, participants reiterated that the prison becomes home to inmates (particularly the long-timers who age and die in place) and that relational bonds are formed with other inmates. Grief reactions to the loss of a fellow inmate were recognized as personal and pervasive. Unmet bereavement needs of inmates, especially those involved in providing EOL care as volunteers, were noted, “There is a lot of unresolved grief for those [inmates] who stay behind. ‘Is this going to be me if I’m a lifer? Is this what I have to look forward to?’” Universally, the respondents endorsed a need for grief support for inmates. However, perceptions of grief responses and the potential of providing grief support services for staff were equivocal. Some participants thought staff members’ grief responses were normal and should be supported; while others felt such reactions would be criticized as inappropriate, and should be left alone.

Many of the administrators related that the death of an inmate was naturally traumatic for those directly and indirectly involved with the inmate who died. In some exemplars, staff had come to know the inmate as a person. In others, the inmate’s death reminded the staff members of their own mortality. “It’s hard to watch anyone die you know. Personally, I think you’re affected by that no matter what the person was like.” Formal response to unexpected deaths (called CISM—Critical Incident Stress Management) was described vividly in cases of suicide; however, respondents pointed out that this staff support mechanism was not routinely employed in expected deaths (e.g., deaths from long-standing chronic health conditions). A small segment of participants expressed regret that no similar program was in place to support staff after loss of inmates from an expected death, “Obviously, the caregiver is going to be in that bed one day himself and he realizes his own fate.”

In contrast, others related that expressions of loss by staff were complicated by the opinions of some that staff grief over the death of an inmate is inappropriate. This perception was rooted in views on the staff-inmate relationship that precluded personal bonds between the two. Challenging this perception, one administrator noted, “Certainly you can’t expect that there isn’t some sort of attachment...but everyone doesn’t accept that.” This attitudinal challenge to grief support for staff posed a significant barrier, even among those who did not share the sentiment.

Discussion

The numerous challenges to conducting research in prisons have been well-documented (e.g., see Apa, Bai, Mukherejee, Herzig, Koenigsmann, Lowy & Larson 2012). Beyond these challenges, research designed to change practice requires careful attention to the contextual influences in the targeted setting. In this study, the preliminary contextual evaluation of administration provided critical insights regarding the organizational structures, attitudes and beliefs held by the administrative echelon of a state prison system. As shown in Table 1, these insights shaped approaches to changing practice in the larger study.

Understanding the contextual background of this prison system, from the perspective of administrators, permitted the research team’s careful planning of strategies to create and sustain practice change. Even though this organization is hierarchical, with a clear chain of command, passionate staff members were making a difference in changing care practices for a given inmate in a difficult situation. Staff generated special requests that progressed up the chain of command and the SCI superintendent held the authority to allow change in protocol. These cases of special dispensation could have a profound impact on the quality of an inmate’s dying and on the provider’s sense of value; however, positive outcomes were

often silenced, or kept within the SCI walls, while unanticipated or negative outcomes were shared network-wide. This communication pattern limited the administrators envisioning new strategies, or building a repertoire of practices that may be useful in their settings; thus, limiting dissemination of best practices supported positive outcome data.

Historically, organized attempts to change practice were volunteer efforts. Volunteers can only devote so much time to an effort, threatening long-term sustainability of the practice initiatives. Budgetary constraints are real and health care demands are escalating due to the changing demographic of inmates served. Cost effectiveness is perceived as doing more with the resources on hand, requiring creative approaches to integrating new practices into the system of care. Re-shaping the perception of prioritized needs by exposing unmet needs and related outcomes appeared to be a viable strategy for shifting limited resources toward end-of-life care initiatives.

Attitudes and beliefs were dominant in consideration of security demands, community relations, and staff support. Conflicting values were expressed in each theme, revealing strategies for consideration in the practice change initiatives. Stakeholder analysis would be useful to examine the power and influence of varied segments on end-of-life care practices and to plan for the involvement of key stakeholders in the development of practice initiatives. Processes of group interactions must be carefully facilitated to challenge perceptions by exposing alternative worldviews. Collectively, these thoughtful approaches to practice change begin to shift the paradigm to balance competing demands and improve quality of care.

Arming SCI staff with new institutionalized tools to care for the dying could liberate the support of more humane death in prisons. For example, a brief introductory module on inmates aging and dying in prison could be integrated into all staffs' initial academy training and subsequent inservice education. Opportunities for more formal continuing education on end-of-life care could be established through online modules or partnering with local colleges or care providers. Education and community partnerships may contribute to building more positive community relations.

Findings from the administrative arm of the contextual evaluation of a state prison system were critical to establishing the backdrop for subsequent changes in practice. The impact of administrators on the culture of the setting is significant. Merging perceptions of organizational structures, values and beliefs held by administrators, front line staff, and community advocacy representatives permitted a much deeper understanding of the contextual features of changing practice in this hierarchical bureaucracy. This type of preliminary work is crucial to infusing new practice initiatives in complex organizations.

Further research is needed to examine the net effect of interventions designed to stimulate organizational change to enhance EOL care for inmates. Research in women's prisons is of particular interest. Far fewer females are incarcerated in state correctional institutions than males, reducing system-wide demand for services. Women inmates' options for transfer to care-intensive institutions are limited due to segregation (i.e., specialized care facilities are male facilities). As a result, many women live and die in their home institution without the benefit of extended system-wide care options that address the needs of the male majority.

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Table 1

Evaluative insights and implications for practice change

Evaluative Insights	Implications for practice change
Leadership at the SCI level influences the culture	Endorsement of the leadership will be critical to practice change
Centralized policies provide guidance for practice; is permissive rather than directive	Ensure adequacy of centralized policy; however, do not rely on policy as a source of change
Passionate staff members of lower organizational echelons can motivate practice change	Empower frontline staff members committed to the desired practice change
Security considerations permeate all actions	Adapt best practices to address security needs Involve security staff in planning/executing practice change Anticipate attitudinal barriers
Lack of familiarity with best practices and model programs inhibits envisioning possibilities	Expose administrators to exemplars from similar contexts Create a central repository for best practices within the system
Case-by-case management is common and typically goes unnoticed	Expose potential for inequity of special dispensation versus system approaches Open communication channels to build repertoire of useful strategies
Lack of comprehensive evaluation of end-of-life care services	Create evaluative component to practice change
Community sentiments/relations are complicated by context of prison care	Address strategic interactions with community to establish stronger care networks
Budgetary constraints demand efficient time management	Practice change must be incorporated into workflow; do not anticipate added staff Plan for sustainability (beyond volunteerism)
Attitudes regarding appropriate staff/inmate relationships confound supportive care strategies targeting staff (e.g., grief support)	Extend accepted supportive care strategies into new contexts Acknowledge the impact of relationship boundaries on personal experiences (e.g., disenfranchised grief)