AN EVALUATION OF PRISON HOSPICE SERVICES AND A PROPOSAL FOR IMPLEMENTATION IN ARIZONA

by

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DEDICATION

This project is dedicated to my son Eric who, from the ages of six through nine, has exhibited tremendous understanding, patience and restraint while I worked through graduate school. He is a constant reminder of the joys in life and an inspiration to always do my best.
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ABSTRACT

Hospice care is slowly gaining acceptance as an integral part of end-of-life care throughout the United States. The prison system is experiencing a graying of the population similar to that of the free world. Longer mandatory sentences and entry into the prison system occurring at a later age contributes to this phenomenon. The purpose of this paper is to review the existing literature regarding prison hospice programs and identify a theoretical framework that may assist in the development of a prison hospice program in the Arizona State Prison System.
CHAPTER I

The hospice movement in the United States began approximately 40 years ago. Since then, it has grown to become an important part of end-of-life care. A portion of this increased awareness and utilization of hospice services is due to the approval of the Medicare hospice benefit in 1982 under the hospital insurance program. The Medicare hospice benefit pays for all hospice services for older Americans who are entitled to Part A of Medicare and are certified as terminally ill (Medicare Benefit Policy Manual, 2004). Han, Remsburg, McAuley, Keay, & Travis (2006) found that while hospice care is still underutilized, the total number of adult hospice patients in the United States nearly tripled during the 1990’s. In addition to this, the number of eligible Medicare recipients with Medicare as their primary insurance increased from 63 percent to 79 percent in the same time period (Connor, Elwert, Spence, & Christakis, 2007). The current hospice utilization rate among older Americans nationwide is estimated to be 28.6 percent. Arizona has the highest utilization score in the United States at 49 percent (Connor, Elwert, Spence, & Christakis, 2007). The authors of this study attribute this phenomenon to the age distribution of the state, availability of hospice programs, and a “local culture” of acceptability and desirability of hospice services. Han, Remsburg, McAuley, Keay, & Travis (2006) found that hospice admissions in the United States have grown from 1,000 in 1975 to 700,000 in the year 2000. While there is still much room for growth in the utilization of hospice services within the medical community, it may be argued based on the above utilization rates that there has been increasing knowledge and acceptance of hospice care within the private sector and the medical community. Given the relatively
high percentage of hospice utilization rates in Arizona, it is concerning that the Arizona state prison system does not have a formal hospice program in place.

Problem Statement

The prison system in the United States has been experiencing a graying of its population similar to that of the non-incarcerated population. However, prison inmates do not have the freedom or the facilities available to independently provide for adequate end-of-life care. The Arizona Department of Corrections (AZ DOC) does not currently offer hospice or palliative care services to their inmates as a formalized program (Dr. Steinhauser, personal communication, January 2009). While there are existing national standards in the form of guidelines and clinical recommendations of hospice and end-of-life care in place for all state prison systems, there is no one unified or adoptable system to assist in the implementation of such a program (National Commission on Correctional Health Care (NCCHC), 2008). In prison systems that do not have hospice programs in place, options for end-of-life care for prison inmates are limited. These options include dying in an acute care setting such as a hospital, dying in the prison complex itself, or attempting to obtain compassionate release back into the community (NCCHC, 2006).

Purpose

The purpose of this project is to explore existing Department of Corrections (DOC) hospice programs that have proven to be successful over time. Obstacles to developing and maintaining a hospice program will be discussed along with positives and negatives in existing programs. In doing this, it may be possible to reveal a plausible plan for developing a prison hospice program in Arizona.
Male prisoners account for 90.5 percent of the incarcerated population in the Arizona state prison system. Male inmates tend to have longer sentences, life sentences, or death row sentences when compared with their female counterparts (Bureau of Justice Statistics, 2007). On the national level, inmates 45 years of age and older accounted for 14 percent of the state prison population but accounted for 67 percent of the total number of deaths while incarcerated. Among the national deaths while incarcerated, 85 percent occurred in inmates who were 45 years of age or older at the time of admission to prison. In addition to this, male inmates had a 72 percent higher death rate than female inmates (Bureau of Justice Statistics, 2007). For the purposes of this project, only the needs of male inmates will be considered due to the larger proportion of male inmates in the AZ DOC.

Background/Significance

During the 1980’s, AIDS infection rates and deaths in the prisons had skyrocketed, increasing the interest in palliative and end-of-life care for prisoners. In response to this rise in interest and demand, the U.S. Medical Center for Federal Prisoners opened the first hospice program in Springfield, Missouri in 1987. The California state prison system began the first state prison hospice program in Vacaville a few months later (Ratcliff, 2000). Over 35 prison hospice programs in the United States have since been developed at both the state and federal level, with an estimated 2500 inmates dying annually while incarcerated (Head, 2005). The philosophy and focus of prison hospice programs is similar to that of non-prison based hospice programs. There is typically an interdisciplinary team determining the ongoing individual plan of care for each inmate.
enrolled. The main emphasis lies in providing compassionate care in a supportive 
environment with particular attention on pain and symptom management, comfort issues, 
and exploration of end-of-life concerns (National Prison Hospice Association (NPHA), 
2008).

Life in prison is highly institutionalized. Every inmate must come to terms with a 
loss of autonomy, interpersonal relationships, freedom, and choice. They have been 
removed from family and friends to live in a place where every moment of the day is 
regimented: from the time they wake in the morning to the time they go to bed at night, 
the type of food they may eat, where they reside and who they live with, the amount of 
time they are outdoors, and the clothes that they wear. This lack of control includes 
having no choice in healthcare providers.

Life in prison may be thought of as a culture in and of itself. Threats of violence, 
thief, and abuse are daily issues inmates face. There is never any certainty that the inmate 
will remain in the same job he holds, the same residence, or even the same facility for the 
duration of their prison sentence. In general, there is a lack of trust between inmates and 
staff, including medical staff. Many times fellow inmates become a surrogate family due 
to length of incarceration and the need for a social support group. For many in prison, this 
is the only home that they know (Linder & Meyers, 2007). The average inmate has more 
health problems and ages more quickly than those who have not been in prison. In 
addition to this, more than half suffer from some form of mental illness. James and Glaze 
(2006) estimate that 74 percent of inmates with mental problems and 56 percent without 
mental problems have a history of drug abuse. The average prisoner has had little formal
education and is highly deficient in general health knowledge. (Dr. Steinhauser, personal communication, February 2009).

Understanding the culture of prison is important in providing comprehensive health care for inmates. Knowledge of the culture of prison and the obstacles inmates live with daily provide insight into the inmate’s background and living situation. Cultural competence provides an avenue for the healthcare practitioner to potentially improve patient-provider communication, access to care, quality of care, and outcomes (Linkins, McIntosh, Bell, & Chong, 2003).

Traditionally, inmate deaths, whether expected or not, have not been permitted to occur on the prison grounds. There has been a fear among medical and corrections staff that an inmate death while in the prison may be construed as being a form of neglect. One of the biggest fears among inmates is dying alone while institutionalized (Linder, Enders, Craig, Richardson, & Meyers, 2002; Tillman, 2000). In that respect, many inmates dying from declining health due to chronic illness have been removed from their prison “homes” and taken to an acute care setting outside of the prison to avoid possible legal and ethical issues related to neglect or perceived substandard healthcare by the prisoner’s surviving family members (Ratcliff, 2000). It is commonly believed that allowing an inmate to die in prison will cause unrest within the inmate population and potentially challenge the authority of the security staff (Dubler, 2001). While there is not a formal hospice program in Arizona, medical providers try their best to make the dying inmate as comfortable as possible (Dr. Steinhauser, personal communication, February 2009). They are typically housed in sheltered housing away from the general prison population where
nursing staff is readily available at all hours. When a death is imminent, the inmate is removed to a more private area of the prison so that inmate morale is not adversely affected (Dr. Steinhauser, personal communication, February 2009).

According to statistics from the Arizona Department of Corrections, there are currently a total of 39,853 male prisoners incarcerated in state prison systems throughout Arizona. There has been a 5 percent increase in incarcerated males from the year 2006 to 2007. Two-thirds of these inmates are age 30 and older, with 117 males serving a death row sentence. There are also 1,459 inmates serving life imprisonment sentences in Arizona. As of January 2009, there are 5,656 inmates in Arizona being treated regularly for chronic diseases. This constitutes approximately 18 percent of the total prison population (AZ DOC, 2009). The average length of a prison sentence is 29 months. In 2008, there were a total of 98 state prisoner deaths while incarcerated in Arizona (AZ DOC, 2009). Of these deaths, 42 were due to natural causes, one was accidental in nature, and 55 are pending investigation (AZ DOC, 2009). Because there is no established prison hospice in Arizona, not one of these inmates was enrolled in a hospice program prior to their deaths.

Definitions

Arizona Department of Corrections (AZ DOC):

*Each state of the United States maintains a department of corrections. As such, they are the local government responsible for managing the treatment of convicted offenders for the duration of their sentence. This management includes housing, nutrition, education, and health care.*
County jail:

The jail system houses detainees who are awaiting trial for their alleged crime. After a detainee has been deemed guilty, they return to the jail pending their sentencing trial. Once their sentence has been handed down by the court, they are assigned to one of the prison complexes as a state inmate (Correctional Officer Abbot, personal communication, April 2009).

State inmate:

A state inmate may be defined as a person who has been convicted of a crime and sentenced to mandatory housing within a state level prison facility. They have ultimately lost the freedoms granted them as residents of the United States and have become wards of the state in which they were sentenced for the duration of their prison term. This term is interchangeable with prisoner.

Hospice care:

The hospice philosophy of care may be defined as an interdisciplinary approach to end-of-life management. The emphasis is living and dying with dignity in as much comfort as possible. Special importance is placed on symptom management, pain control, family involvement, and palliative care in a compassionate environment. In the United States, hospice care is generally initiated in patients with terminal diseases and a prognosis of six months or less (National Prison Hospice Association, 2008).
Palliative care:

*Palliative care is a type of medical service in which the reduction of pain is the goal of treatment. It may apply to any patient with any medical diagnosis, and is not reserved for those who are at the end of life. Palliative care is often a large part of hospice services.*

Advance directives:

*Advance directives are legal documents expressly in which a person states their wishes regarding medical decision-making when they are unable to make them for themselves. Advance directives include living wills, health care proxy, and durable power of attorney for health care.*

Do-not-resuscitate (DNR):

*A DNR order may be part of the living will advance directive. This would indicate that the person does not wish for life-sustaining measures to be continued in order to prolong the dying process.*

National Commission on Correctional Health Care (NCCHC):

*This organization was developed in the early 1980’s by the American Medical Association to develop policies and programs for health standards in jails and prisons. They offer a voluntary health services accreditation program for correctional institutions. The Standards for Health Services are currently used in a variety of correctional settings to provide efficient, quality care to inmates (NCCHC, 2008).*

Prison infirmary care:

*Infirmary care in the prison is provided when an inmate requires daily monitoring for a medical issue by skilled nursing staff. Medical issues may be acute or chronic in nature,*
and includes those inmates needing assistance with activities of daily living (NCCHC, 2008).

Sheltered housing:

This type of housing within the prison refers to a protective environment for patients that do not require ongoing care by skilled nursing staff. These beds may be found in the infirmary or in other selected areas of the prison. It is considered to be comparable to home care for those not incarcerated (NCCHC, 2008).

Compassionate release:

Compassionate release is an authority granted to the court system in which a state prisoner may be released from his sentencing obligation. There must be a finding of “extraordinary and compelling reasons” for such a decision to be made (NCCHC, 2008).

Significance to Advanced Practice Nursing

Medical care in the prison setting is a challenging, unique career choice in general. Advanced practice nurses (APN) may act as primary care providers in the Arizona Department of Corrections (Dr. Steinhauser, personal communication, February 2009). The APN who is passionate and committed to providing holistic end-of-life care in this type of environment has the potential to change lives—the lives of the patient, of correctional officers, of medical staff, and of other inmates. The APN would be a major stakeholder in the development of the interdisciplinary team providing care. Nurse practitioners in the correctional setting may help gather a team of professionals together and promote open dialogue among members so that security and medical needs are heard
and a mutual exchange of ideas may begin. Reviews of successful programs prove that the obstacles of implementation are not insurmountable.

The background and education of an APN allows for the creation of a holistic plan of care that is individualized for each patient. Using the Theory of Comfort model as a guide, the APN has the potential to affect all members of the hospice team. The patient will experience death as they wish it to be within the confines of a prison environment. They may experience death in a dignified, respectful setting, surrounded by loved ones and people trained to guide them through this process. This caring environment may extend to correctional officers and other inmates as well, and even has the possibility of changing the feelings of distrust between these two groups with time.

Summary

The 1976 ruling in the court case *Estelle v. Gamble* ensures that all prisoners have a constitutional right to health care while they are incarcerated (NCCHC, 2006). The United States government is obligated to provide health care services which are equal to those available in the general public as prisoners do not have the capability of providing health care for themselves. The 1983 ruling in *Wellman v. Faulkner* established that a medical system of care must be in place in the prison system that meets “minimal standards of adequacy” which is measured as a comparison to community standards (Linder, Enders, Craig, Richardson, & Meyers, 2002). Medicare standards are presently used as the standard of care for hospice services. Once a person has been tried and convicted of a crime, their punishment is incarceration, or removal from society. Inferior health care, including end-of-life care, should not be accepted as part of this punishment
system (Linder & Meyers, 2007). A lack of these services adversely affects inmates who find themselves with terminal diseases. They often die alone, in an unfamiliar setting, and with less than optimally controlled pain (Dr. Steinhauser, personal communication, February 2009).
CHAPTER II

This chapter will present a review of the literature concerning general inmate health issues and barriers to implementing hospice programs. The clash of cultures between security and medical objectives will also be discussed. Specifically, it will address common issues found among existing programs in the implementation and maintenance of hospice care in the prison setting.

Inmate Characteristics

According to Zimmerman, Wald, & Thompson (2007), many inmates are former and/or current addicts, whether those addictions are to alcohol, drugs, or sex. Many have also had a lifetime of poor coping skills and do not take responsibility for their mistakes (Personal experience, 2009). Manipulative behavior is common in the prison setting and is often related to addictions or survival in a harsh environment (Zimmerman, Wald, & Thompson, 2002). In spite of these potential impediments to healing, inmates have a tendency of banding together and following the “prison code.” There is a sense of loyalty and caring among inmates that might not be expected in such a population (Personal experience, 2009).

Graying of the Prison Population

The prison system is experiencing a graying of the population similar to that of the United States as a whole. Strict mandatory state and federal sentencing laws, longer sentences for drug-related criminal convictions, and the “three strikes” laws requiring a mandatory life sentence for a third felony conviction contribute to an aging prison population (Linder & Meyers, 2007). From 1990 to 2000, the combined federal and state
prison populations experienced an average 6.5 percent yearly increase (Linder, Enders, Craig, Richardson, & Meyers, 2002). In 2006, the national average state prison population growth rate was 2.8 percent, and the national average length of incarceration is 22.6 years. In addition to this, the national average age of entry into the prison system is slowly but steadily increasing, from 29.9 years to 31.5 years within the same time period (Linder, Enders, Craig, Richardson, & Meyers, 2002). All of these factors contribute to the graying of the prison population.

**Health Issues**

In general, the inmate population suffers from more chronic diseases earlier in their lives. The Bureau of Justice (2007) lists the top three causes of death among state inmates from 2001-2004 as cardiac disease (27 percent), cancers (23 percent), and liver disease (10 percent). There is a higher incidence of health issues associated with risk factors such as substance use and addiction, prostitution, alcohol abuse, homelessness, and violent or risk-taking lifestyles. Incarcerated individuals are more likely to have experienced a history of limited access to healthcare, poor health literacy, poverty, and untreated or undiagnosed mental illnesses (Linder & Meyers, 2007). While in prison, further health risks involve limitations on dietary choices and physical activity, sharing of needles, and violence. Common chronic conditions found among the prison population include HIV/AIDS, hepatitis B and C, liver disease such as cirrhosis, tuberculosis, diabetes, and cardiac diseases such as hypertension, endocarditis, and cardiomyopathy (Linder, Enders, Craig, Richardson, & Meyers, 2002). These diseases tend to present at a younger age than
most of the free population due to the above risk factors (Linder, Enders, Craig, Richardson, & Meyers, 2002).

_A Clash of Cultures_

Prison culture and hospice philosophy do not share many of the same ideals and values. The mission statement of the Department of Corrections is “to serve and protect our communities and their crime victims by effectively employing the field’s best security practices and proven re-entry programming to prepare offenders for the release and reintegration in the communities of Arizona as civil, productive citizens” (AZ DOC, 2009). As such, there is a necessary agenda of discipline and structure in order to fulfill this mission. Inmate comfort, care, family unity, and individuality are not priorities in such a program (Cain, 2000; Tillman, 2000). Having a prison hospice program that is focused on inmate comfort and preferences offers prisoners some autonomy at the end of life in a controlled environment. However, hospice care is generally not seen as a chief concern to security. In fact, this autonomy, albeit limited, may be viewed as a potential breach of security and protocol. Historically, terminally ill inmates were removed from the prison to an acute care setting in their final hours. Having a death occur at the prison was viewed as disturbing to other inmates and a potential threat to security. Removal from the prison facility was the preferred protocol despite the added monetary cost of inmate transportation, security risks upon removing the inmate from the secured environment of the prison, and the wishes of the inmate to remain among friends and family in their final hours (Linder, Enders, Craig, Richardson, & Meyers, 2002). An existing do-not-resuscitate (DNR) order while at the prison does not necessarily mean it
Inmate distrust of security and medical staff is another part of the prison culture in direct conflict with hospice philosophy. The art of hospice care is rooted in trust: the interdisciplinary team must trust that the patient is truthfully providing information about his wishes, and the patient must trust that the interdisciplinary team is acting upon those wishes to the best of their ability (Linder & Meyers, 2007). Prison hospice has the added responsibility of providing care based on this type of trusting relationship in a safe, secure environment. Final decisions about what type of care is permitted ultimately rest on the shoulders of the correctional staff (NPHA, 1998). For a prison hospice program to be successful there needs to be a balance between safety and comfort care with mutual understanding of the roles and responsibilities of security and medical personnel (Boyle, 2002).

Most Recently Compiled Data

The United States Department of Justice (1998) compiled data regarding hospice and palliative care in the prison system. A written survey was sent to 53 correctional departments throughout the country. At that time, twelve formal hospice programs were in place, all with their own specific policies and procedures. Eight agencies were developing formal hospice programs, twelve were considering hospice, and nineteen departments of corrections did not have a hospice program or another form of palliative care available at the time. Half of the existing formal prison hospice programs required a DNR order as part of the admission process. Arizona was one of the nineteen states that
did not have a formal hospice program or alternative means of palliative care, and were not considering hospice at the time (United States Department of Justice, 1998).

Currently, there are no plans for the development of a prison hospice program in Arizona (Dr. Steinhauser, personal communication, February 2009).

**Existing Prison Hospice Programs**

The existing literature about prison hospice programs is scant. Three programs have been described in depth in the literature: The Louisiana State Penitentiary Hospice Program at Angola (Tillman, 2000; Cain, 2000; Evans, Herzog, Enders, & Meyers, 2002), the California Medical Facility (CMF) in Vacaville (Linder, Knauf, Enders, & Meyers, 2002), and the Maryland Division of Correction Hospice Program (Boyle, 2002). Basic components of each will be briefly outlined in the table below.
Table 1.
Characteristics of Existing Prison Hospice Programs

<table>
<thead>
<tr>
<th></th>
<th>Angola</th>
<th>Vacaville</th>
<th>Maryland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Established</strong></td>
<td>1998</td>
<td>1984, licensed</td>
<td>Not documented in the literature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>by state of</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>California</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1996</td>
<td></td>
</tr>
<tr>
<td><strong>DNR</strong></td>
<td>Required</td>
<td>Encouraged but</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>not required</td>
<td></td>
</tr>
<tr>
<td><strong>Life expectancy</strong></td>
<td>Less than or equal to six months</td>
<td>Less than or equal to six months</td>
<td>Less than or equal to six months</td>
</tr>
<tr>
<td><strong>Use of inmate volunteers</strong></td>
<td>Extensive participation, strict participation criteria</td>
<td>Called Pastoral Care Services volunteers, rigorous security clearance required</td>
<td>No, possible consideration in the future</td>
</tr>
<tr>
<td><strong>Community partnership</strong></td>
<td>Provide supplies, education, mentoring, networking</td>
<td>Participate in the prison hospice, provide education to staff</td>
<td>Participate in prison hospice, provide guidance and education</td>
</tr>
<tr>
<td><strong>Staff training</strong></td>
<td>Quarterly inservices for medical and correctional staff</td>
<td>Separate training modules for volunteers/workers, correctional staff, administration, and medical personnel</td>
<td>32 hours for medical and support staff, two hours for correctional staff</td>
</tr>
<tr>
<td>Volunteer training</td>
<td>40 hours of initial training, four-hour monthly meetings</td>
<td>Sixteen hour training program</td>
<td>Trained in hospice care and corrections</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------------------------------------------</td>
<td>-----------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Bereavement services</td>
<td>Thirteen month follow-up care provided for family, yearly memorial services</td>
<td>Monthly services on prison grounds for inmate “family,” phone call and letter sent to outside family</td>
<td>Available on request from inmates, hospice workers, refer outside family for services in their community</td>
</tr>
<tr>
<td>Medical parole</td>
<td>Available, but limited access due to harsh sentencing laws</td>
<td>Available, release depends on nature of the crime</td>
<td>Preferred course for terminally ill inmates</td>
</tr>
<tr>
<td>Visitation policy</td>
<td>Very liberal policy, inmate determines who are the members of his “family”</td>
<td>Family visits encouraged, assist with local housing for families in need</td>
<td>Only granted on a case-by-case basis</td>
</tr>
<tr>
<td>Interdisciplinary team</td>
<td>Manages all hospice patients</td>
<td>Meets weekly, daily rounds by physician</td>
<td>Meets weekly</td>
</tr>
</tbody>
</table>
Admission Criteria

Prison hospice programs exist independently of Medicare, Medicaid, or private insurance involvement or regulation. In this respect, prison hospice programs do not need to adhere to admission criteria found in programs in the free community. The State Penitentiary at Angola in Louisiana requires a terminal illness diagnosis with a life expectancy of six months or less. A DNR order is mandatory for admission. This is due to the institutional policy that any inmate in serious or critical condition must be transported for stabilization in an outside medical facility (Tillman, 2000). The inmate may request admission into the program or may be referred by medical personnel. Prior to his acceptance, the inmate must have had a thorough explanation as to his prognosis and understand the philosophy and goals of the hospice program. He must be cognitively able to give informed consent upon admission. As of 2000, family members or health care proxies were not permitted to “serve as surrogate decision-makers” for potential hospice patients. The cited reasoning is that inmates are considered wards of the state. The inmate may not be receiving solely curative treatment either due to infeasibility of treatment or patient refusal of further treatment. However, if the physician feels as though the treatment is palliative in any way, such as may be the case with radiation therapy or chemotherapy, it is supported and encouraged by the Angola hospice program interdisciplinary team (Tillman, 2000).

The Maryland Division of Correction Hospice Program’s medical staff refers all inmates to hospice with a six month or less life expectancy. The inmate must consent to
entrance into the hospice program and a DNR order is necessary for admission (Boyle, 2002).

*Do-Not-Resuscitate and Advance Directives*

The relationship of mistrust between inmates, correctional officers, and medical staff has historically extended into the realm of advance directives in the prison system. Correctional officers would prefer to remove actively dying inmates from the prison facility, believing that a death occurring on prison grounds would become a breach of security (Correctional Officer Abbott, personal communication, 2007). Dying inmates are often removed from the prison facility at the discretion of the security staff via ambulance to the local hospital even when a DNR order is in place (Dr. Steinhauser, personal communication, January 2009). In the experience of this author, inmates themselves may not trust in the medical staff enough to believe that signing a do-not-resuscitate (DNR) order would be in their best interest. Instead, the inmates may believe that this is a way for the state to save money by not performing expensive tests or transporting inmates for medical care outside of the facility. They do not understand that having advance directives in place provides them with more control over their care. Even when an inmate has agreed to palliative care measures rather than curative measures, he may not have a firm grasp on the concept of DNR and what cardiopulmonary resuscitation physically does to the body (Linder & Meyers, 2007).

Advance directives including a DNR order are not explicitly required for enrollment in all prison hospice programs; rather it is determined by each individual facility offering the care. The Maryland Division of Correction and the Louisiana State
Penitentiary Hospice Programs both require a DNR order as part of their admission criteria (Boyle, 2002; Linder, Knauf, Enders, & Meyers, 2002). On the other hand, the prison hospice at CMF Vacaville encourages a DNR order but does not require one for admission (Linder, Knauf, Enders, & Meyers, 2002). To avoid the question of coercion or force, Neveloff-Dubler (2001) suggests utilizing an outside party such as a prison chaplain or outside community religious authority to address advance directive issues with the inmates.

Use of Inmate Volunteers

The use of inmate volunteers in prison hospice programs is highly controversial (Ratcliff, 2000). There is great potential for abuse and misuse of perceived power. However, inmate hospice patients are more likely to trust and feel more of a connection with another inmate than they would with most medical or correctional staff. Inmate volunteers are also more readily accessible because they reside within the facility to assist with care should an emergency arise (Maull, 1998). An added secondary benefit to the utilization of inmate volunteers is the effect it has on the volunteers themselves. Many inmate volunteers report experiencing personal growth, greater respect for life, and increased understanding of human nature serving as a prison hospice volunteer (Tillman, 2000). The use of inmate volunteers also sends a positive message to fellow inmates that they are deserving of a dignified death even while in prison.

The State Penitentiary at Angola in Louisiana relies heavily on inmate volunteers in their hospice program. The entire volunteer staff is composed only of inmates. Angola is a maximum security prison with the majority of inmates serving long sentences. In the
state of Louisiana, life in prison means a life sentence without the possibility of parole. It is estimated that 85% of the inmates at Angola will die there (Tillman, 2000). The inmates who become hospice volunteers therefore have a vested interest in the program itself. They have an extensive screening process that automatically excludes inmates who have recent drug convictions, serious disciplinary actions while in prison, or convictions of sexual crimes against children. Inmate volunteers assist with activities of daily living, interpretation and translation services, clerical work, designing educational materials, peer education, and companionship (Tillman, 2000).

The Prison Hospice at CMF Vacaville also uses inmate volunteers in their program. It is considered an earned privilege to become and remain a hospice volunteer. Their exclusion criterion includes no disciplinary actions within the past year and no personal history of drug addiction. Inmate volunteers, also called Pastoral Care Services volunteers, perform duties similar to those performed at Angola (Linder, Knauf, Enders, & Meyers, 2002). On the other end of the spectrum, the Maryland Division of Correction does not use inmate volunteers in their program due to institutional policy of not placing one inmate in a position of power or influence over another inmate (Boyle, 2002).

Community Partnership

Partnership with existing community hospice programs is another option some state Departments of Corrections have chosen as part of their hospice programs. The hospice at the California Medical Facility Vacaville partners with several local hospice centers from which community volunteers are recruited to work in the hospice program at the prison. These community volunteers donate at least one hour each week to the hospice program.
at Vacaville and receive ongoing training and education throughout the year. In return, the inmates donate funds from food sales events at the prison to local service agencies in the community. When inmates are granted compassionate release from the prison system, they are able to become patients at several regional hospice centers with existing, established relationships with the prison system. In this way, continuity of care is maintained by continuing hospice care for the inmate upon his release and transition back into the community (Linder, Knauf, Enders, & Meyers, 2002).

The Maryland Division of Corrections Hospice Program also utilizes community volunteers. These people are trained by both hospice and correctional personnel and attend regular interdisciplinary meetings. Boyle (2002) maintains that these interactions offer an important link between the free community and the inmate population while providing essential care to the inmates based on hospice values.

**Staff and Volunteer Training**

Another area of concern involves staff and volunteer training. The current NCCHC guidelines state that adequate training must be provided for hospice staff and volunteers, but the definition of “adequate” is determined by each individual institution. The Hospice program at CMF Vacaville uses three separate training modules depending on the level of involvement in inmate care. All training is provided by the West Coast Center for Palliative Education through the University of California, Davis and is based on the National Hospice and Palliative Care Organization’s curriculum. The first module is designed for inmate staff and volunteers. They are taught listening skills and methods of practicing tolerance and compassion. In the second module, correctional officers,
administrative personnel, and medical staff learn concepts regarding symptom management and ensuring safety while providing compassionate care. The final module is provided specifically for physicians and staff appointed by the Chief Medical Officer to teach them about managing complex symptoms in this population, interpersonal skills, communication with family, and administering controlled substances in the prison setting (Linder, Knauf, Enders, & Meyers, 2002).

The hospice program at Angola truly incorporates inmate hospice volunteer training as an integral component of the program. Inmate volunteers are required to complete forty hours of initial training. The volunteers learn concepts about hospice care, death and dying, communication, bereavement, stress management, safety, infection control, confidentiality, patient rights, and the roles of the volunteer and the interdisciplinary team (Tillman, 2000). Medical personnel and correctional officers receive quarterly educational inservices about hospice care in the correctional environment appropriate to their role in hospice services. Training and materials are provided at no cost to the prison by University Hospice, a local organization (Evans, Herzog, & Tillman, 2002).

Training for hospice staff at the Maryland Division of Correction Hospice Program consists of 32 hours for medical and support staff by the Joseph Richey Hospice. Within these sessions topics such as the concept of death, hospice care, bereavement services, and managing medical concerns are discussed. In addition to this, weekly mentoring visits by the Joseph Richey team are conducted in the prison infirmary itself. Correctional officers are provided with a separate two-hour training session to provide an
understanding of the philosophy of hospice care in a correctional environment (Boyle, 2002).

_Pain Management_

The court cases of _Washington v. Glucksberg_ and _Vacco v. Quill_ are two cases that specifically address end-of-life issues in the prison setting. The rulings from these two cases determined that there is a caregiver obligation to address pain and suffering for terminally ill inmates (Neveloff-Dubler, 1998). However, it is not uncommon to find that providers in prison are overly cautious in prescribing pain medication for inmates needing end-of-life care. This is due to a concern for addiction to the medications, potential litigation, and institutional restrictions on narcotic prescribing (Maull, 1998).

The Louisiana State Penitentiary Hospice Program in Angola has developed a successful program for adequate pain relief. The hospice medical director acts as the attending physician for all enrolled hospice patients which relieves other physicians of the task of prescribing large doses of narcotic pain medications for hospice patients. They have identified which modes of medication administration have more of a potential for being tampered with, and therefore tend to avoid prescribing them. Instead, they have found that long-acting medications in pill form are more easily accountable for by the medical staff and tend to provide adequate pain relief (Tillman, 2000). Necessary precautions must be taken to ensure that controlled medications do not fall into the wrong hands. Narcotics and other mind-altering or sedative drugs are often used throughout the prison as a bartering tool. In this respect, they may be traded by inmates for favors,
protection, extra food rations, debt settlement, or whatever is of value to the inmate (Dr. Steinhauser, personal communication, January 2009).

Another issue involves the inmate’s acceptance of the offer of pain medication. Tolerating physical pain may be construed as a measure of strength within the prison population, and many inmates remain stoic in their reporting of pain so that they do not appear weak in front of the other inmates (Tillman, 2000, personal experience, 2009). Nurses must therefore become more creative in the way they present the options of pain medication and recognize non-verbal signs of pain (Personal experience, 2009). For instance, the nurse may emphasize that adequate pain relief may help the patient tolerate foods and liquids and may assist the patient in achieving better quality of sleep. In this way, the focus is shifted from pain control to nutrition, hydration, or rest (Personal experience, 2009).

Family Visitation

Correctional visitation privileges are highly regulated. According to the inmate’s custody level, they may be conducted only on certain days of the week, for specific amounts of time, and in specified areas of the prison (Correctional Officer Abbot, personal communication, June 2008). They are never completely private in nature. For established hospice programs within the prison system, there is not a question of whether family visits will be allowed. Limited correctional visitation policies and conventional definitions of who constitutes a family limit visitation privileges for inmates receiving hospice care. In the prison setting, inmates have been removed from society as a protective measure. This removal includes not having routine contact with family
members. Some inmates, due to recidivism or lengthy sentences, have essentially become estranged from family members in the free world. For many inmates, their “family” is then composed of other inmates. The definition of family to an inmate may therefore be more unconventional than what is considered to be “normal.” The inmate family becomes even more important to hospice patients for daily contact and communication. However, depending on the institution, inmate “family” members may not be recognized as such and therefore not be included in the plan of care (Linder & Meyers, 2007).

The Maryland Division of Correction Hospice Program offers ongoing visits from the chaplain. Boyle (2002) states that special visitation arrangements must be made in advance for hospice patients due to the physical location of the infirmary in this maximum security prison. Visitation allowances are granted on an individual case-by-case basis. However, this issue is one of the planned program refinements for the future.

The Hospice at the California Medical Facility (CMF) Vacaville encourages family visits for its inmates. There is no explicitly stated definition of family in the literature for this institution. CMF Vacaville assists visiting families in finding temporary housing through the local Salvation Army. For more long-term accommodations, local churches have found private residences willing to house family members of those in the hospice program (Linder, Knauf, Enders, & Meyers, 2002).

The Louisiana State Penitentiary Hospice Program at Angola claims to have the most liberal visitation policy in the United States (Tillman, 2000). The inmate determines who is considered to be his “family,” and this family is allowed to have contact with the hospice staff twenty-four hours a day. The hospice staff is actually encouraged to interact
with family members of hospice patients. In the prison setting, this is generally not the norm unless a patient is close to death. When a hospice patient is actively dying, all family members, including children and other inmates, are allowed to sit in a continuous vigil at the patient’s bedside (Tillman, 2000).

**Bereavement Services**

Offering bereavement services after an inmate in a hospice program has passed away is optional for existing prison hospice programs. Community hospice programs generally offer thirteen months of follow-up services for family members and friends of hospice patients who have passed away. The CMF Vacaville Hospice Program does not provide follow-up counseling for family members of hospice patients. This is considered a breach of security and is not allowed by correctional policy. They do, however, hold monthly memorial services at the prison for inmate “families.” Group and individual counseling is available from the chaplain and mental health staff for those who need additional assistance with the grieving process (Linder, Knauf, Enders, & Meyers, 2002).

The Hospice Program at Angola performs a bereavement needs assessment early in the admission process to hospice services. It is an ongoing process that allows for early recognition of future needs. This aspect of the program provides follow-up bereavement care for the family up to one year after the death of the inmate. The hospice staff writes letters, makes telephone calls, and refers family to outside counselors. Funerals are often conducted on the prison grounds because of inmate wishes or the family’s lack of funding. When an inmate is buried on prison grounds, the casket is made by inmates at the prison and volunteers are encouraged to assist in preparing the body for burial and in
acting as pallbearers at the funeral. The hospice staff members at Angola help inmate volunteers prepare a yearly memorial service to remember the inmates who have passed away (Tillman, 2000).

Medical Parole

Medical parole, or compassionate release, is a program available in some jurisdictions whereby an inmate who is terminally ill may be released early from their prison sentence. Safety of the public is one of the primary concerns with medical parole. The eligibility criteria and lengthy review process often prevents inmates from being granted medical parole (Mauell, 1998; Linder & Meyers, 2007). There is also a public fear related to the release of certain types of criminals such as illegal drug sellers, child molesters, and violent crime offenders. Public officials making the decision to grant medical parole may be hesitant based on public opinion and the lack of a guarantee of the length of inmate survival once released (Zimmerman, Wald, & Thompson, 2002). Unfortunately, many inmates either die while waiting for a decision to be made or are released at such a stage in their illness that quality of life and time with family is impaired (Linder & Meyers, 2007).

Medical parole is the favored method of managing terminally ill inmates in the state of Maryland. When an inmate is granted medical parole, they are released to family members willing to care for them or to a long-term institution. They are required to follow all parole regulations and are returned into custody if they are violated. For medical parole to be considered in Maryland, the inmate must meet at least one of three specific criteria: they must be diagnosed with a terminal illness with a prognosis of six
months or less to live; they must have complex medical needs that the prison system is not able to accommodate; or the care they receive in the community will be more beneficial than care in the prison system. In 1999, approximately half of those who applied for medical parole in Maryland were released back into the community while the other half died waiting in prison (Boyle, 2002).

Challenges to Prison Hospice Programs

Challenges to establishing and maintaining a prison hospice program include institutional policies, financing, liability issues, and opinions of the public, inmates, medical staff, and correctional officers (Ratcliff, 2000). The prison system generally adopts an attitude of conformity. There are institutional policies and rules that must be followed by each inmate, and when these rules are disobeyed, there are negative consequences. Inmates are also classified according to a system based on their danger to society (reason for incarceration) and danger to others. The higher the numerical rating, the more “dangerous” the inmate is, which restricts what little freedoms are available at the prison. There has been a belief that hospice programs in the prison would cause security risks based on the amount of personal contact time between inmates and medical staff (Correctional Officer Abbot, personal communication, August 2008). Crowded conditions at the prisons also challenge the establishment of hospice programs. Physical space is limited even in the infirmaries, which may limit the availability of hospice care to the inmates (Ratcliff, 2000). It is also challenging to find secure areas within the prison for extended family visits.
Financing a separate hospice program may not be feasible in this population. Oftentimes the budget is not adequate enough to support existing programs, let alone for the introduction of a new undertaking. Hospice patients often require specialty beds, equipment, extra food rations, frequent nursing interventions, and large doses of pain medications. The Hospice Program at Angola, which was implemented and continues to exist without a separate budget from the prison medical system, has creatively circumvented this problem through the use of inmate volunteers, community organizations, and a dedicated staff willing to search for alternative funding (Tillman, 2000).

The prison population is considered to be highly litigious. Medical providers have voiced concerns about liability when aggressive treatment options are not utilized (Ratcliff, 2000). They fear that the inmate or their family may sue for neglect if more aggressive treatment is not attempted even when the inmate is no longer interested in curative treatment (Linder & Meyer, 2007). This creates a huge barrier to establishing hospice services where the philosophy of care is palliative rather than curative (Ratcliff, 2000). Ethical concerns about coercion and neglect arise when inmates are required to sign DNR orders and forego curative treatments (Tillman, 2000.)

Personal prejudices of the public, the inmates, the medical staff, and correctional officers present another barrier to hospice care in the prison. Although there is little written evidence to support this, many members of the general public do not feel as though inmates deserve to die with dignity, based on the nature of their crimes (Cohn, 1999). This prejudice may also be shared by correctional officers and medical personnel.
within the prison system (Tillman, 2000). The inmates themselves may be resistant to the idea of dying while in prison, even if the death is dignified. There is a feeling of inmate mistrust of correctional and medical staff within the prison system that may prevent open communication and true understanding of hospice philosophy (Tillman, 2000).

Summary

This chapter identified common obstacles that need to be addressed when implementing a prison hospice program. The needs and limitations of the inmate, the correctional officers, the medical staff, and the community at large must all be taken in to account before final decisions are made.
CHAPTER III

This chapter will propose a theoretical framework appropriate for the implementation of a prison hospice program in Arizona. This will include current policy, best suggested practices, and suggestions for successful implementation of a formal hospice program in the Arizona state prison system.

Theoretical Framework

The suggested theoretical model for implementing a prison hospice program in Arizona is Kolcaba’s Theory of Comfort (Merkel, 2007). With the use of this theory, a holistic view of the patient may be taken to provide individualized comfort care. The Comfort Theory recognizes four general contexts in which human needs are met: the physical, environment, sociocultural, and psychospiritual contexts. The physical context refers to sensations and the maintenance of homeostasis. The environment is the surrounding or background of experience. Sociocultural issues involve interpersonal relationships, family traditions, and rituals. And lastly, the psychospiritual aspect pertains to internal awareness of the self, self-esteem, and meaning in one’s life. There may be distress in any of these four contexts. Relief is defined as the state of being in which a discomfort is eased or alleviated (Merkel, 2007).

Patient outcomes are affected by the comfort interventions provided when there is a state of distress. Human needs may be met by using technical, coaching, and/or comforting types of interventional care. Enhancing comfort will enable the patient to participate in health-seeking behaviors. These health-seeking behaviors include physiological, psychological, social, cultural, philosophical, and spiritual activities. Use
of the Comfort Theory in prison hospice care will allow the patient to explore aspects of
the self that may not have been otherwise attainable. The Comfort Theory allows for
individual expression of care, with the unit or recipients of care very generally defined. In
the prison hospice setting, they may include the patient, the caregivers, the medical staff,
the correctional officers, and other inmates. In this way, application of the Comfort
Theory in the prison setting has the potential to affect more than just the patient. The
benefits may be experienced throughout the prison itself as its influences are
disseminated by those who participate in the program.

Best Practices

The Robert Wood Johnson Foundation, a philanthropic organization dedicated to
improving health and health care for Americans, supported the Excellence in End-of-Life
Care program which funded the GRACE (Guiding Responsive Action in Corrections at
End-of-Life) Project in 1998. The Volunteers of America organization led the initiative in
collecting information about end-of-life practices in existing federal and state prison
hospice programs. They compiled a record of what was recognized as best practices at
the time under four categories: care, safety, security, and justice (Ratcliff, 2000).

The category of care encompasses availability of services, team members, and the
plan of care. They determined that end-of-life care should be available to all inmates with
a terminal illness regardless of security level or length of incarceration. Comprehensive,
individualized end-of-life care should be provided to the inmate and family members by a
trained interdisciplinary team consisting of at least a physician, a nurse, a mental health
professional, and a chaplain. The care of the inmate should not be interrupted by a change in their housing situation or release back into the community (Ratcliff, 2000).

Safety and security are inherently important in the correctional setting. All members involved in the hospice program must be protected from harm by the physical environment. Correctional staff have the added burden of protecting inmates and medical personnel from harm caused by themselves and others (Ratcliff, 2000). To achieve these two goals, the correctional facility must be up-to-date on health and environmental codes, have disaster plans in place, and have a written suicide prevention and intervention program (Ratcliff, 2000).

The concept of justice applies to patient care and staff well-being. The standards set forth by the GRACE project emphasize equality without discrimination in the availability of hospice care to inmates. Psychosocial and spiritual care should be available around the clock, with extended family visitation privileges granted. Bereavement services should be provided for family, inmates, and staff with an individualized plan of care in place for each inmate. Medical and security staff and volunteers must uphold defined ethical professional standards such as maintaining inmate confidentiality and respect while preserving professional boundaries (Ratcliff, 2000).

Ratcliff (2002) was also able to recognize several commonalities among successful existing hospice programs. Most had the highest administrative support for their program and at least one loyal and dedicated staff member who truly believed in the need for hospice care. Inclusion of security staff in the planning and operations of the hospice
programs appeared to be of benefit as well. And finally, support from local community hospice programs was found to be indicative of successful programs.

The NCCHC publishes guidelines (Anno, 2001) and standards (NCCHC, 2008) for adequate health delivery in the prison system. The guidelines are general enough that individual institutions may use them to plan a hospice program that fits their needs. The guidelines suggest including ongoing education for medical and correctional staff; specific palliative care protocols; adequate formulary with ample medications that are secure yet available; specialty food and fluids; extended visitation rules; and bereavement services for family members and fellow inmates (NCCHC, 2001).

The standards of practice for the prison system are more specific (NCCHC, 2008). Hospice and palliative care are not mandatory. Each prison should strive for a “good death” for the inmates regardless of whether a hospice program exists. This entails having a supportive environment where the inmate may die with dignity, surrounded by friends and family, and in as little pain as possible. If a hospice program does exist, enrollment should be based on the inmate’s informed choice. There should be adequate staffing of medical and security employees who have been trained in the philosophies of hospice and palliative care. The NCCHC (2008) defines terminal illness is defined as having a prognosis of one year or less to live. It is recommended that an interdisciplinary team be formed to coordinate the individual plan of care for each hospice patient. Inmates are permitted to establish advance directives including a living will, health care proxy, and DNR orders. However, it is up to the institution whether this will be a hospice admission requirement. These directives must be signed after the appropriate education has been
given to the inmate regarding the meaning of the directives and the consequences of their decisions. Pain and symptom management should be of utmost importance in end-of-life care. In the correctional setting, all controlled substances must be maintained in a secure environment with strict accountability. When appropriately trained and supervised, the use of inmate volunteers in prison hospice programs is encouraged. They should not be permitted to make decisions, or handle medications, surgical instruments, or sharps equipment. They may be allowed to participate in support groups and assist with activities of daily living, but may not provide patient care without direct supervision. All features of the standards of practice must be clearly written and defined prior to implementing the use of inmate volunteers.

Outcomes

Yampolskaya & Winston (2003) designed the Prison Hospice Survey intended to identify the principle components and major outcomes of existing prison hospice programs. The five principle program elements include: adjustment to hospice programs in the prison, formation of a multidisciplinary team, extent of inmate volunteer involvement, comfort care and privileges, and end-of-life care and requirements. It was found that each individual institution had to decide on these principles in the formation and maintenance of their hospice programs. The interplay of the five program elements influenced expected and unexpected outcomes. Recognized outcomes of the study included cost-effectiveness, positive effects on inmate volunteers, and the experience of comfort care. Hospice care proved to be cost-effective with the use of community and inmate volunteers. Hospital visits were kept to a minimum with mandatory DNR orders.
The use of inmate volunteers had a positive effect on hospice patients, volunteers, and other inmates by demonstrating caring in a restricted environment. The experience of hospice care in the prison allowed the patients to experience better pain management while remaining in a familiar environment with support from their peers (Yampolskaya & Winston, 2003).

**Suggestions for Initiating a Prison Hospice Program in Arizona**

The Arizona Department of Corrections currently has two existing policies addressing the management of end-of-life care. The policy entitled “Management of Terminal Illness” (AZ DOC, 2008) outlines guidelines for healthcare personnel in providing end-of-life care. Procedures for obtaining a DNR and other advance directives orders, adequate pain control, roles and responsibilities of health care providers, and policies for “hospice-type” services are described within this policy. This is not a framework for a formal hospice program (AZ DOC, 2008). The policy “Hospice Services Support Organization” (AZ DOC, 2007) describes responsibilities and outlines for the future development of a formal prison hospice program in Arizona. Key components of the future program will include:

1. A multi-disciplinary team approach with key members identified in the policy;
2. Encouragement of family involvement and visits from family;
3. Inmate volunteers are to be permitted with adequate training and screening;
4. The inmate must be diagnosed with a terminal disease and prognosis of one year or less to live;
5. Responsibilities of health care providers are clearly defined;
6. Follow-up care for hospice employees and inmate orderlies are to be provided following a patient’s death;

7. Memorial services may be organized by Religious Services and will be open for all inmates, medical staff and correctional staff.

Again, this policy exists in the event that the Arizona Department of Corrections decides to implement a formal prison hospice program in the future.

While these existing policies suggest an understanding of the need for and openness to implementation of a formal hospice program in Arizona prisons by correctional authorities, they do not make them mandatory. They are definitely a positive step in the right direction. The question then becomes: How do you transform the principles outlined in existing policy to make a formal prison hospice program a reality in Arizona?

To begin with, an anonymous survey regarding interest levels in establishing prison hospice care may be inexpensively performed using the opinions of current inmates, medical personnel, and correctional officers. The options to identify oneself as being interested in helping in the formation of a prison hospice program should be part of this survey. Based on successful hospice programs in state prisons across the country (Ratcliff, 2002; Tillman, 2000; Cain, 2000), the one obvious missing piece in Arizona is a champion to the cause of providing hospice care.

Once interest has been established, key members from the security and medical realms should meet to discuss options for the program based on the existing prison policies and best practices set forth in the literature. The National Prison Hospice
Association (NPHA, 1998) has provided prison hospice operational guidelines for the establishment and maintenance of prison hospice programs. The guidelines are intended to assist each individual institution in creating their own hospice policies that are unique to their institution. These may be used in conjunction with the recommendations of the NCCHC in forming a prison hospice program in Arizona. Several issues not explicitly addressed in the existing policies include:

1. The definition of family. The focus of palliative care is the patient and the family. In the prison setting, family may include biologic relatives and members of the prison “family.” The NPHA suggests allowing the inmate to define who he considers to be family (NPHA, 1998).

2. Inclusion of correctional personnel. The NPHA proposes that including security personnel as part of the interdisciplinary team will promote staff cooperation throughout the process while providing needed information about security practices that may not be apparent to an outsider (NPHA, 1998).

3. Budgetary concerns. Several existing hospice programs operate within the existing medical budget. Partnering with local hospice communities who may serve as mentors, educators, and sources of donated time, supplies, and income may help offset some of the initial upstart costs of the program.

4. Location of hospice services. This is based on the size of the prison, the available staff, the budget, and the desires of the inmates. Having a separate hospice unit allows staff to provide focused hospice care but may be seen as a “death row” among inmates. With the relatively low number of inmate deaths while in custody
in Arizona, preparing a separate hospice facility does not seem feasible. Another option is to house hospice inmates within a designated infirmary. Medical staff may find it challenging to shift between hospice and general medical care, and inmates who are not part of the hospice program may be disturbed by visitors and more frequent interventions. It may also be more confusing to non-hospice inmates if special allowances such as extra food rations, more frequent pain medications, and extended visitation times are granted to hospice inmates. However, it may benefit the hospice patients to have more “healthy” inmates in close proximity. The final option is to provide hospice care to inmates who are healthy enough to remain in the general population. Maintaining their current housing situation may enable hospice inmates to feel more “normal” and be more continually surrounded by their peers. When inmates are permitted to remain in the general population, they must be able to perform activities of daily living with minimal assistance, which may exclude some of the hospice participants (NPHA, 1998).

The difficulty in making suggestions for the establishment of a hypothetical prison hospice program within Arizona lies in the uniqueness inherent to each program. There is no cookbook recipe that has consistently worked in prison hospice programs. The best advice would be to keep an open mind and be prepared for ongoing change. Using Kolcaba’s Comfort Theory as a guiding principle for the hospice program will help enable its participants to embrace the patient and possibly each other in mind, body, and spirit.
Summary

Prison hospice is an area of health care that is largely unexplored in recent research and literature. However, several existing programs have proven that with support from both medical and correctional personnel, prison hospice programs may flourish. Potential benefits apply to the patients, the correctional staff, the medical staff, and prisoner volunteers.
REFERENCES


