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The Intersection of Aging, Health, & Correctional Systems: An Exploration of Experiences, Approaches, & Policies Using a Person-centered Framework

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ABSTRACT

THE INTERSECTION OF AGING, HEALTH, & CORRECTIONAL SYSTEMS:

AN EXPLORATION OF EXPERIENCES, APPROACHES, & POLICIES

USING A PERSON-CENTERED FRAMEWORK

By

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MAY 2024

Committee Chair: Dr. William J. Sabol

Major Department: Criminal Justice & Criminology

This dissertation consists of three interconnected papers that study the intersection of correctional systems and aging in the United States, specifically in prisons and community supervision. The papers examine existing policies and the experiences of older adults using a person-centered framework. The first two papers explore data collected through semi-structured interviews with community supervision officers and people with experience under community supervision. The first paper investigates a person-centered community supervision model and highlights how it applies specifically to older adults, defined as those aged 50 or older. There is evidence of the implementation of this model, but there is an opportunity for further development. The data presented underscores the need for a more precise definition of a person-centered approach in community supervision and more attention to the age-related needs of people under supervision. The second paper explores the unique challenges of people aged 50 or older who are under community supervision, such as adapting to technology, securing stable housing, and managing chronic health conditions. It further reveals the gaps in knowledge of officers concerning aging-specific resources and the universal experiences pertinent to all age

groups. The third paper is a content analysis of end-of-life decision-making policies in U.S. departments of corrections. It underscores the variability in accessibility and specificity of such policies, advocating for a more person-centered model that aligns with community standard quality of care. The research signifies that current prison systems have opportunities for enhancing policy and potentially affecting the quality of end-of-life care in prisons. Collectively, these papers emphasize potential improvement and growth in person-centered approaches for correctional systems and the opportunities to address the challenges of a growing older adult population. These findings highlight the need for additional research and collaboration between the fields of criminal justice and gerontology. The relevance extends beyond research to practitioners and policymakers in criminal justice and aging services whose work directly impacts this population.

THE INTERSECTION OF AGING, HEALTH, & CORRECTIONAL SYSTEMS: AN EXPLORATION OF EXPERIENCES, APPROACHES, & POLICIES

BY

VICTORIA EMILY HELMLY

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree
of
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ACCEPTANCE

This dissertation was prepared under the direction of the candidate's Dissertation Committee. It has been approved and accepted by all members of that committee, and it has been accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Criminal Justice & Criminology in the Andrew Young School of Policy Studies of Georgia State University.

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Dedication

I would like to first thank my family. I would have never reached this goal without your support. To my mom, my appreciation and love for education come from you, our family's first "Dr. Helmly". Thank you for instilling the love of learning in me. Thank you to my sister, Katie, for being my number one fan my entire life, and for your help with citations for 15 years. I wish I could promise that I won't need help with citations ever again, but that might be a lie. And, to my dad: I know you may not be able to fully understand this milestone and what it means, but I know you have always been proud of me, and I will keep trying to make the world better for you even when you are unable to understand. I love you.

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Language

This dissertation uses several terms or phrases that may hold different meanings to different audiences or readers. Because language has weight and is particularly important to the research presented, I briefly explain key terminology used throughout this dissertation.

The term "criminal legal system" refers to the broad agencies and actors that are a part of the process of law enforcement in the U.S., from arrest to court systems to incarceration. I use the term "correctional system" to refer specifically to jails, prisons, and community supervision, which includes parole and probation. The term "criminal justice" refers to the field or discipline.

I was mindful in describing marginalized groups and opted to use person-centered or person-first language. This includes referring to people who have been incarcerated or under community supervision using terms such as "incarcerated person," "formerly incarcerated," or "people with experience under community supervision" rather than using "offender," "ex-offender," "parolee," etc. To remain consistent with the aging services and gerontology fields, I use the term "older adult" to describe people in their later years of life. If I am referring to a specific age group, it is defined within the paper.

Introduction

This dissertation consists of three papers that explore the intersection of aging and the correctional system through a person-centered framework. The interpretation and application of the term 'person-centered' varies across fields and audiences; however, there is a common agreement that it involves delivering care or services customized to an individual's unique and current needs and preferences. The research includes the experiences of people aged 50 or older and those with life-limiting illnesses who are incarcerated, formerly incarcerated, or on community supervision. The first and second papers present findings from interview data collected for this dissertation, and the third paper is a previously published paper in which I conducted content analysis of end-of-life decision-making policies in U.S. departments of corrections and the Bureau of Prisons.

Chapter 1

This paper explores a person-centered community supervision (parole and probation) model specifically as it applies to people aged 50 or older, although the findings are applicable across age groups. The "person-centered model" concept is explored within the paper, including how participants define the term. The research seeks to understand the implementation and perceptions of this model from the perspective of officers and people under supervision. Data collected through 24 semi-structured interviews with community supervision officers and people currently or previously on community supervision was used to answer the research questions. The themes and findings from interviews were used to understand the person-centered model implemented by the state agency and the experience of people under community supervision. This research reveals that while the concept of person-centered community supervision remains nebulous to many, some officers intuitively adopt a person-centered approach in their work

because of their beliefs about supervision. Interviews cover some key challenges faced in implementing a person-centered supervision model, primarily from high caseloads and limited time to meet with people on their caseloads. While some participants perceived the person-centered model as successful and evident in current supervision interactions, others shared that there was little evidence of it. The paper emphasizes the need for a clearer definition of a person-centered community supervision model while contributing to discussions on personalized approaches in the criminal legal system. It can be a resource for practitioners and policymakers to improve community supervision for people of all ages.

Chapter 2

This paper presents research to expand the understanding of the experiences, including the challenges, of people aged 50 or older under community supervision. It explores this through data collected from semi-structured interviews with community supervision officers and people with experience on community supervision. Common challenges for older adults reported by participants include technology, housing, and managing health conditions. Findings from this research are informative and useful to both criminal justice and aging services professionals and policymakers as they illuminate some of the challenges that older adults on community supervision face. The paper also recognizes the universal experiences of people in every age group highlighted by this research. Additionally, findings on the perspectives on aging in corrections and the gaps in officers' knowledge of aging-specific resources are examined as themes. This research sheds light on the gaps in knowledge of community supervision officers about aging-specific resources and the lack of training around aging-specific issues.

Chapter 3

This paper is a content analysis that examines the language of end-of-life policies and the availability of documenting end-of-life wishes. It details the accessibility and specificity of these policies. This research aims to define and identify end-of-life decision-making policies in U.S. departments of corrections and the Bureau of Prisons and to describe and analyze the existing end-of-life decision-making policies in U.S. departments of corrections and the Bureau of Prisons. We reviewed publicly available policies from 37 of 51 U.S. prison systems (73%). Areas of commonality include the importance of establishing healthcare proxies and how to transfer end-of-life decision documents. Differences include who can serve as their surrogate decision-makers and the accessibility of decision-making documents. The research highlights that many prison systems have an opportunity to enhance their medical decision-making policies to bring them in line with community standards of quality of care and adhere to a more person-centered model of care. The variation we observed in policies may reflect variation in the quality of care at end-of-life. This paper was published in January 2022 in the *International Journal of Prisoner Health*. I co-authored the piece with Marisol Garcia and Drs. Benjamin Howell and Brie Williams. As the first author, I have received written approval from my co-authors to use this paper as part of my dissertation.

This research aimed to increase the understanding of the experiences of older people and people with a life-limiting illness in correctional system settings, including jails, prisons, and community supervision. The research presented in the subsequent chapters was built from a current understanding of the policies, challenges, and opportunities for older people in the criminal legal system while allowing the data to tell the story.

Theory & Frameworks

Theoretical frameworks from social work, gerontology, and criminology help to understand the experiences of people who have been incarcerated or are under community supervision. These frameworks are also useful in considering how systems, including the criminal legal system and the aging services network, can address the challenges of this population and ultimately bolster better outcomes, which are explored in further detail in this section. This section explores the theoretical backdrop of the three papers, including the person-centered framework prevalent in gerontology and aging practice and how it is applied in the context of the criminal legal system in the subsequent chapters.

Person-centered Theory, Approaches, & Models of Care

Several different disciplines have studied and employed person-centered frameworks. The approach and understanding of what "person-centered" means differs across fields; however, the consensus is that it entails individualized care or services that meet a person's current, specific needs and preferences. In line with the work of Carl Rogers and person-centered theory, this concept focuses on empathy and self-direction by the person receiving services. Rogers's theory posits that relationships that allow for choice and expression of feelings and thoughts will produce better outcomes (Kirshenbaum, 2004).

The concept of a person-centered approach is studied in gerontology and employed in caring for older adults in clinical and residential settings. The American Geriatrics Association states, "Person-centered care means that individuals' values and preferences are elicited and once expressed, guide all aspects of their health care, supporting their realistic health and life goals" (American Geriatrics Society, 2016). Federal nursing home regulations include a requirement for developing person-centered care plans for each resident, which involves considering the

resident's goals for their care (42 CFR § 483.21). The "culture change movement" has become prominent in nursing home settings. This person-centered movement seeks to shift the traditional institutional model of nursing care into a model that is more like a person's home. The Pioneer Network, a leader in the culture change movement, acknowledges that implementing person-centered care into spaces that traditionally do not employ this model requires the commitment of organizations and policy. They define culture change in the following way:

> "Culture change is the common name given to the national movement for the transformation of older adult services, based on person-directed values and practices where the voices of elders and those working most closely with them are solicited, respected, and honored. Core person-directed values are relationship, choice, dignity, respect, self-determination, and purposeful living" (Pioneer Network, 2024).

Measuring person-centered care or models is one of the key challenges in studying the framework in any setting or field. Though it is a well-known concept in nursing and care work, particularly in caring for older adults, there is no single definition or a well-established measurement (Kogan et al., 2016; Byrne et al., 2020). Even in long-term care settings where the concept of person-centered resident care is growing, finding a way to observe or quantify it remains challenging (Kogan et al. 2016). One study attempted to do so by determining areas where it could be measured and observed, including the admissions process, care planning, routine care, dining, responsiveness, and activities (Johs-Artisensi, 2017). Existing research that examines the implementation of person-centered care in residential settings for older adults indicates positive outcomes, including for staff and residents (Brownie & Nancarrow, 2013). Tools for measuring person-centered models have been developed but have not been thoroughly studied and tested. There is a need for additional exploration of these tools so that their

reliability, validity, and applicability can be fully determined and standardization can be achieved (Edvardsson & Innes, 2010; Doll et al., 2017; Fazio et al., 2018).

Though the concept of person-centered care is more widely known in healthcare, challenges persist in implementing it. Research indicates that applying person-centered care in everyday nursing tasks is challenging and is seen as going above and beyond normal expectations (Byrne et al., 2020). Experts suggest that including person-centered care training in healthcare professionals' training and ensuring that this model is used in all levels of management and systems is necessary to implement person-centeredness into patient care (Coulter & Oldham, 2016). There may be differences in attitudes and perceptions about person-centered care based on demographics, such as gender or age. A study of the perceptions of person-centered care by staff in long-term care found that the older the staff, the less likely they were to support person-centered care (Boumans et al., 2021).

Given what is known, I presume that the issues that pervade the understanding and implementation of person-centered models in healthcare and elder care persist in the context of prisons and community supervision as well. To fully embrace the concept of person-centeredness in the context of prisons or community supervision, the people implementing these models must clearly understand what it means in their everyday jobs.

Person-centered Models in Community Supervision

Within criminal justice, there have been shifts in approaches, wavering between punitive and rehabilitative. In recent years, the field of criminal justice has been more open to rehabilitative strategies, including in community supervision, as more punitive approaches have proven to be not as successful. The implementation of evidence-based practices that are more rehabilitative has grown, albeit with challenges (Taxman, 2018). Staff generally have a favorable

opinion on using evidence-based practices, even when they have a lower understanding and implementation of the practices (Debus-Sherrill et al., 2023). The organization or agency plays a significant role in officers' perceptions and willingness to implement these practices. For example, some research indicates that when officers have a more positive view and relationship with their agency and leadership, they are more likely to adopt evidence-based practices in their work (Viglione & Blasko, 2018). However, other evidence shows that the education level of staff plays a more significant role in their adoption of evidence-based practices than their perceptions of the agency (Debus-Sherrill et al., 2023).

Wilson et al. (2022) examined the reception of evidence-based practices and officers' confidence in applying them to their work. Gender and race differences exist in officers' comfort level and confidence in implementing some of the evidence-based practices. For example, women and Black officers were more comfortable implementing the new models of supervision, whereas men and White officers were more comfortable with a traditional supervision model (Wilson et al., 2022). There is some data on using person-centered or client-centered approaches to community supervision; however, it is limited and does not focus on older adult supervisees. Existing evidence suggests that person-centered approaches to supervision are more successful when there is support from leadership and the judiciary community (Viglione & Blasko, 2018). Motivational interviewing is one of the evidence-based practices researched in parole and probation populations. This technique focuses on the belief that the person under supervision can move toward behavior change and make positive decisions in their own life (Iarussi & Powers, 2018). Though motivational interviewing is not necessarily labeled a "person-centered" approach, it fits into this model. For example, motivational interviewing aims to tap into a person's reason for change, which is a strengths-based and personalized approach. Further, this

aligns with Carl Rogers's person-centered theory. Within the field of psychotherapy, this theory claims that allowing the client to express their own goals and the therapeutic relationship is directed by the client (Kirschenbaum, 2004). In a guide published by the U.S. Department of Justice National Institute of Corrections, the authors note that MI's origins are in chronic disease management and addiction, and it was unexpected for many to see it take hold in the criminal legal field. MI is a "person-centered method of fostering change by helping a person explore and resolve ambivalence" (Walters et al., 2007). Evidence indicates that implementing MI communication strategies among probation officers is often combined with more directive methods, and the uptake of MI varies based on individual traits and agency culture (Viglione et al., 2017).

In Georgia, the Department of Community Supervision announced the implementation of a person-centered model for supervision in November 2020. A press release states that employing evidence-based strategies such as Trauma-Informed Care has created a suitable climate to introduce a person-centered framework into its model. Though DCS does not define this framework officially, the Commissioner states, "Rather than define someone by their crime or conviction, we recognize people as unique individuals with their strengths, needs, and goals" (Georgia Department of Community Supervision, 2020). This statement aligns with the definitions of person-centered care in healthcare settings where a person is not seen as only their disease or disability but recognized as a person first with unique attributes and assets. Likewise, it matches the person-centered theory because it implies self-direction and a focus on individual strengths.

Person-centered End-of-Life Care in Prisons

With an increase in the older age segment of prison populations, there is a growing need for consideration of end-of-life decisions and care within the prison setting. Although most incarcerated people will be released back into the community, some people die in custody. In 2019, over 4,000 people died in state and federal prisons, and almost 80% of those deaths were from illness (Carson, 2021). End-of-life care programs, including hospice services, exist in prisons across the U.S., though implementation challenges and data collection about these programs persist (see Prost et al., 2020; Maschi et al., 2014; Linder & Meyers, 2009). Person-centered end-of-life care includes allowing people to make their own decisions about their care and the life-sustaining measures they want to receive. In community settings, this has the ability to document their wishes through advanced directives, living wills, and do-not-resuscitate orders and access to hospice care if desired. Within the prison context, the prison's policies and environment limit the adoption of person-centered end-of-life care for incarcerated people (Burles et al., 2016; Stensland & Sanders, 2016).

Person-centered Language & Terminology

Person-centered language (sometimes referred to as "person-first," "patient-centered," etc.) is a component of person-centered models of care and services. Person-centered language considers personhood before a person's health status or other features. Person-centered language is highly relevant in the field of aging, mental health, physical disabilities, and other health-related spaces. Examples of this language include "person living with dementia" rather than "demented patient/person," "person with a disability" rather than "disabled person," or "person experiencing homelessness" rather than "homeless person". In some fields, person-centered language can also mean reducing the use of the term "patient" when a person is not in a hospital

or doctor's office setting—for example, referring to people living in nursing homes or assisted living communities as "residents" rather than patients because that is where they reside. The goal of person-centered language is first to consider the identities and strengths of a person to reduce stigma.

Person-centered language in the criminal legal system is not as widely used as in health, disability, or social service fields; however, it is a growing area of focus. Academia and advocacy organizations have called for more person-centered language when writing and speaking about people involved in the criminal legal system (see Tran et al., 2018 and Solomon, 2021 in The Marshall Project). Though person-centered language is becoming more accepted and preferred, it is not without debate. Even so, evidence suggests that the use of person-centered language decreases the negative stereotypes of formerly incarcerated people. There is a link between the words or terminology people hear or read about incarcerated or formerly incarcerated populations and their attitudes and feelings toward and about that population (Jackl, 2021). There is a lack of data to support significant impact or behavior change with the implementation of person-centered language.

Ecological Frameworks

To study aging within the context of corrections, I used an ecological framework to consider this population's experiences. This framework aids in understanding the impact of this population's immediate environment and the broader systems that have impacted their trajectory and current circumstances. Further, it incorporates the individual-level attributes and their interaction with the broader ecosystem. An ecological framework encompasses the larger sociopolitical climate, an individual's social support network, and personal characteristics and strengths (Brofenbrenner, 1979, as cited in Greene et al., 2007). This framework can be one way

to guide person-centered approaches to care or services. Considering a person's situation using an ecological framework offers a way to address their individual needs.

To better understand the strengths and needs of the study population, I suggest considering individual-level factors within the context of relationships and broader systems. The accessibility and availability of resources, including healthcare, housing, and employment opportunities, are examined within an ecological systems framework. Even further and equally important, the role of stigma, poverty, structural racism, criminal justice policies, and the economy should be part of the assessment (Miller et al., 2021). These are all vital in understanding how a person arrived at their status or situation, including how they first came into contact with the criminal legal system, their sentencing, and their re-entry experiences.

Within the prison context, I applied ecological systems theory or framework to examine an incarcerated older adult's attributes including their age, health status, and strengths within the context of their social and physical environment. The use of the person-environment fit concept within ecological theory explains how a person's physical and social environment impacts a person's well-being. An environment that is beneficial to an older person's quality of life is one that accommodates their needs and does not add additional stressors (Greenfield, 2012).

Ecological systems theory is illustrated by assessing individual attributes, immediate environment or resources, and the policies and systems impacting this population. For example, an incarcerated older adult's immediate contacts or resources, such as their close family or friends, correctional officers or other staff, and any groups or activities they regularly engage in within the prison, are important. In addition, the accessibility of the physical space of the prison matters for people with mobility, cognition, sight, or hearing challenges. Beyond these factors, the prison environment and policies, healthcare services, and any other resources they have

access need to be considered. Even more broadly, criminal justice and social policies, the political climate, systemic racism, and cultural norms play a role in the experience of an incarcerated older person. The same assessment is applied to understanding an older adult's challenges, perspectives, and needs on community supervision. In this case, the person's neighborhood and community should be assessed along with their access to healthcare, transportation, and appropriate employment or engagement activities.

Within an ecological framework, consideration of the population's positionality, health status, and opportunities is important. Older people involved in the criminal legal system are more likely to have been poor and have low educational attainment (Hayes & Barnhorst, 2020; Rabuy & Kopf, 2015). As with any study of the criminal legal system, race and ethnicity cannot be ignored, as these systems disproportionately impact Black and Hispanic populations (Wertheimer, 2023; Klein et al., 2023; Pro et al., 2022). This disparity is due to several reasons, including racial discrimination within the criminal legal system and high concentrations of poverty (Hinton et al., 2018; Essex & Hartman, 2022). Though the papers included in this dissertation do not specifically explore race and ethnicity as factors, recognizing how they shape these experiences is important. In these papers, where older or medically fragile people are the population of interest, how this group's socioeconomic status, educational history, previous involvement with the criminal legal system, and systemic racism impact their well-being, relationships, and outcomes are an underpinning of the research.

Further, how age and disability status impact a person's experiences is important. For the purposes of these papers, this includes their time incarcerated and under community supervision. As with racism, ageism and ableism are systemic issues in many areas of life in the U.S., including in the media and the workplace (see Ng, 2021 and Posthuma & Campion, 2009). The

World Health Organization defines ageism as "the stereotypes, prejudice, and discrimination towards others or oneself based on age." Similarly, ableism refers to these thoughts and actions about people with disabilities. Even physicians and other healthcare professionals have biases about age, which negatively impact older adults' well-being (Ouchida & Lachs, 2015). The prevalence of ageism has not been explicitly studied within a criminal legal context. Still, as it pervades throughout society, it can be assumed that ageist ideas and beliefs persist within correctional settings and in criminal legal contexts. Moreover, prison and jail settings are generally not structured for older people or people with disabilities, including in the physical space and the programming (Skarupski et al., 2018; Kerbs & Jolley, 2009; Williams et al., 2006). Ignoring the needs of this population in these spaces because most people are young and non-disabled highlights the ageism and ableism in these systems.

To further this point, examining the intersectionality of age and criminal legal status or background aids in understanding the marginalization of this population. Intersectionality was originally used to describe the sexism and racism that Black women encounter in the criminal legal system (Crenshaw, 1989). Intersectionality highlights how a person's identities and experiences occur concurrently and are layered. For example, one's age, health or disability status, gender, race, and criminal legal background are not isolated characteristics. For older adults who are under community supervision or are incarcerated, the intersection of their identities are important in considering discrimination and disadvantage as well as a person's unique needs and available resources.

Importation and Deprivation

Within a prison setting, considerations of how the environment influences a person and how the person influences the environment are useful in understanding experiences. The theories

of importation and deprivation are relevant to understanding how prison impacts older adults because they explain the effect of "prisonization", which refers to how someone adapts to the prison environment. The effects of a prison environment are influential for healthcare decision-making, well-being, and accessing resources post-incarceration.

Importation refers to people's characteristics that they bring into prison, such as their age, physical traits, and health (Steiner et al., 2017). These factors are relevant in studying incarcerated older adults and people who are at end-of-life because advanced age, disability, and poor health all will have a role in the adaptability to prison life. These effects carry over into a person's well-being once released from prison, including their time under community supervision.

Deprivation refers to the losses involved in incarceration and how a person adapts to the environment. Generally, deprivation refers to the loss of autonomy and the power structure in prison (Sykes, 1958). Deprivation is important to consider in the experiences of incarcerated older adults, their ability to cope with the loss of prison, and how that may impact their health and well-being. Similar to importation, this is applicable in studying the re-entry experiences of older people as the impacts of deprivation will remain post-release.

Desistance

There are many theories as to why people desist from crime, and age or getting older is often cited as one of the reasons. Many theorists have contributed to the argument of how age plays a role in desistance, including whether it is purely biological or psychological or if it is the social factors commonly associated with aging. For example, social bonds, changing roles, and employment are thought to play a role (see Rocque, 2015). Further, desistance should be thought of as an ongoing or fluid concept, as someone may return to criminal activities after a period of

desistance (Sparkes & Day, 2016). Regardless of the nuances within the debate, it is commonly known that generally, age is a factor in desistance from criminal behaviors.

Desistance theory helps explain the "age crime curve", which shows that generally, crime decreases as a person ages. Data indicates that older adults have lower rates of crime commission (Siegel, 2011; Laub & Sampson, 2003). Though this argument has nuances, including variation between types of crime, the evidence still points to the general reduction in crime over the life course (Laub & Sampson, 2003). Rakes et al. (2018) found differences in recidivism between age cohorts of older adults, which offers a more specific approach to studying age and crime. They found that the oldest group was less likely to return to prison than the younger groups (Rakes et al., 2018). Similarly, Laub & Sampson (2003) find that the likelihood of committing a crime is reduced as a person's age increases. Though their research generally applies to a much younger age group, I find it applicable in some ways to my research findings and population of study.

Although the research presented in this dissertation does not examine the desistance of older adults or the reason older adults are incarcerated or on supervision, desistance and recidivism among older people are relevant because it was an emergent theme in the interview data. The interviews revealed examples of older adults discussing how their age contributed to their desistance from crime, though they may be considered 'persisters' for most of their lives. Further, community supervision officers share their perspectives on older adults and the decreased likelihood of recidivating or violating supervision in the interviews. From a policy perspective, the lower recidivism for older or medically fragile people is important in understanding reasons for medical parole and compassionate release policies, which are discussed as implications of this research. The decreased likelihood of recidivism also lends

itself to the argument against keeping older people incarcerated or on community supervision for long sentences.

Older Adults in the Criminal Legal System

Although the existing literature in aging and the criminal legal system is growing, it is underexplored. Data on the number of older people in prisons, jails, and on community supervision are informative in understanding the breadth of the issue and what can be expected for these systems in the future. Additionally, data on physical and mental health conditions, type of crime convictions, and sentence lengths give a better understanding of this population's current and future needs. Nonetheless, the data that explores the ways that older people experience the criminal legal system, the policies that protect or harm this population, and the resources that this group holds tell a more holistic story of the intersection of aging and the criminal legal system.

Prevalence

The United States continues to experience a growing older adult population due to the aging of the Baby Boomer cohort and longer life expectancies (Administration for Community Living, 2022). The prison system is experiencing this same increase of older adults, but at an even higher rate. Older adults are the fastest-growing age group in prisons, comprising 3% of the prison population in 1993 but 10% of the prison population in 2013 (Carson & Sabol, 2016). In 2019, men aged 50 or older comprised 20% of sentenced incarcerated individuals in U.S. prisons (Carson, 2020). Most older adults have aged in prison, though this is not true for everyone. Data indicates that 60% of incarcerated people aged 55 and older have aged in prison while the other 40% entered prison at 55 or older (Carson & Sabol, 2016). The growing number of older adults poses challenges to the correctional system, particularly because of this population’s increased

need for healthcare. Because prisons are not designed or equipped to sufficiently handle chronic conditions or physical impairments common in older adults, the environment is difficult for older adults to manage.

Profile of Older Adults in the Criminal Legal System

Generally, the age that demarks an "older adult" in prison is younger than the age used to describe the non-incarcerated population, due to their incarceration experience, access to healthcare, and lifestyle factors (Williams et al., 2012). This demographic generally experiences an accelerated aging process, displaying a higher prevalence of comorbidities compared to individuals in the broader community, as a history of incarceration increases the risk of many chronic conditions even when controlling for other related factors (Garcia-Grossman et al., 2023). Because of eligibility for certain age-related programs, such as Medicare, the age of 60 or 65 is used to define an "older adult" in the community; however, when researchers discuss older incarcerated populations, they generally use age 50 or 55 (Bedard et al., 2016; Snyder et al., 2009; Psick et al., 2017; Abner, 2006). Further, experts agree that while an agreed upon age marker is needed to categorize "older adults" involved in the criminal legal system, a person's health and physical care needs should be considered in when studying this population (Williams et al., 2012). The focus of the data collected for this study is on people aged 50 or older when describing "older adults" on community supervision to remain consistent with most of the research in this area (Merkt et al., 2020). The factors discussed below include physical and mental health and the costs of caring for people who need additional services. As discussed in preceding sections, the consideration of health and disability are key in understanding how a person experiences incarceration or community supervision using an ecological framework.

These factors play a role in how a person can adapt to an environment, how they engage with the criminal legal system, and how policies impact them and their available resources.

Older age does not guarantee illness or disability, but the risk increases with age. Most incarcerated older adults have more than one chronic health condition (Gates et al., 2018; Prost et al., 2021). Not unexpectedly the high rate of chronic illness translates into increased use of medical services in prisons (Maschi et al., 2014). Furthermore, physical and cognitive disabilities are prevalent in older adults, and people in jails and prisons have higher rates of disability than the general population (Bronson & Berzofsky, 2015).

History of trauma, including during incarceration, is prevalent among people of all age groups in these settings, including older adults (Maschi et al., 2014; Maschi et al., 2015). In addition, many older people in prisons report victimization, abuse, and medical neglect (Kerbs & Jolley, 2007; Maschi et al., 2014; Smoyer et al., 2019). Mental health conditions are also common in incarcerated populations. Further, older adults have an even higher rate of mental health disorders compared with younger people in prisons (Haesen et al., 2019; Prost et al., 2021). Social support and community ties play a role in the well-being of older adults in the correctional systems, and these can be damaged or broken by incarceration. Many older adults in prisons report very little contact with social support networks (Maschi et al., 2014). Likewise, man older adults on parole and probation report the loss of connections to family, friends, and community (Lares & Montgomery, 2020).

Incarcerated older adults have a wide range of needs, resources, and experiences (Maschi et al., 2014). Although age links this group together, the heterogeneity of the group should not be ignored. Rather than argue that older people in correctional systems have the same experiences, I

argue that age should be considered among the other attributes and identities that a person holds, such as gender, race, sexuality, and socioeconomic status.

Costs of Care

Caring for older adults in prisons and jails is costly, primarily due to their healthcare needs. As previously stated, the higher spending on incarcerated older adults includes the cost of assistive devices such as wheelchairs or hearing aids, as well as specialized medicine and treatments, which at times require transporting the person to an outside medical facility (Ferri, 2013; Office of the Inspector General, 2016). From 2009 to 2016, the cost obligated for healthcare per person in federal prisons increased by 36%. Notably, during that same period, the average age of the prison population increased by two years (from 38.2 to 40.5), and the percentage of people aged 55 and older in prison increased from 8.4% to 12%. In 2016, the Bureau of Prisons' medical care budget was $1.2 billion, with almost 40% attributed to care outside the facility (U.S. Government Accountability Office, 2017).

The high cost of caring for an aging population is one of the prominent arguments in compassionate or medical release policies. Releasing a person back into the community relieves the financial burden to the prison system of providing medical care and handling additional needs that come with chronic illness or disability. This argument is attractive to systems that are overcrowded and saddled with caring for people across the lifespan with limited resources. However, the onus of caring for this person is not erased, but rather shifted. Releasing a person with life-limiting illness or other high health care needs from prison can be complicated and, depending on the person’s situation, the transfer of responsibility is then on systems such as Medicaid, Medicare, and long-term care.

Existing Policies, Programs, and Interventions

Among the policies in the U.S. that were created to navigate the increase in older people in the criminal legal system, compassionate release or medical parole policies are the most widely researched and known. Although I could not identify a nationwide effort or programming aimed at addressing the needs of older people in correctional settings or systems, some of the existing efforts are explored in this section.

On the federal level, the term "compassionate release" is used to refer to the policy of releasing incarcerated people who are medically fragile or have terminal illnesses. States refer to this practice with various terms, such as "medical parole" and "elderly release". In 2018, there were 46 states with laws for early release or parole due to health or age (Holland et al., 2018). Compassionate release is criticized because it is underutilized due to strict criteria and complicated processes to become approved (Green, 2014). Federally, criminal justice reform under the First Step Act focused on recidivism and reducing the prison population size. Part of this legislation aims to make compassionate release more efficient and accessible to more people by expanding eligibility (Congressional Research Service, 2019). It is not yet clear whether states will follow the lead of the First Step Act and expand eligibility and curtail bureaucracy in the application and approval process. The vast majority of incarcerated people in the U.S. are under state jurisdiction (Carson, 2020). Therefore, to make a significant impact, states must address the inadequacies of state-level compassionate release policies.

True Grit is a program in Nevada designed for older adults in a prison setting and those transitioning back into the community after prison. Participants are housed separately from the rest of the prison population and offered activities that are cognitively stimulating and appropriate for those with arthritis. These include creative arts programs, substance use groups,

and presentations on healthy food and chronic conditions. They also have peer support programs and spiritual activities. The discharge planning process includes collaboration with outside resources to help prepare people for release (Maschi et al., 2014).

The subsequent chapters are three stand-alone papers that offer new insight into the experiences of older adults within prisons and under community supervision in the U.S. Through policy reviews and interviews with officers and people with experience on supervision, these studies add to the current knowledge about people impacted by the criminal legal system, namely older adults. They argue for the need for more attention to the needs and challenges of this group and do so through the lens of a person-centered framework, keeping the well-being and rights of older adults at the center of the story.

Chapter 1: An Exploration of a Person-Centered Community Supervision Model for People Aged 50 or Older

1.1 Abstract

This paper details the findings of a qualitative study that explores the implementation, understanding, and perceptions of a person-centered community supervision model, specifically as it applies to people aged 50 or older who are on parole or probation. Data collected through semi-structured interviews with community supervision officers and people currently or previously on community supervision is explored. The paper presents themes and findings from interviews designed to understand the experience of older adults on community supervision within a person-centered framework.

This research reveals that while the concept of person-centered community supervision remains nebulous to many, some officers intuitively adopt a person-centered approach in their work. Interviews cover some key challenges faced in implementing a person-centered supervision model, primarily from high caseloads and limited time to meet with people on their caseloads. While some participants perceived the person-centered model as successful and evident in current supervision interactions, others shared little evidence of it.

The research emphasizes the need for a clearer definition of a person-centered community supervision model while contributing to discussions on personalized approaches in the criminal legal system. While additional research to evaluate a person-centered model is needed, this study can be a resource for practitioners and policymakers to improve community supervision.

1.2 Introduction & Background

Person-centered approaches within the context of the criminal legal system are not yet well-researched. However, in gerontological research and aging practice, the concept of "person-centered care" is well-known, usually referring individualized and strengths-based care rather than one-size-fits-all. The American Geriatrics Association states, "Person-centered care means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals" (American Geriatrics Society, 2016). The use of the term "person-centered" in the criminal legal system is less established, though it appears in some current models and approaches. This research attempts to understand how a person-centered model is implemented and perceived in the context of parole and probation, particularly considering the needs of older people, whose experiences may differ from those in younger age groups due to differing healthcare needs, family dynamics, and histories.

The United States is an aging country, with a growing number of people entering what is considered "older adulthood," including people impacted by the criminal legal system. In prisons, older adults are the fastest-growing age segment, and most people who are in prison will eventually be released back into the community (Carson & Sabol, 2016). Research in the intersection of criminal justice and gerontology is growing, however, more data is needed to fully understand this population's needs, challenges, and impact on the larger system.

Though it is not formally defined, the age that demarcates an "older adult" in the community is typically 60 or 65 due to eligibility for programs through the Older Americans Act or Medicare. However, researchers studying aging in the criminal legal system typically use age 50 or 55. This is because this population "ages more rapidly" (Bedard et al., 2016; Snyder et al., 2009; Psick et al., 2017; Abner, 2006). Further, experts agree that while an agreed upon age

marker is needed to categorize “older adults” involved in the criminal legal system, a person’s health and physical care needs should be considered when studying this population (Williams et al., 2012). For this study, the age of 50 is used when describing “older adults” on community supervision to remain consistent with most of the research in this area (Merkt et al., 2020).

1.2.1 Research Setting

Outside of the convenience and established connections of the researcher, the state of Georgia was chosen for this research for several reasons. Georgia has a high rate of parole and probation sentences, which means there are a lot of people on supervision in the state. In 2016, 1 in 55 adults in the U.S. were on community supervision, and in the state of Georgia it was 1 in 18 (Horowitz, 2018). Because the research was focused on the experiences of older people on parole and probation, the age demographics of the state is also important. By 2030, an estimated 20% of Georgia’s population will be aged 60 or older, ranking the state in the top ten fastest growing older adult populations in the U.S. (Georgia Department of Human Services, 2021).

Narrowing in on the specific population of interest, the data shows that this population is significant. In the state of Georgia, as of May 2023, there are 42,920 people aged 50 or older on parole or probation, which is 22.4% of the total number on supervision. In addition, there are 45,411 people between age 40 and 49 on parole or probation who, depending on their sentence length, will soon be in the over 50 age category. This data is important when considering the future needs and challenges for officers and agencies. Figure 1 shows the parole and probation population by gender, race, and age group.

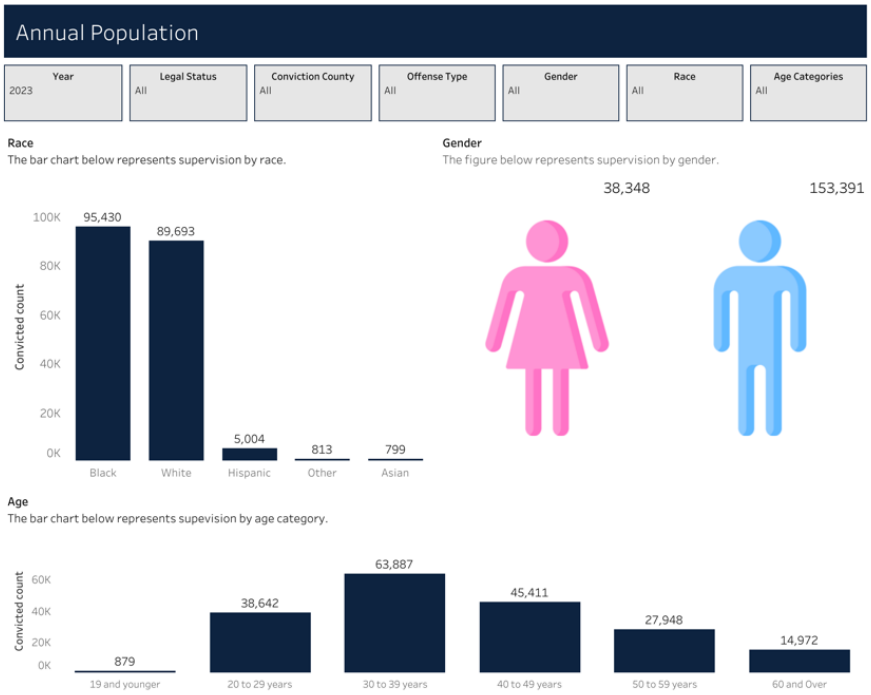

Figure 1: Georgia's Community Supervision Population in 2023

To study this population, it is important to consider the larger context in which the subject is embedded, including state agencies and policies. In Georgia, the Department of Community Supervision (DCS) oversees the supervision of adults with felony parole and probation. This agency was created in 2015 after state legislation restructured the existing responsibilities and oversight of parole and probation entities in Georgia. Officers who supervise people on parole and probation in DCS are referred to as community supervision officers.

In a November 2020 press release, DCS notes that they adopted a person-centered framework into their model of supervision. Though this person-centered supervision model is not clearly defined or operationalized in the press release or in other publicly available documentation, it aligns with a general culture shift that the agency has worked toward in recent years. The commissioner is quoted stating, "We are in the people business, and rather define

someone by their crime or conviction, we recognize people as unique individuals with their own strengths, needs, and goals" (Department of Community Supervision, 2020).

DCS has been incorporating evidence-based models into their practices that attempt to move toward a more individualized approach to working with people under supervision, including a Trauma-Informed Care model and the Enhanced Supervision Program (ESP). In partnership with the Urban Institute and the American Probation and Parole Association, DCS conducted a pilot study of the use of Procedural Justice, a concept that they consider falls under the umbrella of the person-centered supervision model. In DCS's 2023 research agenda, person-centered supervision is listed as a priority. Though the person-centered framework is not specifically mentioned in the DCS official mission or vision, the adoption of evidence-based practices is stated, as well as the desire to be a leader in "innovative and progressive community supervision" (Department of Community Supervision, 2023).

This paper explores the themes that emerged about a person-centered model of community supervision from interviews with community supervision officers and people who are currently or formerly under community supervision. On the outset, this research was intended to examine how this model is implemented specifically for older adults, defined by a person aged 50 or older, however, interview data uncovered themes that are applicable across age groups. The literature that informed and bolstered this research comes from the fields of gerontology and criminal justice, including studies that are at the intersection of these disciplines.

1.3 Literature Review

1.3.1 Intersection of Aging & Community Supervision

Literature on the aging of incarcerated and formerly incarcerated populations is growing, and the specific challenges and needs, such as their physical and mental health, is gaining

attention. However, there is a call from researchers and experts to add to this body of work, and for more collaboration between practitioners and policymakers in aging and criminal justice. (Metzger et al., 2017; Higgins & Severson, 2009; Williams et al., 2012). Collaborations such as the Aging Research in Criminal Justice Health (ARCH) network exemplify this growing interest and work in this area, but also highlight the need to expand the resources and research on this population.

Successful re-entry for people of all ages includes addressing their needs holistically, including transportation, financial support, identification and documentation, housing, employment, physical and mental health, substance use concerns, and social support (La Vigne et al., 2008). Older people recently released from prison may need specific services and attention due to their age and age-related physical changes. This depends on their individual needs, including their health status and resources (Williams et al., 2012). Existing studies show that challenges for recently released older adults include transportation, getting medications, housing, and re-entering the workforce (Lares & Montgomery, 2020).

Caregivers of older adults who have recently returned to the community following incarceration report similar challenges for this group, including managing their health and reconnecting with the community. In addition, caregivers report that older adults struggle to independently achieve tasks, such as apply for benefits, which can be complex (Jiminez et al., 2021). Older adults on parole or probation have a higher prevalence of mental illness (Bryson et al., 2019). This is consistent with what we know about incarcerated older adults, who have higher rate of mental health disorders compared with younger people in prisons (Haesen et al., 2019; Prost et al., 2021). For those on community supervision who have recently been

incarcerated, social disconnection is prevalent when they return after being removed from their communities for a period. Reasons for this include stigma and financial hardships (Wyse, 2018).

One way to approach the needs of this population is using an ecological framework, which considers individual, community, and systemic resources and challenges (Miller et al., 2021; Greene et al., 2007). Within this framework, each person is viewed within the context of their unique situation. For example, their gender, race, disability status, social support network, neighborhood, and access to healthcare play a role in how they navigate re-entry and/or community supervision. The existing data presented supports the argument that individualized approaches, such as a person-centered model, are needed for older adults on community supervision. By considering a person's age in tandem with their health, socioeconomic status, and social support, challenges with successful re-entry can be addressed. A one-size-fits-all approach to re-entry and supervision may not be suited for an older person, particularly if they are not re-entering the workforce and have multiple chronic health conditions that limit their ability to live independently. Furthermore, even though older age ties this population together, they are a heterogeneous group with different backgrounds, challenges, and supports (Maschi et al., 2014). Thus, a person-centered approach to re-entry and supervision is appropriate as it aims to consider a person holistically, while also attuning to the person's preferences and goals.

1.3.2 Person-centered Approaches in Elder Care

Person-centered care has taken hold in elder care and aging practice. Aligning Carl Rogers' work in the field of psychotherapy, the model is strengths-based and client-directed (Kirschenbaum, 2004). Person-centered care is most widely known and researched in long-term care settings, such as nursing homes, particularly as it relates to caring for people with dementia (Fazio et al., 2018). Generally, it refers to caring for a person holistically and ensuring that a

person has choice in their lives. The Centers for Medicare & Medicaid Services (CMS) defines person-centered care as the following:

> "Integrated health care services delivered in a setting and manner that is responsive to individuals and their goals, values and preferences, in a system that supports good provider–patient communication and empowers individuals receiving care and providers to make effective care plans together." (Centers for Medicare & Medicaid Services, n.d.)

Although person-centered care is well-known in healthcare practice, there is a lack of well-established, validated measures for evaluating its usage and outcomes (Edvardsson & Innes, 2010; Doll et al., 2017; Fazio et al., 2018).

As person-centered care has become more well-known and recognized by large organizations and accreditation bodies, the adoption of it is still falling short. Some argue that this is partly due to a lack of a unified definition or understanding of what person-centered care means (Love & Pinkowitz, 2013). In a healthcare setting, person-centered care contrasts with the medical model, which is the framework that is familiar to professionals in these settings and adheres closest to regulatory standards. The fear of breaking rules or policies often prohibits the adoption of person-centered care by people who work in or oversee nursing home care, but this is often due to a misinterpretation of regulations (Rill & Gonzalez, 2019; Engle et al., 2017). Other barriers to implementing a person-centered model of care include staff turnover, low staff morale, and a perceived lack of resources or time (Engle et al., 2017).

Because there is a range of specific interventions or models in person-centered care for older adults, there are challenges in concluding the effectiveness or outcomes generally. However, specific approaches have been examined in the literature, including how they impact residents or patients and staff members who care for them (Brownie & Nancarrow, 2013). One

specific model, the Eden Alternative, was found to improve the satisfaction of family caregivers of nursing home residents after this model was implemented in the nursing home (Rosher & Robinson, 2005). This same model was found to lessen boredom and feelings of powerlessness among nursing home residents (Bergman-Evans, 2013).

1.3.3 Person-centered Approaches in Correctional Systems

There have been shifts in approaches in the field of criminal justice in the U.S. over time, wavering between more punitive to more rehabilitative. Within the rehabilitative framework, the development and use of evidence-based practices have grown, although challenges in the implementation have persisted (Taxman, 2018). While the concept of person-centeredness in community supervision is less prevalent compared with aging and disability services, parallels can be drawn with emerging trends and approaches. Evidence-based models, such as motivational interviewing (MI), have elements that ring true to person-centered theory and have similar goals to models in other fields.

The reception of evidence-based practices by parole and probation officers is influenced by the organization and agency dynamics. Parole and probation officers' willingness to implement these practices is often tied to their view of the agency and their relationship with its leadership. Officers who maintain a positive outlook and a strong relationship with their agency are more open to adopting evidence-based practices into their work (Viglione & Blasko, 2018). In addition, the setting of the officer's encounter with the person under supervision appears to make a difference; when officers meet with supervisees at their home, they are less likely to use a more person-centered communications approach compared with interactions in the office (Vigilone et al., 2017). Gender and race differences exist in officers' comfort level and confidence in implementing some of the evidence-based practices. For example, women and

Black officers were more comfortable implementing the new models of supervision, whereas men and white officers were more comfortable with a traditional supervision model (Wilson et al., 2022).

Motivational interviewing is one of the evidence-based practices that has been researched in parole and probation populations. This technique focuses on the belief that the person under supervision can move toward behavior change and make positive decisions in their own life (Iarussi & Powers, 2018). In 2007, the U.S. Department of Justice National Institute of Corrections published a guide on the benefits of evidence-based practices, namely motivational interviewing (MI), and how to implement this practice for people working in the field. This guide refers to MI as a "person-centered method of fostering change by helping a person explore and resolve ambivalence" (Walters et al., 2007). MI has been examined in criminal justice literature, although the data is mixed on whether it is effective in reducing recidivism (Viglione et al.,2017). Motivational interviewing aligns with a person-centered framework because it aims to uncover an individual's motivation for change in an individualized and strengths-focused manner. Data suggests that probation and parole officers who are female, have advanced degrees, and are older are more amenable to using MI and align more with its person-centered approach (Viglione et al., 2017).

Person-Centered Language. Person-centered language (sometimes referred to as "person-first," "patient-centered," etc.) is a component of person-centered models of care and services. It considers personhood before a person's health status or other features. Person-centered language is highly relevant and has been used widely in the disability community for many years (Lynch et al., 1994). It is also common in the fields of aging, mental health, and other health-related spaces. Examples of this language include "person living with dementia"

rather than “demented patient/person”, “person with a disability” rather than “disabled person”, or “person experiencing homelessness” rather than “homeless person”. The goal of person-centered language is first to consider the identities and strengths of a person to reduce stigma.

Person-centered language in the criminal legal system is not as widely used as in health, disability, or social service fields; however, it is a growing area of focus. Academia and advocacy organizations have called for more person-centered language when writing and speaking about people involved in the criminal legal system (see Tran et al., 2018, The Marshall Marshall Project). Evidence suggests that the use of person-centered language decreases the negative stereotypes of formerly incarcerated people. There is a link between the words or terminology people hear or read about incarcerated or formerly incarcerated populations and their attitudes and feelings toward and about that population (Jackl, 2021). Though person-centered language is becoming more accepted and preferred, it is not without debate.

There is a lack of data to support significant impact or behavior change by implementing of person-centered language. However, it is widely accepted and practiced in many different fields and areas of research. The research presented in this paper did not seek to measure impact or behavior change; rather, it sought to gain insight into how the study population views the use of person-centered language and their perceptions of its impact, if any.

This paper presents the findings from interviews with people who have lived experience on community supervision and officers who work in the field. The research aimed to understand the experiences of people aged 50 or older under community supervision and the concept of a person-centered model of community supervision; however, many of the findings are relevant for people under community supervision at any age. While the themes from the interviews

pertain to people across their life course, the primary objective of this study was to understand the application of the person-centered model from a gerontological perspective.

1.4 Methods

Data for this study was collected through semi-structured interviews and analyzed using thematic analysis. The aims of the study were couched within the interest of the specific needs and challenges of older people, though most of the themes found are applicable across age groups. The data detailed in this paper come from the following research questions:

1) How is the implementation of a person-centered framework perceived in a community supervision context by officers?

2) How do community supervision officers and people on supervision understand person-centeredness within a community supervision context?

Data for this study are from interviews with people who have experience on parole or probation in Georgia, and with community supervision officers working in Georgia (one participant is a counselor). After receiving IRB approval in the fall of 2022, recruitment began. Participants were recruited for the study mainly through word-of-mouth referrals. Participants who were previously or currently on parole or probation were recruited through community organizations. Leaders and case managers of these organizations distributed a recruitment email (Appendix) or gave my information to clients or participants. The first several community supervision officers I interviewed were referred from another study, and the officers contacted me about their interest. The remaining officers were referred to me from a participant, who sent out an email to their coworkers about the research and my contact information.

The semi-structured interviews were conducted with participants between December 2022 and May 2023, in tandem with additional recruitment. All interviews were done via video

conference and phone calls, though in-person interviews were offered in my recruitment. These conversations were audio recorded with consent from the participant and were transcribed using a transcription service. Interviews lasted from 18 minutes to over two hours. There were 24 participants in this study and compensation was given to participants for their time.

On the outset of this research, the goal was to interview two groups: 1) people who were currently community supervision officers in Georgia and 2) people who were currently under community supervision (parole or probation) and were aged 50 or older. Though most of the participants matched these criteria, eligibility was expanded during recruitment as I recognized that others added valuable perspectives to the research, and it did not waver from the research questions. This included a counselor working in community supervision and a handful of participants who had experience under community supervision in the recent past. Minor adjustments were made to probes and language of the interview guide to adapt for different roles, including asking people who were not currently on supervision to try to recall the time period when they were under supervision.

Participants who were currently or previously on community supervision all had residency in Georgia and had experience under supervision in Georgia. Each participant was asked to self-identify their gender, race, age, and highest educational level at the beginning of the interview: seven participants identified as a woman, and seven identified as a man, nine participants were African American or Black, and five as white or Caucasian. The ages of these participants ranged from 37 to 64, with most participants between age 50 and 60. Educational attainment varied; several participants never finished high school or had a high school diploma or equivalent, however, several had some college or college degrees.

The second participant group, community supervision officers (and one counselor), all worked in Georgia and supervised people in Georgia. Further, the circuits they worked in ranged in geographic location and type (rural, suburban, and urban). Participants self-identified their demographics, in addition to how long they have been working as community supervision officers. Five participants identified as men, and five as women. Three participants were African American or Black, six were White or Caucasian, and one was Asian American. The ages of these participants ranged from 27 to 51. Participants ranged in job tenure from under two years to over 26 years. They served a range of geographic locations across the state, including rural, urban, and suburban areas.

Interview questions (see Appendix) for officers included inquiries about their current job description and their educational and work history to better understand how they came to be a community supervision officer, their tenure on the job, and if they have a specialized caseload. Before delving into questions about the person-centered approach, I asked if they were familiar with this term or model. I inquired about how they learned about the concept and their perceptions. I included questions such as, "How do you apply the concept of person-centeredness to your work?" to learn more about how they implement the model.

In the interviews (see Appendix) with people who have experience on community supervision, I asked them to share about their background before asking about their incarceration history. I inquired about their health and any physical limitations to understand their potential needs and barriers. In the questions about community supervision, I included prompts such as, "Tell me about a time when your community supervision officer was flexible with you or demonstrated support or understanding of a challenge you were experiencing". To learn about their perceptions of person-centeredness, I asked how they would define this term and if they feel

that it applies to their experience on community supervision. I inquired about person-centered language and the term that they prefer as someone who has been incarcerated and/or on community supervision.

To analyze the interview data, I used reflexive thematic analysis (Clarke & Braun, 2017; Braun & Clarke, 2021). Prior to coding, I reviewed and cleaned the interview transcripts to ensure data quality, while listening to the audio of each interview. This step involved becoming more familiar with the data (Braun & Clarke, 2021). I relied on both a priori and emergent codes during my iterative coding process. The a priori codes were broad and included themes determined by sections of the interview guide, such as 'definitions of a person-centered supervision model', and 'language or preferred terms', which were couched in what I knew from previous related literature and my experiences. From those broader codes, narrower themes emerged during initial coding, and codes were developed that were more specific to the data.

After initial coding, I used NVivo 12 to code each interview transcript with the codebook. A few additional codes and subcodes were added during the coding process, including the code 'caregiving' to capture the experiences of participants who held this role. The final codebook had 18 parent codes, with some codes containing several child codes. I ensured that the data was thoroughly analyzed through the process of transcription, review, and reflection of the data, and multiple rounds of coding. This resulted in several reviews of each transcript, including listening to the audio of the interviews, and reading transcripts multiple times.

1.5 Findings

Interviews with both officers and people under community supervision revealed the perceptions and experiences of the implementation of a person-centered model of community supervision. Though the views of this model varied across participants, patterns emerged from

the conversations. This section describes salient themes related to a person-centered supervision model and its implementation including how the concept of person-centeredness is defined, the challenges in using a person-centered approach in community supervision, person-centered terminology or language, and the application of a person-centered model specifically for older adults under supervision. Much of the findings are applicable to people across all age groups under community supervision, while others were more specific to an older population.

1.5.1 Definitions and Perceptions of a Person-centered Supervision Model

Each participant was asked about the definition of person-centered supervision, and answers varied, but there were commonalities among the responses. For participants who were currently or formerly under supervision, several participants mentioned that the supervision they receive should be individualized and meet their specific needs or concerns. One participant noted,

> "If I were to define that, it would be asking the individual that's on probation, 'what is it they hoped for? What is it you want to do with your life? Not what I feel like you should do…What do you really want to do? What will help you not to go back to jail or prison? What can I do to assist you in whatever it is you're trying to do to not go back to jail?' Because nobody wants to go back to jail…it's something that's lacking."

Another participant added that officers should have a trauma-informed approach to supervision, noting that everyone who has been through the correctional system has some kind of trauma, and officers should use an approach that is understanding of that experience. Some participants noted that they had support from family or friends, but that not everyone has this support, therefore a person-centered approach would include additional time and resources for people without social support. A couple of the participants were unfamiliar with the term and were unsure of how to

define it or what person-centered supervision might entail, therefore this question was more challenging and did not garner a detailed response.

For officers, there was a general familiarity and experience with the term. One officer stated that while there is not a definition of person-centered supervision, he understands what it means. He said, "…that is something that we just developed on our own, I guess. But with regards to what it all entails, it's just really meeting the people addressing these for that specific individual and meeting them at their needs." Other officers had similar definitions of the term, including statements about finding resources for people and treating people with respect. The officers did not point to an official definition or policy that explicitly states what person-centered supervision means but were familiar with the concept through their agency or supervisor.

The person-centered model was entangled with the agency's use of ESP, and officers often spoke about them as one in the same and they brought up the ESP model as part of their explanation of the person-centered framework. When asked about the training or education received on the person-centered model, most officers discussed e-mails they received, and training on ESP. One officer shared that though they received training, they thought that the leadership in their circuit made a larger impact on how it is implemented, which aligns with the literature. They stated,

> "They train, you know, they are very much 'we are enforcing policy, as it is written, we are people centered, you focus on what the person specifically needs'. But that's only eight weeks, the rest of your career is spent in your office with your chief, your assistant chief, if they are not adopting it as well, like, you're not going to it's not going to stick and a lot of offices, they don't. It doesn't stick."

Some participants, both officers and supervisees, discussed how they have observed changes over time in how community supervision is conducted, or with the culture of the agency. Some who were currently or previously on supervision gave examples of how they have had a more positive experience with DCS in recent years and shared hope about the shift in culture and approach to supervision. Most of the officers shared a similar sense of hope for the future of the agency because of the changes they have experienced. One officer stated,

> "I feel like DCS has realized that probation and parole supervision hasn't always been as optimal as it's supposed to be. But they're at least trying to do different, and I can commend them for that. Of course, it might not be perfect. Of course, there's gonna be areas when we fall short and need to improve on, but I feel at least I feel at least a little hopeful that at least DCS is doing something about instead of just being like, 'well, it's been like this forever. So why don't we just keep doing it?' You know, they're at least like well, let us get some researchers in here. Let's see how we can do something better. Actually putting money behind what they're saying. They're not just telling us stuff they hope works. They're actually putting best practices in place that have actual scientific backing behind it."

Similarly, another officer shared how she is dedicated to continuing that change within her own circuit. She stated,

> "we're just trying to rebrand ourselves. And, you know, DCS is like a mouthful. Nobody understands what we are. So, I think the rebrand was not super successful. But we're working on it. I'm working on it, at least locally, and I'm trying to make people just buy into what we are doing, and think that we're worth something."

The sentiment about the change in community supervision over time was expressed by people with experience under supervision as well. One participant who had recently been released from probation, years before he was supposed to, shared that he has seen a difference in the way that community supervision has been handled over the years. He shared,

> "I got off probation years ahead of time, and see, that would have never happened 15 years ago. As a matter of fact, I've served every day of my adult life on paper every day up until a year ago. That's ridiculous. Absolutely ridiculous and I've been harassed every day of my adult life for, okay, yeah, I did the crimes I get that, but this has just been up until actually my 50s that is actually not been such a negative experience. It's life changing."

Another participant also noted that they observed shifts over time, including the opportunity to participate in recovery programs of their choosing rather than what was prescribed by the courts or by their officer. They noted that there was previously no choice in programming.

1.5.2 Challenges in Implementing Person-centered Community Supervision Model

Participants discussed areas that impeded the ability for a person-centered model of community supervision to be implemented successfully including organizational systems or culture barriers. While this research did not evaluate caseloads, staff levels, or written policies, it relies on the statements from participants to tell the story of the perceived and experienced barriers.

High caseloads and inadequate staffing were mentioned in interviews with officers and people currently or formerly under supervision. Some participants explicitly stated that high caseloads and understaffing are a barrier to implementing a person-centered orientation to community supervision. One officer noted, "we're understaffed, so there's potential for, if I had

less people on my caseload, I feel like I could do a lot more with my people". A participant who is currently on probation has observed the crowded community supervision office and the high caseload of her officer. She stated, "they have so many people that I just don't think they have time to take the time to even help their people. I think they want to probably try to help them, but they just can't, they don't have the means". Participants shared that caseloads vary between officers depending on the type of caseload (specialized and higher risk caseloads are smaller) and the staffing levels of that circuit.

Based upon the interview data, I contend that the number of contacts and the length of contact between officers and persons under supervision is a potential barrier to employing person-centered supervision. Several of the people with lived experience of supervision who I interviewed were under a lower-level supervision (for people deemed as "low risk") and had very little to no contact with their assigned officer. Participants described their requirement as calling into an automated system once per month. Some participants were unable to offer details about their interactions or relationship with their officer because they do not have any familiarity with them. For example, one participant noted, "I am on probation, but I have no idea who my probation officer is". Another participant felt that the contact she had with her officer shifted after she paid her fines and fees. She stated, "and then once I paid them off, they didn't care nothing about me. I paid $3,500 and they was good", and noted that she has very little contact with her officer now. When a participant was asked if he feels his officer ever helps him with resources with housing or other challenges, he responded, "no, no, I don't even see 'em long enough." According to the participants in this study, the length of time that officers spend with the people they supervise is rather short, with responses ranging from 2-3 minutes to 10 to 15 minutes. Participants noted that the first visit or meeting is much longer than the others.

Although the short time spent between officers and the people they supervise is viewed as a barrier, particularly because it gives limited opportunity for resources or support to be offered, it is also seen as positive by some. For example, several participants were satisfied with the minimal contact with officers, including the frequency and length of each contact. This appears to be because of the role that they see their officers playing, one of law enforcement and punitiveness rather than a resource or a support. This was evident in a participant's description of community supervision officers as "intimidating" as she also added that "they carry a gun". One participant shared the conflict between the desire for minimal contact, but also for support with resources by saying, "…everyone hates to talk to their probation officer, you know, so it would be hard to say, 'hey, can I have more contact with you?' You know, that's like…why would I do that? You know, you want it to, but you want to be in and out as fast as you can."

When I inquired about person-centered community supervision, officers included a description and discussion about ESP in their responses. Ultimately, every officer I interviewed discussed ESP in some capacity. It was evident from the interviews that ESP is prominent within the agency. Participants noted that the importance of ESP was communicated frequently to the officers by leadership, including mandatory training. Most of the officers mentioned challenges with implementing ESP and shared a sentiment that the method felt unnatural and forced. Most of the interviewees expressed that leadership expects them to use ESP in every interaction with people under their supervision, and that it must be documented. One officer described ESP as a "very rigid conversation", and another said that using ESP in every interaction with a supervisee is "truly unrealistic". This appeared to be a barrier to some officers, specifically those who felt that they were already practicing a person-centered supervision approach. One officer shared the

following statement, in the context of how it felt when the model was officially implemented, when she thought was already implementing a person-centered approach before:

> "For me, it was kind of funny, because I've kind of done that from the beginning, because it made sense. Every person is going to have different needs. And you need to tailor every single person's case plan to what they need. Specifically, if I'm telling you, you need to do ABC, me telling Bobby Joe to do ABC doesn't mean it's necessarily going to help Bobby Joe, he needs to be doing DFG. So like, for me, it's kind of been something I've been doing. But I didn't realize it was like, not the same as what we had been doing. All of our emails, I mean, lately in the past year have been 'Person Centered Supervision is the big thing'. And they actually recently installed or like, implemented software, like on the portal, when you log in to look at a person. We now have like a tracker to show like, here's the needs, like mental health needs substance abuse needs employment needs…have you addressed that this month, or within this period of, like that you need to speak to this person, have you used ESP? Have you seen this person, the amount of times you're supposed to see this person, have you done the things you need to be doing? And it makes me anxious, because it's like a lot of red at the beginning of every month for my people because I'm supposed to see them every single month."

Other examples of challenges or barriers in implementing the model were shared, including agency policy and disagreement in approaches with the judges in their counties. Officers shared that some of the variability in approaches between counties or circuits are due to leadership within the circuit or the judges in their county. One officer gave an example of a time when a person under their supervision was denied a travel permit to attend a close relative's funeral in another state. Some officers indicated there are times when being person-centered

means straying from policy if it results in better outcomes for the person under supervision without jeopardizing safety. One officer shared,

> "sometimes policy tells you to do something, but at the same time be like… what are we really here for? We're really here to try to produce successful outcome outcomes for people and because policy may tell me to do this, but I know if I do this, I'll be more impactful for this person if I did this. Like it's that constant battle sometimes from policy and reality."

1.5.3 Person-centered Language

Interview questions inquired about participants' thoughts on person-centered language, and whether they thought that using different terminology impacted behaviors or attitudes. When asked about preferred terms to refer to someone who is formerly incarcerated or under community supervision, several of the participants with this experience said that they preferred the term, "returning citizen" rather than terms such as parolee, probationer, ex-offender, etc. In contrast, one participant shared that they disliked the term "returning citizen" because they do not feel like it accurately describes their status or rights.

Many of the participants with supervision experience felt that the words and language impact attitudes and behaviors. They shared that they felt that words carry weight and meaning, and the labels placed on people demonstrate how a person thinks about them and their place in society. One participant shared the following about the words people use to describe those who have been involved in the criminal legal system:

> "I think it's imperative that as people become more sensitive to how they communicate, and address and describe returning citizens, it's very important that they understand that what they say…words carry weight. And if you're still speaking as ex-offender, or ex-

inmate, or felon, you know, then you're telling me immediately that you have no regard for me, or my ability to succeed in the free world, that you're always going to see me as what I've done."

Officers were asked about their experiences and beliefs related to person-centered terminology, including agency guidance and their perceptions of it. Many officers described how DCS changed the words they are using when referring to people who are under supervision. Rather than the terms "parolee", "probationer", or "ex-offender", they are using the term "supervisee". Some officers shared that this guidance was expressed to them in an email from leadership, and one officer stated that there were warnings about being reprimanded for using the term "offender" in documentation or on the job. All the officers had positive or neutral views about the language shift, and most said that they have no problem with discontinuing the terms with more negative connotations. However, some officers shared that their co-workers are not all on board with the shift or that it is more difficult for them to change their language if they have been working in the field for a long time. One officer stated the following regarding the language change:

"Previously, it was like 'offenders'. But that was obviously you know, it's got super negative connotations. People, I still hear people calling them offenders. And I don't love that or 'defendants' because they were a defendant in their case. Technically, I guess that's fine. I just still don't like it. It's that just the negative connotation. And it brings them back to them being in court when you say, like, if you're texting, you're like, hello, defendant, so and so please. You know, like, it's just, this is not cool."

1.5.4 Person-centered Supervision Specifically for Older Adults

Most of the findings presented are applicable across age groups, however, on the outset, this paper's purpose was to explore a person-centered model of supervision specifically as it applies to older adults. What I found from participant interviews are examples of person-centered behaviors or policies that benefit older people under supervision; however, I also found areas where this model has room for improvement in addressing age as a component of a person-centered approach.

Technology was mentioned by participants repeatedly as a significant challenge for older adults on community supervision. This issue is relevant in communicating with their officers through video visits, applying for jobs, or keeping in touch with their social support networks. Interviews revealed that video calls are often used in place of in-person visits for regular check-ins with people under supervision. Some participants mentioned that text messages are used to communicate between officers and supervisees as well. Several officers mentioned that when older people on their caseload are struggling to use their smart phones to answer video calls, they have adapted to meet their needs by changing the visit to meet in-person or teaching the person how to use the technology. One officer noted, "a lot of times the older population, they don't either have a smartphone or they don't know how to use it. So, it's really that there wasn't that it was not unusual for you to me as an officer to spend time showing them how to utilize technology for our video interactions."

Most of the officer participants were unfamiliar with aging-specific resources, and only one officer mentioned that issues specific to aging were part of any training or education that they had completed for their job. Though there is evidence of person-centered approaches to community supervision, there are some gaps in how they are tailoring this approach to people in

later life who may have different needs and challenges. Although the number of older adults on supervision is small compared with the younger adult groups, this varies between officers and regions. Among the interview participants in my research, officers who were currently or previously assigned to a sex offender caseload reported higher numbers of older adults on their roster.

1.6 Discussion

This research offers insight into community supervision officers' and individuals under supervision's perceptions and experiences with a person-centered community supervision model. Although participants had varied perspectives on whether the current way supervision is being conducted is "person-centered", it was apparent that the agency is attempting to make changes in its culture. Barriers or challenges in implementing a person-centered approach include high caseloads and a limited amount of contact between the officer and the supervisee, though this was not seen as negative by all participants. In addition, officers noted challenges with the specific model (ESP), describing it as rigid and hindering them from having natural conversations with the people on their caseload. Although this study examined the person-centered model through a gerontological lens, it is important to note that most of the findings are applicable across age groups and have implications across the life course.

There is evidence that the approaches and models that are being employed align with established definitions of person-centered approaches. For example, although participants shared common frustrations with the ESP model, there are aspects of this model that align with Carl Rogers's concept of person-centered theory. This theory posits that a model of self-direction and a belief in self-actualization is key for positive outcomes (Kirschenbaum, 2004). Based upon the description of ESP from officer participants, the goal is to allow the person under supervision to

make their own determination of next steps and alternative choices to work toward their desired goals. Further, the agency commissioner's statement about their person-centered model aligns with definitions of person-centered care in health and elder care fields.

There was a divide among participants on whether community supervision is person-centered. While most officers agreeing that they are employing this model, only a few of the participants with experience on supervision agreed. However, the ways that the participants defined the framework were in alignment. Moreover, the definitions matched the established theory and definitions of the concept in other fields. For example, the word "individualized" or similar phrases were repeated in interviews when asked. Participants agreed that a one-size-fits-all model is not person-centered, and that community supervision should respond to their unique needs and situation.

There were some important findings related to the consideration of age and health status within the person-centered approach. Interviews revealed that there are ways that the agency and the officers consider a person's age and health in the delivery of supervision, such as through adapting community service requirements or advocating on behalf of people with cognitive impairment to not receive violations. However, there is room for improvement to become fully person-centered, which includes the consideration of a person's age and health status consistently. Officers receive very little (if any) training and education related to age-related needs or differences and lack knowledge of the resources or supports that are specific to an older population. Although these actions may not be a significant solution to the issues facing this population, it would be an additional step toward the individualized approach that DCS is attempting to achieve.

Through the lens of an ecological framework, there is evidence that person-centered community supervision is being implemented, but that there are opportunities for improvement and growth. Ecological frameworks consider the systems that are impacting a person, from the individual to societal level, which includes their available resources. Attention to a person's age and health status and the interaction of these factors with the broader systems can ensure that needs are being met and can lead to better outcomes (Greenfield, 2012).

Given what is known about person-centered theory, person-centered care in aging and gerontology, the structure of U.S. community supervision, and findings from the interviews in this paper, the following are the questions that need further exploration and recommendations to improve or expand the current person-centered supervision model.

1. How are officers educated or trained on the person-centered supervision model? How is it defined in this education and how often is it re-introduced? To get a better understanding of the content and how officers are familiarized with the education, it is also important to find out who created the content, who conducts or leads the trainings or education, the format, and how officers are assessed and able to offer feedback and suggestions.
2. What are the standard assessments of people under community supervision? Do these include considering someone's age, health, and physical conditions? Drawing from an ecological model, officers should assess a person's needs and strengths based upon personal attributes (including age and health status), social capital, physical environment, available resources, and systemic barriers.
3. What are the specific ways that the goals and strengths of people under supervision are incorporated into their supervision? If not already in place, each person under

supervision should be asked to identify their strengths, goals, and desires systematically. This should be part of the policy and practice of the agency, and the responses should be self-determined, outside of what has been determined by an officer or court.

4. Interview data suggested that there is very little education on older adults or issues related to aging and how that could impact a person's success and experience under community supervision. Therefore, I recommend that officers' required training, including ongoing training, should cover special populations, including older adults, and how the needs of these populations may be different from the average person on supervision. Officers should have resources on-hand that address specific needs, including those that are aging-specific. Age, health, and disability status should be considered in a holistic assessment of the person.
5. Additional research and exploration are needed to understand how caseload size and time spent between officers and the people on their caseload are hindering the implementation of a person-centered model. As evidenced by the interview data, participants felt that officers did not have enough time to spend with them to offer support and resources to help them achieve goals, improve their quality of life, etc., while also recognizing that spending more time with an officer could translate to punishment or other negative outcomes. This issue involves a culture shift that will likely take significant time to overcome or change.

1.7 Limitations

The limitations of this research should be considered. The recruitment of participants for this study was limited to the resources available and the ability to access potential participant

groups. This may have resulted in bias in participant interview responses. In addition, all interviews took place virtually. Although in-person interviews were offered, most participants opted for a virtual interview or were limited to virtual because of their geographic location and limited window of availability. This could have potentially impacted responses to interview questions. It is important to note that a small number of participants who were currently or previously under supervision were unhoused at the time of the interview and some participants had to borrow technology (computer or smart phone) to participate in the virtual interview. Due to one participant's circumstances and resources, they were only able to participate in an interview very briefly. This resulted in much less data from this participant compared with others. Further, my positionality as a researcher could have impacted participant responses. I remained cognizant of this during recruitment, data collection, and analysis.

1.8 Implications

The implications of the research underscore the need for better conceptual clarity and standardized guidelines for person-centered community supervision. The study's outcomes contribute to the ongoing discussions on the importance of promoting personalized approaches in the criminal legal system. The existing knowledge that implementation of new approaches or culture changes are more successful when leadership and the broader community embrace them (Viglione & Blasko, 2018) is key in moving this model forward. This sentiment was expressed by some of the officers who referred to their chief's adoption of the method and the overall culture shift of DCS. Further, there is evidence that the positive attitudes of officers toward their agency is important in adopting new models of supervision (Viglione & Blasko, 2018). However, what was found in this study somewhat misaligns with this finding. Although most of the officers interviewed for this study held positive views of DCS, they struggled to be positive

about the specific model of ESP within the person-centered framework. This mismatch could be due to several reasons, including a lack of fully understanding the intentions and benefits of the model or how ESP fits within the broader person-centered framework. To fully understand this, additional research is needed. Ultimately, this data can serve as a resource for policymakers and practitioners in correctional systems seeking to improve community supervision practices for people of all ages.

This research is only one step toward understanding a person-centered community supervision model. Interviews with agency administration and leadership is needed to better understand the model, including the development and training of it. Ultimately, an evaluation of the framework is needed to understand its impact for people under supervision, the agency, and the broader community. This would shed light on how it impacts outcomes for supervisees and officers.

Chapter 2: Older Adults' Experience Under Community Supervision

2.1 Abstract

The issue of aging in the criminal legal system is garnering greater attention from both researchers and policymakers; however, it remains insufficiently explored. This study examines the experiences of people aged 50 or older serving time on parole or probation, referred to in Georgia as community supervision. This paper explores data collected through semi-structured interviews with community supervision officers and people currently or previously on community supervision. It presents themes and findings from interviews about the community supervision experiences of people aged 50 or older. Themes include perspectives on age as it relates to community supervision and gaps in officers' knowledge about aging-specific resources. Common challenges reported by participants include technology, housing, and health conditions. Findings from this research are informative and useful to correctional systems, aging services professionals, and policymakers as they illuminate some of the challenges that older adults on community supervision face. It sheds light on the gaps in knowledge of community supervision officers about aging-specific resources and the lack of training around aging-specific issues.

2.2 Introduction

Older adults account for a growing proportion of people involved in correctional systems in the United States, including those incarcerated in prisons, jails, and on community supervision. In prisons, older adults are the fastest-growing age segment. They comprised 3% of the prison population in 1993 but 10% in 2013 (Carson & Sabol, 2016). Most of these people will eventually be released back into the community, and a portion will be serving parole or probation sentences. An estimated 585,000 people aged 50 or older are on probation, and over

285,000 aged 50 or older are on parole in the U.S. (Substance Abuse & Mental Health Data Archive, 2020).

Research on older adults' experience with incarceration and re-entry is increasing, yet it remains an underexplored area. The growth in this area is exemplified by the growing number of researchers interested in this area. The development of the Aging Research in Criminal Justice Health (ARCH) Network in 2019 is one of the ways these researchers are collaborating and extending this work. This is a national collaborative effort to bring together experts who study the intersection of aging, health, and the criminal legal system and support and fund junior investigators to expand this field of inquiry. ARCH recognizes the profound need for additional data to better understand how older adults experience every area or level of the criminal legal system (Aging in Criminal Justice Health Network, 2023). The work presented in this paper attempts to add to that body of knowledge.

Generally, the age that demarks an "older adult" in prison is younger than the age used to describe the non-incarcerated population, due to their incarceration experience, access to healthcare, and lifestyle factors (Williams et al., 2012). This demographic commonly experiences an accelerated aging process, displaying a higher prevalence of comorbidities compared to individuals in the broader community, as a history of incarceration increases the risk of many chronic conditions even when controlling for other related factors (Garcia-Grossman et al., 2023). Because of eligibility for certain age-related programs, such as Medicare, the age of 60 or 65 is used to define an "older adult" in the community; however, when researchers discuss older incarcerated populations, they generally use age 50 or 55 (Bedard et al., 2016; Snyder et al., 2009; Psick et al., 2017; Abner, 2006). Further, while an agreed-upon age marker is needed to categorize "older adults" involved in the criminal legal system, a person's

health, and physical care needs should be considered when studying this population (Williams et al., 2012). The focus of the data collected for this study is on people aged 50 or older when describing "older adults" on community supervision to remain consistent with most of the research in this area (Merkt et al., 2020).

Successful re-entry for people of all ages should address their needs holistically, including transportation, financial support, identification and documentation, housing, employment, physical and mental health, substance use concerns, and social support (La Vigne et al., 2008). Older adults have similar challenges and needs as younger people, however, there are specific considerations that should be made. For example, age-related health conditions, changes in ability or desire for employment, different family structures, and age-specific benefits are important to consider as areas of need for older people. These factors contribute to the aspects of community supervision that older people may experience differently than younger age groups.

2.2.1 Research Setting

The research presented in this paper was conducted in the state of Georgia and examines the experiences of people who are familiar with community supervision in this state. Outside of convenience and the established connections of the researcher, the state of Georgia was chosen for this research for several reasons. Georgia has a high rate of parole and probation sentences. In 2016, 1 in 55 adults in the U.S. were on community supervision, and in the state of Georgia it was 1 in 18 (Horowitz, 2018). Further, Georgia is an aging state, with the 9th largest population of people aged 60 or older in the U.S. (Georgia Department of Human Services, 2021). Additional data and demographics of Georgia are explored in the literature review.

2.3 Literature Review

Regardless of their history in prison, most incarcerated people will return to the community at some point, including older adults. The probation and parole population in the U.S. has experienced dramatic growth, though there have been some slight decreases in recent years. Around 3.9 million adults are under community supervision in the U.S., which translates to 1 in 66 people in the total U.S. population (Kaeble, 2021).

An estimated 585,000 people aged 50 or older are on probation, and over 285,000 aged 50 or older are on parole in the U.S. (Substance Abuse & Mental Health Data Archive, 2020). In 2020, Georgia released 3,230 people from state prisons aged 50 or older, almost 18% of the total released that year (Georgia Department of Corrections, 2022). In the same year, 5,752 people age 50 or older were on parole in Georgia, which was 28% of the parole population. Currently, 42,920 people aged 50 or older are on parole and probation, over 22% of all age groups (Georgia Department of Community Supervision, 2023).

This population's needs and challenges should be examined from the individual, community, and systems levels to understand their experiences holistically. Therefore, an ecological framework is appropriate and valuable (Greene et al., 2007). This framework offers a multi-system approach to understanding the population and how each system interacts, including their health, accessibility of needed resources, and the systems that impact them. Existing data about older adults on community supervision (and groups who may share similar experiences) gives insight into present needs and potential strategies for improving outcomes.

2.3.1 Health & Health Care

Older age does not guarantee illness or disability, but the risk increases with age. Most incarcerated older adults have more than one chronic health condition (Gates et al., 2018).

Furthermore, physical and cognitive disabilities are prevalent in older adults, and people in jails and prisons have higher rates of disability than the general population (Bronson & Berzofsky, 2015). The healthcare needs of incarcerated older adults result in higher healthcare costs for prison and jail settings. Specifically, in Georgia, the healthcare costs for older people in prison are nine times higher than for younger adults (Dawkins, 2013).

The high prevalence of chronic illness in incarcerated populations holds true for recently released people (Williams et al., 2010). Further, people with a history of incarceration have higher emergency room use than people without this history (Erlyana et al., 2014). Older adults incarcerated in jails report high usage of emergency departments before they were in jail and many plan to use the emergency department for care post-release (Chodos et al., 2014). Furthermore, the risk of death is higher for people recently released from prison. A study found that the death rate for this population is over 3 times higher compared with people who were not recently incarcerated. The risk of death post-release is especially high during the first two weeks (Binswanger et al., 2007).

Older adults in prison fear managing their health conditions in the community once they are released (Avieli & Band-Winterstein, 2023). Many people experience trauma when transitioning in and out of prison, which profoundly impacts people's health and well-being. This transition is complicated by a lack of social support and challenges in securing essential resources like safe housing, both of which significantly affect health outcomes (Massoglia & Remster, 2019). Moreover, mental illness is prevalent among parole and probation populations, similar to prison populations (Gates et al., 2018; Bryson et al., 2019). However, there is a lack of research that examines the experiences, clinical assessments, and specific diagnoses of older people with mental illness in the criminal legal system (Maschi & Dasarathy, 2019).

2.3.2 Challenges for Older Adults in Re-entry

Frequent challenges for recently released older adults include managing physical and mental health conditions, transportation, getting medications, stable housing, and re-entering the workforce (Lares & Montgomery, 2020; Williams et al., 2010). Caregivers for recently released older adults report similar challenges, in addition to struggling to be self-sufficient and complete tasks independently. The combination of older age and incarceration experience makes things harder for this group, including signing up for social welfare benefits. To further complicate the matter, recently released older adults hesitate to trust people providing care for them through these challenges (Jiminez et al., 2021).

Social disconnection and loss of familial ties are challenges for older adults on community supervision who have been incarcerated (Avieli & Band-Winterstein, 2023; Western et al., 2015). Challenges with reconnecting with social support networks include stigma, financial strain, difficulty finding employment, and loss of familial ties after being away from them for so much time (Wyse, 2018). Experiences for older adults on community supervision or in re-entry vary depending on an array of factors including health status, gender, and social support. For example, older people who identify as LGTBQ+ have additional barriers and stigma due to their identity and history in the criminal legal system (Maschi et al., 2016). This furthers the notion that older adults on community supervision are a heterogeneous group, and their specific situations and backgrounds should be considered in research and practice in this area.

2.3.3 Resources & Approaches

Scholars in social work call for the consideration of frameworks from their field to address the challenges of helping older people reintegrate after incarceration. Several geriatric assessments exist that could be applied to a population impacted by the criminal legal system

(Higgins & Severson, 2009). Ecomaps are a suggested tool for supporting this group because they consider not only the person's attributes and current support system but also the larger systems that impact their ability to live in the community successfully (Miller et al., 2021).

Some services and programs specifically work with older adults transitioning out of prison or jail or are on parole or probation; however, there is little data on the impact or reach of these programs. For example, the Senior Ex-Offender Program (SEOP) in California claims to be the first in the country to focus on the needs of formerly incarcerated older adults. Their services include case management before, during, and after a person transitions to the community from prison. The program focuses on the specific needs of its older clients, including housing and healthcare (Bayview Senior Services, n.d.). The Project for Older Prisoners (POPS) assists with early release for older adults in prison who are eligible. Part of this process is ensuring the person has stable housing, healthcare and other benefits, and employment options if applicable (Office of Justice Programs, 1991; Snyder et al., 2009).

Health insurance and health care can be challenging to navigate for people coming out of incarceration. Medicaid is an important resource for helping formerly incarcerated people access health care post-release, especially considering most people in this group are of low-income (Albertson et al., 2020). For people aged 65 or older or with a qualifying disability, Medicare is an additional benefit available. Although the Medicaid and Medicare process can be cumbersome, new legislation is aimed at helping recently released people apply. The Incarceration Special Enrollment Period (SEP) went into effect on January 1, 2023, and is available for anyone released after that date. The SEP makes it easier for formerly incarcerated older adults to enroll in Medicare, particularly those who are not Medicaid-eligible (Burke & Keane, 2023). Further, some states have piloted programs within Medicaid Health Homes

specifically for people with chronic conditions coming out of prison or jail. Though these models are not designed specifically for older people, many older people will benefit because of the higher risk for health conditions. The pilot programs have made a promising impact so far, but have not been formally evaluated (Spillman & Allen, 2017).

A person leaving incarceration to return to the community needs support in ensuring they have resources and services to succeed upon re-entry. However, this process can be fraught with barriers and gaps (Hagos et al., 2021). The onus of release planning and transitioning from prison to the community is not agreed upon between agencies or entities, though it is recommended that both facilities and community supervision play a role (La Vigne et al., 2008). In the Medicaid Health Home pilot programs, discharge planning and the transition from incarceration to the community were vital to a successful re-entry (Spillman & Allen, 2017). For some older adults, long-term care residential settings are needed for their level of care upon release from prison. A Canadian study found that finding placement in a long-term care setting for someone transitioning out of prison is challenging due to ineligibility and stigma (Poulin et al., 2023).

2.3.4 Knowledge & Training for Professionals

It is challenging to find literature on education on aging or issues related to older adults for professionals in any aspect of the criminal legal system. One training documented in the literature has been replicated in two states. It covers topics such as chronic illness common among older adults and resources and benefits available to older adults and was overall well-received by prison staff (Cianciolo & Zupan, 2008; Masters et al., 2016). Some state correctional agencies claim that they provide training to correctional officers in working with older adults and aging-specific concerns. Even so, training on older adults was among the lowest out of the special population offerings, with topics such as mental illness and gangs ranked among the

highest reported (Burton et al., 2018). The existing data on education and training for professionals in the criminal legal system on aging-related issues and resources demonstrates the gap in research, practice, and policy.

The National Association of Area Agencies on Aging (N4A, which has since changed its name to USAging) surveyed all the Area Agencies on Aging (AAAs) about their work with people currently or recently released from incarceration. Of the respondents, only 9% report having a program for this group. Examples of existing programs include case management and support for housing, employment, and transportation for older people coming out of jail or prison. One program brings an evidence-based chronic disease education workshop into prisons. Given that 74% of the polled AAAs responded that they were interested in serving older adults who were currently or formerly incarcerated, there is an opportunity for aging services to engage with this population (National Association of Area Agencies on Aging, 2017).

Existing data indicates that the intersection of aging and the criminal legal system can result in specific barriers or challenges. Many older adults who have a history of incarceration or have been under community supervision have specific needs that are not necessarily present for people in younger age groups or people who have not had experience in the criminal legal system. The data presented in this paper adds to the growing literature on how older adults experience community supervision and how community supervision officers approach their work with this group.

2.4 Methods

Data for this study was collected through semi-structured interviews and analyzed using thematic analysis. The research questions explored in this paper are:

1. What are the challenges of older adults on community supervision in accessing needed resources and navigating community supervision and/or life after incarceration?
2. What are the challenges of community supervision officers in working with older adults to help them navigate community supervision and find resources and support?
3. What are the perceptions and attitudes of community supervision officers in working with older adults? What about this population is perceived as different from younger people under community supervision?

Data for this study are from interviews with people who have experience on parole or probation in Georgia and with community supervision officers working in Georgia (one participant is in a counselor role). After receiving IRB approval in the fall of 2022, recruitment began. Participants were recruited for the study mainly through word-of-mouth referrals. Participants who were previously or currently under supervision were recruited through community organizations that support people who have experience in the criminal legal system. Leaders and case managers of these organizations distributed my recruitment email (Appendix) or gave my information to clients or participants. The first several community supervision officers I interviewed were referred from another study, and the officers contacted me about their interest. The remaining officers were referred to me by a participant, who sent an email to their coworkers about the opportunity.

The semi-structured interviews were conducted with participants between December 2022 and May 2023, in tandem with additional recruitment. All interviews were done via video conference and phone calls. These conversations were audio recorded with participant consent and transcribed using transcription software. Interviews lasted from 18 minutes to over two

hours. There were 24 participants in this study, and compensation was given to participants for their time. A copy of the interview guides can be found in the Appendix.

At the outset of this research, the goal was to interview two groups: 1) people who were currently community supervision officers in Georgia and 2) people who were currently under community supervision (parole or probation) and were aged 50 or older. Though most of the participants matched these criteria, eligibility was expanded during recruitment after I recognized that others added valuable perspectives to the research, and it did not waver from the research questions. This included a counselor working in community supervision and a handful of participants who had experience under community supervision in the recent past. Minor adjustments were made to the probes and language of the interview guide to adapt to different roles, including asking people who were not currently on supervision to try to recall the time when they were under supervision.

Participants who were currently or previously on community supervision all had a residency in Georgia and had experience under supervision in Georgia. Each participant was asked to self-identify their gender, race, age, and highest educational level at the beginning of the interview. Seven participants identified as a woman, and seven identified as a man. Nine participants were African American or Black, and five were White or Caucasian. The ages of these participants ranged from 37 to 64, with most participants being between age 50 and 60. Educational attainment varied; several participants had less than a high school or a high school diploma or equivalent, however, several had some college or college degrees.

The second participant group, community supervision officers and a counselor, all work in Georgia and supervise people in Georgia. Participants self-identified their demographics, with the addition of how long they have been working as a community supervision officer. Five

participants identified as men, and five as women. Three participants identified themselves African American or Black, six were White or Caucasian, and one as Asian American. The ages of these participants ranged from 27 to 51. Participants ranged in job tenure from under two years to over 26 years. They served a range of geographic locations across the state, including rural, urban, and suburban areas.

Interview questions for officers included inquiries about their current job description and their educational and work history, to gain a better understanding of how they came to be a community supervision officer, their tenure on the job, and if they have a specialized caseload. To learn about their experience with older adults on their caseload questions such as, "What are some of the differences, if any, between the younger people and the older people that you supervise?" I asked about specific challenges or barriers that they observe in working with older people. This included a question about how they have relied on or made referrals to community organizations to address older adults' needs, if applicable. In addition, I asked them to walk me through a recent interaction or visit with an older person on their caseload.

In the interviews with people who have experience on community supervision, I asked them to share their background before asking about their incarceration history. I inquired about their health and any physical limitations to understand their potential needs and barriers, including chronic illnesses and when they were diagnosed or began to have symptoms. I also asked questions about their ability and access to do or accomplish things in their life that they want or need to do, and how their age, health, and criminal legal history impacts that.

To analyze the interview data, I used reflexive thematic analysis (Clarke & Braun, 2017; Braun & Clarke, 2021). Prior to coding, I reviewed and cleaned the interview transcripts to ensure data quality, while listening to the audio of each interview. This step involved becoming

more familiar with the interview data (Braun & Clarke, 2021). I relied on both a priori and emergent themes during my iterative coding process. The a priori codes were broad and included themes determined by sections of the interview guide, such as 'barriers or challenges in re-entry or supervision', which were couched in what I knew from previous related literature and my experiences. From those broader codes, narrower themes emerged during initial coding, and codes were developed that were more specific to the data. For example, the codes 'housing', 'employment', and 'technology' emerged as subthemes under the existing code of 'barriers and challenges.'

After initial coding, I used NVivo 12 to code each interview transcript with the codebook. A few additional codes and subcodes were added during the coding process, including the code 'caregiving' to capture the experiences of participants who held this role. The final codebook had 18 parent codes, with some codes containing several child codes. I ensured that the data was thoroughly analyzed through the process of transcription, review, and reflection of the data, and multiple rounds of coding. This resulted in several reviews of each transcript, including listening to the audio of the interviews, and reading transcripts multiple times.

2.5 Findings

2.5.1 Experiences, Challenges, & Barriers in Re-entry/Community Supervision

Interviews revealed several challenges that people face after release from incarceration and while under community supervision. Some of these apply to people across all age groups, while others are specific to older people or are further complicated by older age. Although there was agreement among participants about barriers, some of the experiences and perceptions were very different.

Restrictions Due to Background or Status on Supervision. Some of the challenges reported in interviews stemmed from a person's history of conviction of a crime, incarceration, and status on supervision. Some of those include obtaining housing and employment, which are discussed in greater detail in subsequent sections. Some participants discussed the difficulty of not being able to travel or move about in life freely because of their restrictions, including the requirement to obtain a travel pass from their officer to cross state lines. Participants expressed frustration, particularly because it limits their ability to see family members who live in another state. One participant under supervision said,

> "I can't go where I want to go, not without letting my probation officer know. And they have to approve for me to go somewhere. It's not it's not like, 'Hey, man, I gotta extra ticket to the Superbowl, you want to go?' If it was three days before the Superbowl because it wouldn't happen. I couldn't get approved…I can't even leave the state, if I decide I want to go back to my hometown, I would have to let my probation officer know. And they have to approve, I can't just leave."

A few participants conveyed their stress in knowing that they were being monitored more closely or that consequences would be harsher for them due to their supervision status. For example, a participant shared a story about eating at a restaurant that served alcohol and asking her husband if they could leave because she was concerned that she would violate her community supervision rules. Further, one participant discussed being distrustful of others and their actions that could result in his punishment, such as a friend having a gun in their car without his knowledge. He explained the situations he tries to avoid:

> "I am on probation. So, anything... you can call and tell me we are going out to eat. Okay, you come pick me up, you have a gun in your glove box. You're not thinking about your

> gun in your glove box, that gun has been in there for weeks…But guess what, we get pulled over because they feel like we're in this particular neighborhood that particular neighborhood, now they want to search the car, and you? 'search it, no problem'…Now you run names. 'Oh, you're on parole you're not supposed to be around a gun. Let us take you in'. No, you don't go anywhere, because your car, your gun, no problem. I have to go because I'm around a gun. So you know, it's those little bitty things that will really get you."

Technology. Nearly every participant mentioned technology as a challenge for older adults recently released from incarceration. Because digital literacy is essential for everyday life, there are many ways in which this is a barrier. For example, many jobs require resumes or online applications and managing finances is often done online. One participant noted her perception of how the use of a smart phone is needed in most aspects of daily life,

> "You have to be connected to your cell phone for everything now. And for someone who never had a cell phone in their hand for 27 years, you're telling me I have to do my job application with my phone, I have to do my banking on the phone, I have to do student loan application for two hours on the phone. And I can't even get from point A to point B on the phone."

The person's age when new technology was developed and became common combined with the time spent incarcerated creates a gap in learning and understanding how to use smartphones and other technology.

Officers discussed helping older people on their caseload with technology so that they could participate in video calls or respond to text messages with their officer. During the COVID-19 pandemic, online meetings with community supervision officers became more

common to avoid in-person contact. The agency began using the Google Meet platform for required meetings. However, officers shared that the use of video conference applications was not familiar for many people, especially if they were older or were formerly incarcerated. For example, the counselor explained the difficulty of understanding this challenge as a younger person. She said,

> "And so it's definitely a generational thing of the easiness of it. Because like, I'm 30, I would much rather text you, I hate talking on the phone. With a participant that's like 68 years old, I'm like crap I have to call you because you're not, you don't open up my text message. And that also goes with being very institutionalized, like say they serve 16 years, a lot of the phones and technology that they went in and came out with is not the same. So it's all new for them. Like I had one person that was locked up for 25 years. Never saw a cell phone. Yeah. They're like, what is this? I'm like, okay, so, I don't know how to try to explain this to you. It's a house phone that you take with you."

Several officers discussed helping older people on their caseload learn how to use Google Meet, and some reported that it was easier to meet with them in their homes because the person has so much difficulty with the technology. This experience was shared by some of the participants with experience on community supervision who reported that their officers have had to show them how to use the virtual meeting platform. Like the other participants, officers noted that technology was needed for other aspects of people's lives, including in jobs, which they saw as a barrier for some older people, particularly if they were incarcerated for a long time.

Health and Health Care in Prison. The interview guide contained questions about older adults' health conditions and physical limitations. Some participants reported very good health, while others had several chronic conditions, including cancer, diabetes, arthritis, history of

stroke, hypertension, and cognitive impairment. Officers reported similar health conditions in their older clients, in addition to chronic obstructive pulmonary disease (COPD). Some participants discussed pain, physical disabilities, and the need for assistive devices, such as walking canes and hearing aids. In addition to physical health conditions, both groups reported mental health disorders, including bipolar disorder. Some of the officers reported experiencing the death of older people on their caseload, including a person who was receiving hospice care.

Though the interviews mainly focused on experiences post-incarceration, some participants shared about their experiences with healthcare while incarcerated. A few participants reported experiences of medical neglect, mistreatment, and abuse by healthcare providers and other correctional staff. For example, one participant reported that her symptoms of a heart attack were ignored repeatedly by staff. Another participant shared with me that she received a medical procedure without her consent. Some participants speculated about the impact of incarceration on their health, including one person who is has a stomach condition that his doctor explained is commonly acquired in institutional settings, though he cannot be sure that is where he acquired it. One participant shared that she has chronic pain, and she wonders if the time she spent in prison exacerbated her poor health. She stated,

> "Well, I'm a lot healthier than I was. Prison broke me down. I will say that yeah, I don't know if it was the drug use or prison, but I can barely stand up or walk. Sleeping on a concrete block basically almost killed me, doing that for two years. However, I take 13 pills at night and three in the morning, yeah. And live in pain all day and all night."

Social Support, Income, & Housing. Most of the participants with experience under community supervision reported some social support from family, including adult children and spouses, however, a few participants did not have close family ties. Officers had mixed

responses about the social support networks of the older people on their caseload. Some officers said that the older people had stronger social support compared with the younger adults, while others reported the opposite.

Similar to the findings around social support, there were mixed responses from officers about housing for the older people on their caseloads. For example, one officer said the following, “I mean, most of the older people do have stable housing…I deal with a lot of a lot of homeless population, and, you know, but it's not the older people. So that I feel like, like the younger population are dealing with homelessness…” On the other hand, the counselor stated,

> “A lot of older population are homeless. And that I think stems from the fact that they don't have any other family to live with because they are the older population, whereas a lot of the younger ones are living with like sisters, aunts, uncles, parents, whatever the older population doesn't have that same kind of support as the younger population.”

Just as officers reported different housing situations, the participants with experience on community supervision had a range of housing challenges and successes. Many of them currently or previously lived with relatives. Some people discussed how difficult it was to obtain housing with a criminal background, while others had no trouble getting housing. Some of the ease of finding housing came from using strategies to circumvent background checks or other potential barriers. For example, a participant shared that he used a friend’s name on the rental agreement or lease and another participant said that they reside in places that do not require background checks, such as rooming houses.

Some participants mentioned the challenges of affordability and income in interviews. Officers reported that older people on their caseload have more challenges with finances compared with younger people because their income is limited to social security or disability

income. One officer noted that the older people on his caseload often mention that they have trouble paying their bills because they are on a "fixed income". Participants discussed the challenge of applying for benefits, such as social security, disability, and Medicaid. This is illustrated in the following quote:

> "So the issue of the health insurance with older population is because they've been in and out of jail. So when they go into jail, their Medicare essentially gets stopped, those benefits get stopped. And so then when they come out, they have to try to get them reinstated. So a lot of them struggle with like getting there because they don't have their license, or they don't have the support to help them get there. Or they don't really know how to do the paperwork situation. So they don't really understand how to do it, or they don't have a mailing address to get other benefits sent to."

The complicated process of receiving healthcare or financial benefits prove to be challenging for many people. When asked who or what entity helped with applying for these benefits, the responses varied. Some participants reported doing it themselves and others reported that case managers through the court system assisted them (i.e. accountability or mental health courts).

Jobs and Community Service. Responses about employment varied across participants. Several participants with community supervision experience had been turned away from potential jobs due to their backgrounds. For some, one of the challenges is not only finding employment that will hire them with their background but also finding a position that matches their experience and their physical abilities. A few participants shared that the jobs they have found that will hire people with a criminal record require manual labor or long hours of standing, which is not suitable for people with chronic pain or other health conditions. Several officers discussed the difficulty that older people on their caseload have with finding jobs, especially

ones that are appropriate for the person's physical ability. There was also mention of how jobs that require physical labor contribute to disability. When discussing an older supervisee, an officer shared how the man's job history has contributed to his physical conditions:

> "But, you know, he's, he's got like, a bad back. He's worked manual labor his whole life, because that's pretty much all the jobs that he has been able to get. Because of his record. He's, I mean, his record is horrible. And so he's only been able to find jobs where he's like, laboring for 12 hours a day in the hot sun. So he's, I mean, he's got a pretty big hitch in his giddy up. And his back is definitely, I mean, he's got all these fancy little back bands, the little back supports…I know his body's just been run through."

Some participants were required to participate in community service hours, and a few people had challenges with their assigned placement. One participant described her concern with completing her hours doing lawn care work, which required bending and lifting for long periods, however, she was hesitant to bring it up to her officer out of fear that she would receive an even worse placement. She shared,

> "I wanted to tell him, God, you know, you guys got me doing this physical labor, you know, maybe this should be for guy or something, not a lady at 57. But I don't think that I want to tell them that because I'm afraid they'll put me on like roadside duty or the garbage bin or something. So I don't want to complain very much. Because I don't want to get in a place where I have to do something even worse than what I'm doing right now."

Officer participants discussed community service requirements, and several shared ways in which they can accommodate people who are physically unable to perform certain tasks due to health or physical conditions. For example, in some cases there are options for people to do light

administrative work in the local DCS office or donate items to food drives in lieu of doing service hours. A few officers said that they have requested judges dismiss the community service hours altogether for people who have been determined disabled and unable to work. One officer shared her experience with requesting a dismissal of this requirement:

> "And his big issue is, because of his health condition, he could not be around other people like he, like his heart, he had to have open heart surgery and like bypass multiple times, because he had like a decaying heart, is just falling apart. And he physically could not be around other people. And so I had to do an order, which the judge probably was not super happy to sign it. But I just didn't order to dismiss all of his community service because he physically could not do it because he was a risk to his health."

Caregiving. Although caregiving was not a primary focus of the interviews, some experiences with caregiving were shared. A few of the participants had past or current experience providing care for a loved one while on community supervision, including residing with their parent who had a recent health event. Officers reported several instances of caregiving on their caseload, and the challenges that emerged. This included people navigating the requirements of their supervision. To illustrate this, an officer shared that a person on their caseload was required to attend sessions at a Day Reporting Center (DRC) and was the primary caregiver to his parent with dementia. On more than one occasion, a neighbor called to report that his parent was wandering outside of the home. This person had a suspended driver's license and had to use a public bus to return from the DRC to check on his parent, which further complicated the situation. Other officers shared that they had people on their caseload who resided with a grandparent after their release from jail or prison because that was their only option, therefore, many of these people found themselves in a caregiver role.

2.5.2 Officers Knowledge & Awareness of Aging-related Needs & Resources

Based upon the interviews with officers, there is little to no required education or training on the specific needs or challenges of older people. Officers reported minimal knowledge of resources for the aging population, even when probed about specific agencies. One officer told said, "it's something…I didn't realize before, is that there are actually community supports for old people…never once have I heard of that, like, even in my personal life." This was true for several participants who had no experience with an aging-specific organization or agency, such as the Area Agencies on Aging (AAAs).

Several officers noted that their interaction with older individuals is minimal, thus training or resource knowledge is not relevant to their daily responsibilities. On the other hand, some officers were very eager and interested in learning more, particularly those who saw the current or future need because of the growing older adult population in the criminal legal system. One officer reported being "upset" that she was not more aware of resources specifically for older people. She notes that there is a level of awareness of other resources, including for children, and that she only very recently learned about Adult Protective Services (APS). She shared,

> "…it's something I realized that I didn't realize before is that there are actually community support for old people, when you said that I was like, old people support? Never once have I heard of that, like, even in my personal life. So I feel like, like, we get all kinds of information about how to help our younger people, people with children like DFCS, DBHDD for the mental health, etc. I didn't even realize like, I just learned last week about APS and I don't even know how we'll go about calling them. Yeah, so I'm upset that we don't know more about that."

This officer was among the several who were interested in adding aging organizations or supports to their existing resource lists. Another officer noted his awareness that the older adult population is growing, therefore, people in his position need to increase their knowledge and awareness. He said,

> "I will tell you there is that need… it's just that particular demographic, in the next few years, it's going to just boom. And I can, I can foresee it becoming a bigger issue than what it is right now. And having something already in place to where we can kind of streamline that process to be able to provide the assistance for those that are in that, that demographic, it's easier to have that already prepared. And rather than trying to build something from the ground when it's you when you're in the midst of it. So yeah, I and I will tell you like me as an officer like, yeah, I would definitely need like, we would love to have a resource just as that for those for that particular demographic."

Overall, officers reported an openness to learning about resources available for older adults that could potentially be useful in their jobs. Responses on the amount of contact with older people varied, and one notable difference is that the officers with caseloads specific to people classified as sex offenders supervised more older adults than those with general caseloads.

Older adult participants reported very little support from their community supervision officers with age-specific issues or resources One participant stated, "community supervision isn't even set up to think that way", implying that suggesting age-specific resources or supports is out of the wheelhouse of DCS. Another participant shared that she thinks that there should be a different approach to re-entry for older people, however, from her experience community supervision officers do not have specific aging resources to offer. She said,

> "…when you are released, they just give you the same spiel they give everybody else, expect you to get your job, do this do that, you know…the expectations should be different for those who are aging out. My particular PO is very laid back and didn't have a problem one way or the other. But that they don't have something specific to say, 'here, you need to go see these organizations' or just a resource list for that at all. No, that does not exist."

As noted previously, the participants who received support in applying for age-related benefits received it from case managers of other agencies or entities.

2.5.3 Perspectives on Older Adulthood, Aging, & Desistence

Older adult participants discussed their feelings about older age, including whether their experiences with the criminal legal system have shifted as they have aged. In line with criminology literature, some older participants discussed how they had ended their engagement in crime as they aged and how their perspectives have changed over their life course. They cited maturity and changes in what they care about as they have aged. One person noted, "You get older, you get wiser," concerning how his behaviors have shifted over his life course. Similarly, a participant shared that he felt that as he aged, he learned to, "respect the law a little better," and that his attitude had changed.

Officers were asked about their experiences supervising older people, and if they find differences compared with younger people on their caseload. Some officers discussed the ease of supervising this population, and they perceive older people to be less of a concern because they are less likely to commit another crime or violate their conditions. Part of this stems from the fact that many of the older people have been on supervision before or have been on supervision for a long time; therefore, they know the process and the rules. One officer shared,

> "But they're like they've been around the block before some of them have been on probation so long they like they knew my boss's boss, when she was in my shoes…but uh, yeah, most of them been around the block before they understand what's up. They know what probation is. They know what is expected of them. So most of the time, they're pretty chill. Like, for the most part most my older population just doesn't care. Like they just want to, they just want me knock on the door, say hi to them get out their hair and go about their business because they're trying not to be in trouble."

Similarly, another officer said that in his experience the older people are more compliant with their supervision and added that he perceives them to be "tired of that lifestyle" when it comes to criminal behaviors.

2.6 Discussion

The findings from this study give insight into the experiences of people aged 50 or older on community supervision in the U.S. This study is important because it includes the voices of people with community supervision experience and community supervision officers. Although research in this area is limited, interview findings align with some of what is known about this population. Further, the data supports the need for more attention to this group from researchers, policymakers, and practitioners.

The findings from interviews regarding desistance and older age are important. The participants in this study had varied trajectories, including five participants who were incarcerated only once for one conviction, three of whom served prison sentences that were 25 years or longer. The other participants were in and out of jail, prison, and community supervision for much of their lives, some beginning when they were under the age of 18. Because criminal history and desistance were not central to this study, there are aspects of the participants'

behaviors and turning points that were not captured; however, the relationship between age and criminal behavior was an emergent theme in this research. As described in the findings, some participants talked about age and how it influenced their current desistance from crime. The officers shared their perspective on the relationship between age and criminal activity. The officers' perceptions of older adults as less likely to violate their supervision terms or cause trouble could stem from their professional experiences with older adults or biases and stereotypes of aging.

Generally, research on age and desistance is focused on adolescence and early adulthood; however, it is worth noting the parallels between these findings and the literature on desistance. Data shows that increased age decreases crime commission, though social bonds and other factors play a role in tandem with age (Siegal, 2011; Laub & Sampson, 2003). For older adults specifically, recidivism is lower for those in the oldest age category, further supporting the notion that age plays a significant role (Rakes et al., 2018). This theme held true in some interviews with older adults who suggested their desistance from crime as they have aged, which seemed to be due to a change in attitude and perspective (they referred to maturation, getting "wiser," etc.). The interview findings align with findings in the literature on how older adults' feel about being involved in crime or the criminal legal system as they age (Sparkes & Day, 2016). The findings from this study further support the need for policymakers to consider the sentencing and supervision conditions for older adults, which is commonly suggested by other researchers (see Williams et al., 2012; Psick et al., 2017; Prost et al., 2021, and others).

The two groups were in alignment on several of the challenges that older adults on community supervision face. For example, both groups expressed that technology was a significant challenge for older people on community supervision, both for daily life and for

navigating community supervision. Agency policies around the use of technology to fulfill supervision requirements should be examined based on this finding. Further, this also points to a need for support of older adults transitioning out of prison in navigating technology that is needed for successful re-entry. For aging service professionals, it is important as they consider the additional barrier of previous incarceration to accessing resources online or communicating with their social support networks.

Although a few of the participants reported very good health, there was overlap among both groups in the reported health conditions for people aged 50 and older on community supervision. This aligns with what we know from existing literature on this population (Gates et al., 2018; Prost et al., 2021; Williams et al., 2010). This can inform programming and practice for aging services and the criminal legal system for chronic disease education and awareness of how to offer support to this population. It supports the need for programs such as chronic disease self-management workshops within prison and jail settings (National Association of Area Agencies on Aging, 2017). Further, it highlights the importance of services in the transition from incarceration to the community. Programs that attempt to bridge the gap from corrections to health care in the community, such as the Transitions Clinic Network, are examples of models that can benefit a population with high rates of chronic conditions (Shavit et al., 2017).

Some of the findings about the barriers or challenges experienced by older people under supervision align with what we know about people of all ages in re-entry or with criminal records. For instance, difficulties in finding stable housing and employment are not unique to older adults. Even so, there may be specific needs that make these challenges different, such as considering accessibility and accommodations for someone with an age-related disability or chronic pain, as noted by some of the participants. There was variation in responses from

participants about housing and employment, with some agreeing that housing and employment were significant challenges and others saying the opposite. Though data shows that older adults who have been recently released from prison have a high rate of homelessness (Williams et al., 2010), there are still varying experiences depending on several factors. This could include the time since release, the availability of informal support, or knowledge of how to navigate barriers. The difference could also be from the perceptions of officers and the amount of interaction they have with older adults on their caseload.

Although there were only 24 participants in this study, the varying responses and experiences reiterate the need to consider this population's heterogeneity. Older adults are linked by age, which means they may share common experiences such as age-related chronic illness, and familial shifts, and may be eligible for age-specific benefits; however, other aspects of their identity and experiences should not be ignored. As suggested in the literature, the use of life course perspective and ecological systems theory should be used to better understand the ways a person's history, socioeconomic status, environment, and systemic barriers will influence their ability to successfully reintegrate (Maschi, 2013). The intersection of a person's race, gender, and criminal legal status has an impact on their experience with community supervision when navigating resources. For example, mistrust of medical providers, discrimination by workplaces, and difficulty using technology are all challenges that should be addressed with an ecological framework in mind. Although this study did not examine race specifically, some Black participants shared their experiences with racism within the criminal legal system, from their arrests to their re-entry experiences.

The data presented in this paper extends what we know about older people's experiences on community supervision, however, it supports the need for person-centered and individualized

considerations for the unique identities and histories of people with criminal legal experience. The themes that emerged from this study should be further explored in future research. The addition of administrative data including health conditions, sentence lengths, disability status, and housing situation would deepen the understanding of the experiences of people aged 50 or older on community supervision. Additional interview data from community supervision leadership and the aging services network would be useful in understanding the bigger picture of this issue, including knowledge levels, available training, and readiness to form collaborative relationships between agencies or sectors.

Beyond informing future research on the intersection of aging and community supervision, the data from this study is important for policy and practice. The finding that officers have little knowledge of resources specific to older adults speaks to the need for communication and collaboration between the aging services network and the criminal justice system. Based upon the openness and eagerness of some of the officer participants to become knowledgeable on resources specifically for older adults, there is an opportunity to educate this group. This suggestion aligns with a recommendation from multi-disciplinary experts who suggest that staff in correctional systems should be trained on age-related health conditions and changes, including vision, hearing, and balance deficits, and common conditions including dementia. Further, they suggest that these should be trained in the context of how this may impact a person who is in a correctional context and when people should receive health care evaluations (Williams et al., 2012). Specifically for Georgia, the timing is ripe for a call to action to consider the age-related challenges of the community supervision population. The Georgia DCS employed a person-centered community supervision model in 2020 (Georgia Department

of Community Supervision, 2020). The findings from this study speak to the need for this framework to be extended and inclusive of age-related needs.

2.7 Limitations

The limitations of this research should be considered. The recruitment of participants for this study was limited to the resources available and the ability to access potential participant groups. This may have resulted in bias in participant interview responses. In addition, all interviews took place virtually. Although in-person interviews were offered, most participants opted for a virtual interview or were limited to virtual because of their geographic location and limited window of availability. This could have potentially impacted responses to interview questions. It is important to note that a small number of participants who were currently or previously under supervision were unhoused at the time of the interview and some participants had to borrow technology (computer or smart phone) to participate in the virtual interview. Due to one participant's circumstances and resources, they were only able to participate in an interview very briefly. This resulted in much less data from this participant compared with others. Further, my positionality could have impacted participant responses. I remained cognizant of this during recruitment, data collection, and analysis.

Chapter 3: A Review and Content Analysis of U.S. Department of Corrections End-of-Life Decision-Making Policies

3.1 Abstract

With a rapidly growing population of older adults with chronic illness in United States prisons, the number of people who die while incarcerated is increasing. Support for patients' medical decision making is a cornerstone of quality care for people at the end-of-life. We sought to identify, describe, and analyze existing end-of-life decision making policies in U.S. departments of corrections. We performed an iterative content analysis on all available end-of-life decision making policies in U.S. state departments of corrections and the federal Bureau of Prisons. We collected and reviewed available policies from 37 of 51 prison systems (73%). Some areas of commonality included the importance of establishing healthcare proxies and how to transfer end-of-life decision documents, although policies differed in terms of which patients can complete advance care planning documents, and who can serve as their surrogate decision makers. To our knowledge, this is the first content analysis of end-of-life decision-making policies in U.S. prison systems. Many prison systems have an opportunity to enhance their patient medical decision-making policies to bring them in line with community standard quality of care. In addition, we were unable to locate policies regarding patient decision making at the end-of-life in one quarter of U.S. prison systems, suggesting there may be quality of care challenges around formalized approaches to documenting patient medical wishes in some of those prison systems.

3.2 Introduction

The U.S. prison population is aging rapidly, eclipsing the rate of increase of the population of non-incarcerated older Americans. Older adults make up the fastest growing age

demographic in prison populations, comprising 3% of the prison population in 1993 but 10% of the prison population in 2013 (Carson & Sabol, 2016). Although prison deaths occur among people of all ages, older adults account for most deaths in prison because of their increased burden of chronic and/or serious life-limiting illnesses (Carson & Cowhig, 2021). As a result, there is a growing need for specialized geriatric and of end-of-life (EOL) care in prisons, including clear delineation of the decisions people, who are incarcerated, can make when facing serious, life-limiting illness.

Medical decisions commonly made at the EOL ("end-of-life decision-making") may including identifying a health care power of attorney and deciding in advance to accept or decline curative medical interventions or advanced life support ("do not resuscitate orders"). Although supporting patients to make informed medical decisions is a core element of community standard care for people with serious, life limiting illness, no studies to our knowledge have analyzed the U.S. prison policies regarding patient autonomy and decision-making among incarcerated patients regarding decisions about medical care at the EOL. In this study, we analyze correctional policies that provide guidance, rules, and/or restrictions on EOL decision-making for incarcerated people across U.S. federal and state prison systems, including the process for documenting patients' EOL wishes. This study describes and compares these EOL decision-making policies and provide suggestions to optimize care in this area.

3.2.1 End-of-life Decision Making

Advance care planning is the process that supports patients to understand and share their goals and preferences for future care. Although appropriate for adults of any age, advance care planning is of particular relevance for older adults and those with terminal conditions approaching the EOL (American Medical Association, 2021; American Geriatrics Society,

2017). Advance directives are a component of advance care plans that allow people to communicate their wishes for care at the EOL with their loved ones and healthcare team. Typically, an advance directive includes a healthcare power of attorney and a living will or statement about a person's care preferences at the EOL. Patients use a healthcare power of attorney to designate a person (or people) to make healthcare decisions on their behalf if they are temporarily or permanently unable to communicate their wishes.

There have been significant efforts to increase the use of advance directives in the U.S. For example, the Patient Self-Determination Act (PSDA) of 1990 requires all healthcare entities receiving Medicare or Medicaid funding honor patients' advance directive documents, including healthcare power of attorney and living wills. The Act requires these facilities to provide education to staff and patients about these documents (Patient Self-Determination Act, 1990). Yet, a relatively low percentage of Americans (26-37%) have completed an advance directive. Studies suggest that completion of advance directives is highest among women, white people, and college-educated people (Rao et al., 2014) and low completion rates are partially driven by lack of awareness of their importance (Yadav et al., 2017).

3.2.2 End-of-Life Decision Making in Prison

The growing number of incarcerated older adults in the U.S. means that more people live with serious illnesses and die behind bars. In 2016, over 4,000 people died while confined to a U.S. federal or state prison. The vast majority of deaths in prison are because of illness, such as heart disease or cancer among people aged 50 or older (Carson & Cowhig, 2021). As such, many incarcerated individuals live with a terminal or chronic condition for days, weeks, months, or years prior to their death. In addition, incarcerated individuals receive health care in community hospitals and clinics for specialized or emergency medical treatment, which makes clear

documentation of a person's medical wishes, and a system for sharing those decisions even more important.

Death is a universal experience; however, there are several factors that determine a person's context of dying, including how much control a person has over their care and experience. Incarcerated people lose many of their rights and international law does not necessarily protect a person's right to choose a particular medical treatment (Cheung, 2019). According to standards set by the National Commission on Correctional Health Care (NCCHC), incarcerated people have the right to EOL care decisions, including whether to receive measures to prolong life (National Commission on Correctional Health Care, 2020). Autonomy in medical decision making is essential at EOL, though often sits in contradiction to priorities or policies in correctional settings.

The policies and the environment of a prison limit the adoption of person-centered end-of-life care (Burles et al, 2016; Stensland & Sanders, 2016). Generally, person-centered care allows the patient to partner with health professionals in decision making, with consideration of the person's preferences, history, and socioemotional wellbeing (NEJM Catalyst, 2017). The rigid schedule, safety procedures, and culture of corrections are not conducive to individualized care plans or holistic models of healthcare. Advance care planning is one tool to support a person's choices as they approach the end of their life.

Social support is important for people who are at the EOL (Dobrikova et al., 2015; Bradley et al., 2018). Friendships and companionships with other incarcerated people appear to be important to older adults in prison. Incarcerated individuals at EOL have less support from family or friends residing in the community than non-incarcerated counterparts. Often, social support is found between incarcerated older adults (Aday, 2005). There are multiple barriers to

implementing advance care planning in prisons, including finding a person to serve as a healthcare power of attorney (also referred to as healthcare proxy or agent). Researchers found that some of the incarcerated participants an advance care planning program had very little contact with loved ones outside of the prison. Even when a person identified a family member or friend that they wanted to serve in this role, it was not always feasible because the person can refuse this designation or the prison was unable to locate them because of change of address or phone number (Sanders et al., 2014). Despite a growing number of incarcerated older adults alongside a rising number of deaths, little is known about EOL decision-making policies in U.S. state and federal prisons.

This study seeks to describe and assess existing policies regarding end-of-life decision-making in state and federal prisons in the U.S. This research aims to report what current corrections' policies say about end-of-life decision making by incarcerated people and offer a perspective on the implications of these policies, while recognizing that additional exploration is needed to fully understand how these policies impact incarcerated people, their families, and the staff of the prisons.

3.3 Methods

We conducted an iterative content analysis of publicly available EOL decision-making policies within departments of corrections for each state and the Federal Bureau of Prisons. To identify publicly available EOL decision-making policies, we used the following procedure. We defined an EOL decision-making policy as one that provides guidance, rules, and/or restrictions on common EOL decision-making procedures and approaches to documentation for people in custody. These decisions and procedures were drawn from those described by the Centers for Medicare and Medicaid Services and the National POLST regarding common decisions made at

the EOL (Medicare Learning Network, 2020; National POLST, 2020). These policies can include language on EOL decision-making documents, such as advance directives, do not resuscitate (DNR) orders, medical autonomy, living wills, or healthcare power of attorney, though not every policy will use these terms and/or include guidance on all of these documents.

To collect policies, we first searched the publicly available department of corrections policies for each state, Washington D.C., and the Federal Bureau of Prisons for policies pertaining to EOL decision making. Most, though not all, states provide an online reference on their institutional websites of department policies (44 of 51, 86%). Within the department of corrections' websites, we conducted internal website searches and reviews of landing pages for policies or procedures to identify EOL policies. We searched all variants of "end-of-life", "advance(d) directive", "terminal illness", "living will", "power of attorney", "hospice", and "palliative," focusing our search on policies pertaining to health services. If no policy was identified by this method, we searched for policies on "medical decision(s)" and "medical autonomy." In addition, the Google "site search" method was utilized using the same key words. Finally, in cases where policies could not be located or appeared incomplete, researchers contacted website administrators, public information officers, and/or healthcare/medical staff for the department of corrections, if available. This search was done between October 2020 and December 2020. For each search the following information was documented: if a policy could be found online, the date the policy was effective or last renewed, the website where the policy is housed, if an inmate handbook could be found and if that handbook included information about EOL decisions, and any additional information of relevance, such as related policies relating to hospice or compassionate release.

We then performed an iterative content analysis using both inductive and deductive methods. Using prior understanding and knowledge of advance directives, we generated an *a priori* list of themes for extraction. All the policies were reviewed to identify content matching the a priori themes, in addition to identifying emergent themes for subsequent content extraction. Following this review, a final codebook, merging a priori defined and emergent themes was constructed. These themes resulted in the coding checklist shown below:

Theme of extraction tool for content analysis of EOL decision-making policies in U.S. departments of corrections:

1. Does the policy state when EOL planning discussion and/or documents will be provided to incarcerated individuals (i.e., during orientation/intake process or admission to infirmary)?
2. Does the policy state if there is an age and/or condition/diagnosis required to execute EOL wishes documentation?
3. Does the policy require evaluation for competency of the inmate to record their EOL wishes?
4. Does the policy mention where an inmate can find the EOL decision documents or ask for them? (i.e., law library)
5. Are there explicit steps or procedures included in the policy on how the person's EOL wishes are documented and executed?
6. Does the policy indicate that the EOL documents will be in the medical record?
    a. If so, does it state where in the medical record it will be stored?
7. Does the policy indicate that the record will be transferred in the inmate to another facility, to the hospital, etc.)?

8. Does the policy state who can be a health-care proxy?
    a. Are other inmates able to serve as health-care proxies?
    b. Are staff able to serve as health-care proxies?
9. Does the policy state who can witness the documents?
    a. Are other inmates able to witness the documents?
    b. Are prison staff allowed to witness?
10. Are non-health-care staff (i.e., correctional officers) required to honor DNRs?
11. Does the policy state a method of indicating a DNR is present? (i.e., a bracelet)
12. Does the policy call for an independent review before withdrawing or withholding care/treatment?
13. Is there a quality metric included in the policy?
14. Does the policy indicate if/how compliance is monitored?
15. Has the policy been revised and/or was the policy created in the past five years?
16. Does the AD/EOL policy refer to medical parole/compassionate release?

Once this codebook was finalized, a final review of each policy was undertaken to extract content for this review. Each policy was reviewed multiple times in its entirety independently by two members of the research team. Researchers then compared notes and reconciled via consensus on any differences in their reviews. We conducted our review of polices of each department between October 2020 and March 2021 and policies were updated if applicable.

3.4 Results

We were able to locate 37 of 51 (73%) EOL decision-making policies for people incarcerated in U.S. prisons. This included Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky,

Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin, Wyoming, and the Federal Bureau of Prisons. Some of these states reference a policy regarding care at the EOL or advance directive documentation but did not offer a specific policy online. For example, Oregon and South Carolina have hospice or palliative care policies that reference advance directives or other EOL documentation, but do not have publicly accessible policies specific to these decisions or documents. The following findings we describe here reflect the 37 policies that we located.

The location or categorization of EOL decision-making policies varied across states. Some states have specific policies for advance directive completion, DNR orders, and other medical decisions at the EOL (such as Georgia and North Carolina), whereas others combine these decisions into one policy. State policies also differed in the language used to refer to EOL documentation. For example, some policies used the term "medical directive" instead of "advance directive" or "healthcare agent" instead of "healthcare proxy". Although there are significant differences between the policies, we found patterns and similarities. Of the policies that we reviewed, several notable themes emerged. We found that most policies outlined the procedures of establishing EOL wishes, including in written advance directives and by assigning a healthcare proxy, and the restrictions or guidelines for establishing these wishes. We also found patterns among the policies in the language around accessibility, eligibility, documentation, and compliance. A summary of our findings comparing the systems is found in **Table 1.**

Table 1 Summary statistics of findings from iterative content analysis of US departments of corrections end-of-life decision-making policies (*N* = 37)

All departments of correction (N = 51)	*N*	*(%)*	*States*
EOL policy located/reviewed	38	75	AZ, AR, CA, CO, CT, DE, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MT, NE, NV, NC, ND, OH, OK, PA, RI, TN, TX, VT, VA, WA, WI, WY, BOP
No EOL policy located	13	25	AL, AK, FL, MO, NH, NJ, NM, NY, OR, SC, SD, UT, WV
Within reviewed EOL policies (N = 38)			
State when EOL documents will be discussed with incarcerated individuals	12	32	
At intake/orientation to facility	9	24	AZ, AR, CA, CO, GA, ME, NV, OK, WI
At admission to health-care services	3	8	ID, PA, TX
States where EOL decision documents can be found or referenced (i.e. law library, etc.)	12	32	AZ, CO, GA, KS, ME, MA, NE, OH, RI, TN, WY, BOP
States who can serve as health-care proxy	19	51	AR, CA, CO, CT, GA, HI, IL, KS, LA, MA, MI, MN, NC, ND, OK, PA, RI, TX, WA, WI, WY, BOP
Can be an incarcerated individual	3		GA, KY,[a] WA
Can be a DOC employee	3		KS,[b] OK,[b] WI[b]
States who can witness advance directive	25	66	AR, CA, CO, CT, GA, HI, IL, IN, KS, KY, LA, MI, MN, NV, NC, ND, OK, PA, RI, TX, VA, WA, WI, WY, BOP
Can be an incarcerated individual	3		GA, HI, RI
Can be a DOC employee	13		AR, CA, CT, IL, IN, LA, MN, NV, ND, PA, WI, WY, BOP
States that EOL documents will be transferred with person to hospital or other facility	16	43	AZ, AR, CA, CT, GA, IL, IA, KS, KY, MD, MA, MN, NE, OK, RI, VA
Policy was created, updated or revised in past five years	25	68	AZ, AR, CA, CO, DE, IL, IN, IA, KS, KY, LA, ME, MD, MA, MN, MT, NE, NV, ND, OK, PA, TN, TX, VA, WY

Notes: [a]Kentucky allows for an incarcerated individual to act as health-care proxy if he/she is a relative; [b]Kansas, Oklahoma and Wisconsin policies allow a DOC employee to be a health-care proxy if they are related to the incarcerated individual

Table 1: Summary Statistics of Findings

3.4.1 Accessibility

One feature that appears in many of the policies is the mention of when and how advance directive or other EOL decision documents are provided or offered to incarcerated persons. Eight of the policies (22%) reviewed specifically state that these documents are offered during intake (i.e., when a person first enters the prison facility) whereas others indicate these documents are discussed and offered during medical encounters, such as physical exams. In some states' policies, such as Pennsylvania, advance directives are offered if/when a person is admitted to the infirmary or other long-term care medical unit or facility. Notably, there are 14 (38%) policies that make no mention of where advance directives can be located or when incarcerated persons should be offered the opportunity to complete an advance directive.

3.4.2 Eligibility

Although most policies (27, 73%) do not have language on who is eligible to complete an advance directive, there were some notable exceptions. For example, in Hawaii, Maine, and Massachusetts, only incarcerated persons with a "terminal illness" are offered an opportunity to complete an advance directive. Moreover, while most policies state that all people should have the opportunity to complete an advance directive, many of their procedures regarding completing these documents were framed around individuals with a certain health status or if the person has been admitted to a special unit or facility, such as an infirmary.

3.4.3 Healthcare Proxies

We found that the policies differ in their approach to engaging healthcare proxies or agents for patients who lose decision-making capacity. While some policies (17, 43%) make no mention of proxies or agents, other states specify explicitly who can and cannot serve in this role. When stated, the overwhelming majority (16 of 20, 80%) of polices state that other incarcerated persons could not serve as a healthcare proxy. Georgia is the only state with a policy that explicitly allows other incarcerated people to serve as healthcare proxies. Of those with stated restrictions on healthcare proxies, 12 (60 %) specifically bar prison staff to serve as proxies, including Arkansas and Minnesota. Of note, Pennsylvania's policy indicates that neither staff nor incarcerated people can serve as proxies unless they are a family member of the patient. None of the policies reviewed explicitly state that staff can serve as proxies. Several policies (11, 30%) mention procedures for determining a healthcare proxy in the situation that an incarcerated person was to become incapacitated and had not previously identified a healthcare proxy.

3.4.4 Witnesses

Policies differ regarding requirements for who can witness advance directive documentation, with 21 departments including a specific provision around this topic. Rhode Island is the only state that explicitly states that other incarcerated individuals can serve as a witness to advance directive documents. On the other hand, when stated, 10 (45%) policies specifically indicate that other incarcerated people cannot serve as a witness to these documents. Policies were also divergent on whether correctional staff or healthcare providers can serve as a witness, with 9 (41%) stating they cannot.

3.4.5 Do Not Resuscitate (DNR)

Many of the policies included guidance about DNR orders. Some states have a separate policy for DNRs, and some have it housed within overarching EOL policies. Several states indicate a method, such as bracelets, for identifying incarcerated people who have DNR orders on file. Some policies state that correctional staff can decline to follow DNR orders if they feel doing so would constitute a "security" threat. The language around this stipulation of a "threat" is vague. Further, the Bureau of Prisons policy specifically states that DNRs should not be followed if the person is in general population.

3.4.6 Documentation & Compliance

Almost every policy reviewed (35, 95%) states that advance care planning documents are kept in the person's medical record. Less commonly, some policies specify the section of the medical record in which the documents can be found, these policies refer both to physical locations of hard copies and placement in digital files. Several policies (17, 49%) indicate that the medical record with the advance care plan documents will be transferred with the person to care outside of the prison, such as a hospital, or if the person is transferred to a different

correctional facility. While no policy stated that advance care plan documents would not be transferred with a person if they were moved to a health care facility or different correctional facility, 21 (57%) did not address this issue.

Several policies (28, 76%) note the ability for a person to amend or withdraw their advance care planning documents, such as an advance directive. A few of the policies indicate that advance directives and other EOL decision-making documents should be reviewed on a regular basis, such as annually. Other policies make no mention of a periodic review or opportunity for revision but none of the policies indicate that changes cannot be made once a document is established.

Notably, 12 of the 37 (32%) policies have not been updated in the past 5 years (2016 or more recent). The "oldest" policy reviewed is Michigan's, with an effective date of 1993 and no revision date noted on the document.

Only one state (Idaho) mentioned review of compliance with the EOL decision-making policy but did not state any measures or procedures that would be put in place to measure or ensure compliance. No policies defined quality metrics or compliance goals for implementation of their EOL policies. Five states (14%) mention training or education regarding EOL issues for staff.

Lastly, we can assume that there are differences in written policies between facilities. For example, Louisiana's policy states that each prison should establish its own policies for advance directives. It is possible that for the states where no policy was located, there are institution-level policies in place.

3.5 Discussion

The increasing number of incarcerated individuals with terminal illness and chronic health conditions necessitates more attention on EOL decision-making in correctional settings. In our iterative content analysis, we were able to locate and analyze the EOL decision-making polices for a majority of the state departments of corrections and the Bureau of Prisons.

3.5.1 Accessibility

Only eight of the 37 (22%) policies indicate that EOL decision-making is discussed during intake to the prison facility, regardless of health status or age. Policies often anchored discussions around EOL decisions to diagnoses, or presence, of a terminal illness. Although the likelihood that a healthy, young person will experience a life-threatening condition and become incapacitated and unable to communicate their wishes is minimal, the risk is not zero. In addition, older incarcerated adults will have a higher likelihood of developing a terminal and chronic health conditions, but discussions of advance care planning should not be limited to if a terminal illness is diagnosed. In non-incarcerated populations advance care planning is recommend by the American Geriatrics Society for older adults before they have a medical crisis or diagnosis of a serious health condition (American Geriatrics Society, 2017). We recommend that correctional systems follow this guidance and offer the opportunity for documenting EOL decisions for people at any age or health status.

In most states (outside of the prison system), the absence of an advance directive means that the person's next of kin (generally spouse or adult children) will have the responsibility of making healthcare decisions for the person (Sabatino, 2021). Because of the nature of correctional system settings, if an individual were to become incapacitated and no advance directive has been previously documented or healthcare proxy identified, there will likely be

delays in identifying and contacting these individuals. In a carceral setting, the absence of an advance directive or DNR means that life-saving measures such as cardiopulmonary resuscitation will be performed, no matter the person's prior wishes, prognosis, or stage of illness. For this reason, it is critical that patients are given multiple opportunities to – at a minimum – identify a healthcare proxy who can make medical decisions for them in the event they are unable to make them for themselves far before they arrive at the EOL.

Qualitative data indicates that autonomy and control over EOL care is important to people who are incarcerated, especially as they have little control over many aspects of their lives (Sanders et al., 2018). The content of the policies reviewed indicate that incarcerated people have some level of control over their healthcare decisions related to EOL; however, some policies indicate a limit to that control, including dictating who can serve as healthcare proxy decision-makers and when DNR orders do not have to be followed.

3.5.2 Proxies & Witnesses

The restrictions that some policies have on who can witness advance directive documents and/or who can serve as healthcare proxies are important to further explore. These limitations can not only create added challenges for the incarcerated person and the prison staff, but also inhibit the ability for the incarcerated person to have their EOL wishes honored. If other incarcerated individuals nor prison staff can serve as healthcare proxies, this may leave an incarcerated person without many other options. Sanders et al. (2014) notes that one of the barriers in implementing advance care planning in prisons is finding a family member or friend to serve as an incarcerated person's healthcare proxy. Policies should be reviewed to make sure that procedures are structured in such a way that incarcerated individuals who wish to document their advance care plans can do so in an efficient manner without unnecessary barriers.

3.5.3 Trust

Some of the findings of this research point to a need for further examination of quality and compliance. The policies that explicitly state that correctional staff are not required to follow DNR orders potentially harm the trust between incarcerated people and staff. As previously mentioned, there are ethical and legal debates over this issue for people in custody of federal prisons (Parks, 2020). We found very little mention of how compliance of policies is reviewed or how quality is ensured. Sanders et al. (2018) found that among incarcerated people with terminal illness there is mistrust in the prison staff to carry out their wishes or to explain their condition to them accurately. Participants in this study were concerned about making EOL decisions with only limited information on their disease progression and without fully trusting that their decisions would be upheld (Sanders et al.,2018). Based upon our review of policies and existing literature in this area, we find that lack of trust is a key challenge for incarcerated populations who want to document EOL wishes. The policies that include exemptions for following DNR orders exacerbate this lack of trust.

3.6 Limitations

This study has several limitations. First, it is likely that policies regarding medical decision making exist in the 14 systems that we were unable to locate using our methods. That said, our content analysis includes over 70% of U.S. prison systems and our methods reflect the public facing polices that are available to incarcerated people's families searching for policies regarding EOL decision-making. In addition, this describes written policies but not the implementation of these policies and we are not able to fully understand the experience of incarcerated people in indicating their wishes about EOL, but instead what the policies state "should" occur. It is also likely that practice varies between facilities in how policies are

interpreted and implemented. For these reasons, in-depth interviews and surveys are important next steps for future research in this area. We can also assume that there are differences in written policies between facilities within a department of corrections. For example, Louisiana's policy states that each prison should establish its own policies for advance directives. It is possible that for the states where no policy was located, there are institution-level policies in place.

3.7 Conclusion

The opportunity to engage in advance care planning is a core component of quality medical care in the setting of serious life-limiting illness. In this content analysis of EOL decision-making policies in U.S. prison systems we found significant variability in the accessibility of the policies eligibility criteria, who can serve as a healthcare proxy, witnessing requirements, use of "do-not-resuscitate" orders, and documentation. Taken together, the variability between correctional policies regarding EOL decision-making suggests an important opportunity to develop national guidance for prisons that reflect community standards in this area.

Standardization of these policies across systems would help to ensure that incarcerated people across jurisdictions have the same opportunity to document their EOL wishes and increase assurance that those wishes will be honored. Ideally, the standardized policy would ensure that documentation of EOL decisions is offered to all incarcerated people at multiple points in time, that there are fewer barriers to who can serve as healthcare proxy or agent and would state clearly how to transfer the policy to other facilities or settings. Because a uniform set of EOL decision-making policies would not guarantee implementation or adherence, any policy rollout should be accompanied by a systematic evaluation of its impact with an eye toward

identification of ways to optimize its use. Such evaluation should prioritize documentation of incarcerated people's experiences with documenting their EOL wishes, the perceptions and knowledge of staff who are charged with implementing these policies, and perspectives of patients' family members.

Conclusion

The papers presented in this dissertation add to the existing body of knowledge on the intersection of aging and correctional systems, specifically in prisons and community supervision. This data gives insight into how policies and approaches in these systems impact vulnerable populations, including older adults. Through a person-centered framework lens, these papers focused on the needs, well-being, and rights of people incarcerated in prisons or under parole or probation in the U.S. The research presented aims to bring attention to this population and inform practice, policy, and future research in this area.

For some audiences, applying a person-centered framework within a system designed to restrict people may seem challenging. Correctional systems are associated with less flexibility and less choice, whereas a person-centered approach centers around flexibility according to people's preferences and needs. Nevertheless, adopting elements of a person-centered orientation is feasible, even in seemingly counterintuitive contexts. In gerontology and aging practice, person-centered care is widely discussed and studied in nursing homes. These institutionalized environments prioritize safety and security, enforced through measures such as locked doors, strict rules, and scheduled activities. However, person-centered models have worked well in these spaces and have promising outcomes (Bergman-Evans, 2013; Brownie & Nancarrow, 2013). Though the nature and regulations of a nursing home are very different from correctional institutions, there are still ways in which elements of person-centeredness can be implemented, albeit imperfectly.

As evidenced by the participant data presented in papers 1 and 2, there are ways in which a community supervision agency is working toward being person-centered. Though it has yet to be formally evaluated and there is limited data, data indicates that officers and people under

supervision have experienced elements of the person-centered model. Notably, several participants expressed changes they have observed over time within the culture and structure of the agency to become more focused on positive outcomes for people under supervision and less on punishment. Further, to my knowledge, the Georgia model is the only one in the U.S. and could stand as a model for others with further research and integration of the approach.

The research presented in these papers may spark some discourse, depending on a person's worldview of the criminal legal system in the U.S. The concept of person-centered models within the correctional system may appear incongruent with the objectives of movements seeking to overhaul or abolish correctional institutions and systems, as advocated by prison abolitionists (Bagaric et al., 2021). Angela Davis, a prominent figure in the abolitionist movement, has asserted that "prison reform has always only created better prisons" (Davis, 2016, p 22). Davis's perspective underscores the argument that reform alone may not address the root of the problem, leading to the contention that abolition should be the ultimate goal. However, my argument rests on the premise that if these systems persist, efforts should be directed toward the human rights of individuals subject to them now. There are people currently in prison and on community supervision whose experiences need to be understood to ensure the consideration of their safety and well-being in policy and practice in the best possible way within the current systems. Although I acknowledge the harms that correctional systems create and exacerbate, I also recognize that research on the existing systems and those impacted by them can potentially offer immediate benefits.

On the opposite end of the spectrum, others may find that this research needs to be more compelling as this population has been convicted of crimes, and this group's needs should not be prioritized. Although my motivation for the research is one of human rights, the economic

argument may be convincing to people who do not share my research agenda. It is very costly to care for older adults in prisons because of healthcare costs; therefore, it is beneficial to consider reducing this spending by considering the research and the policy changes that address it (Office of the Inspector General, 2016; Ferri, 2013). This cost is also true in the community, with high rates of chronic conditions in formerly incarcerated populations and increased use of emergency departments (Erlyana et al., 2014; Gates et al., 2018; Prost et al., 2021). Holistically addressing an older person's needs can reduce the burden on society, including the healthcare system. Further, person-centered approaches within correctional systems may be beneficial in reducing recidivism as it seeks to meet unmet needs that could contribute to crime commission. For example, criminologists have found that social ties and employment are linked to recidivism (Laub & Sampson, 2003; Berg & Huebner, 2010). Likewise, physical health plays a role in a person's desistance from crime (Link et al., 2019). Scholars argue that a holistic approach is a better way to address recidivism for people recently released from prison because it considers people's multifaceted lives and the interplay of their physical, social, spiritual, and emotional well-being (Fahmy & Mitchell, 2022).

Positionality

As encouraged by a reflexive thematic analysis approach, I reflected on my positionality, background, and experiences while collecting and analyzing data (Braun & Clarke, 2020). I was conscious of how my position in the world and worldview impacted my qualitative data collection and analysis. As a young, white, educated researcher with no history of incarceration, I recognize that the recruitment of participants, the interviews, and the data analysis may have all been impacted by my identities and experiences. In addition, my background in gerontology and social work impacted my approach to collecting and analyzing data for the three papers as I

examined the data through a particular lens. Remaining cognizant of this required me to engage more critically with the data and make every effort to ensure that participants' voices and perspectives were captured and reflected in the data analysis. Even so, I recognize that the data presented in these papers were not unaffected by my positionality and biases.

Implications

The research presented gives insight into the experiences of people in prison and on community supervision. The findings indicate a need for more preparedness and attention to the aging population in correctional systems, which has implications for individuals, communities, and the broader systems involved, namely correctional systems and the aging services network. These papers also shed light on applying person-centered models within settings and systems that historically have yet to be considered with this framework, including the challenges and barriers to doing so. The research suggests that person-centered approaches can be embraced, even within system policies.

Because of the growing number of older adults in the correctional system, there is already a call for preparedness by systems that might engage with this population. The data presented in these papers further demonstrates this need, which includes community organizations and human services agencies. Non-profit organizations and other community groups need to be aware that this population may have unique challenges or needs, and their health status, age, and criminal legal history may need to be considered when serving them. For example, the data presented in Chapter 3 should be a call to action by national hospice and palliative care organizations to consider how their work can apply to incarcerated populations. The findings of Chapter 1 highlight the ways that community organizations can work with older adults under community

supervision to alleviate barriers, such as navigating technology, finding housing, and managing chronic health conditions.

This work indicates the need for increased training and knowledge around age-related issues for professionals working in jails, prisons, and community supervision. Officer interview participants reported receiving virtually no education or training on this topic, and they needed more knowledge of the resources in the community for this population. The content analysis of prison policies revealed that very few end-of-life decision-making policies referenced any training or education for staff around these issues. Increased awareness and education on the needs and experiences of older individuals for professionals working in all areas of correctional systems is needed.

Further, professionals need to understand the concept of person-centered approaches and their applicability to correctional systems. As demonstrated in the literature review, the concept of person-centeredness is common in health and elder care, but it is less known to correctional systems. Though officer participants were familiar with the term or model and recounted how they use specific tools in their jobs, they reported challenges in carrying out the agency's mandate. Reviewing and realigning policies through a person-centered framework lens and mechanism to implement officer feedback about the person-centered model may lead to more success.

On a policy and systems level, this data speaks to the need for reimagining and reexamining the policies that keep older and medically fragile people incarcerated or under supervision. It calls for policymakers to consider whether keeping someone with a terminal illness in prison is appropriate. If releasing the person is the best option, there is a systems-level need for preparedness for the person's transition out of prison and into the community. Further,

the research presented calls for systems to consider if current policies and practices are meeting the needs of the older age demographic and considering age along with other aspects of a person's identity and experience.

Future Research

More investigation is needed to understand how person-centered approaches can be implemented in the criminal legal system. The data presented in papers 1 and 2 show how community supervision officers perceive and implement a person-centered model in one state; however, it does not give insight from a leadership perspective. Additional interviews with agency heads would provide a more complete picture of this model. Data from interviews with agency leaders would offer a clearer understanding of how the model is communicated to the officers and the challenges and successes in moving the model forward across the state.

In addition, a content analysis of the official communication and any existing training related to the person-centered model would add to what is known about the person-centered model. Using this data would help resolve any gaps or ambiguities in interview data. For example, officers were able to talk generally about how they learned of the person-centered model and associated ESP with the model. Still, they did not say exactly when they received communication about it, how often it was communicated, and the specific language around it.

The policy content analysis that is discussed in Chapter 3 leaves room for additional data collection methods to better understand prison end-of-life decision-making policies. For example, surveys could gather a more complete set of data about existing policies. However, to further this research even more, primary data collection from the people impacted by these policies is needed. Interview data with prison leadership, staff, and people who are incarcerated would answer questions about how these policies are perceived and implemented. The

congruence, or lack of, between policies and implementation could be observed with this information.

The three papers contribute new insights and confirm what is known about the current state of policies and experiences of older people and people with serious illnesses who are involved in the correctional system in the U.S. The exploration of a person-centered model of community supervision from the perspectives of officers and people with experience under supervision is novel. It sparks additional questions that can be answered through further research. The analysis of end-of-life decision-making policies of prison systems shows what regulations exist but leaves room for exploration of perceptions and, most importantly, implementation.

Appendix A: Interview Guides

Community Supervision Officers

Thank you for your interest and willingness to be interviewed for my research study. As a reminder, you can stop the interview at any time or skip any questions that you do not want to answer. Everything you say in the interview will remain confidential and any information that is published will not be associated with your name or identity. I am interested in learning about the supervision practices of the Department of Community Supervision and the experiences of community supervision officers and staff, like yourself. I want to learn more about how you understand your role as a community supervision officer and about your experiences with the people under your supervision. I am specifically interested in the experiences of older adults who are under supervision and how the supervision practices may look different for this population, so some questions will be focused on this group. I appreciate your honesty and am eager to hear about your experiences and perspectives. Do you have any questions before we begin?

First collect demographics:

- Gender
- Race
- Age
- Highest Educational Level

Background & Role as an Officer

I am interested in learning about your background. Tell me a bit about yourself and how you came to be a community supervision officer.

Probes: Family members in this field? Education—was it related to criminal justice? What jobs or careers did you have prior to this one—were any in CJ field? How long have you been in your current job?

Tell me about the training and orientation you received before you began this job. What continuing education or training are required for you?

Probes: What information did this training cover? How many hours or sessions were/are required? Is there any training or education that you have not received that you think would be helpful to perform your job well?

What do you see as the goals and objectives of a community supervision officer?

Probes: What is your role as a community supervision officer? What are your main job duties? What do you personally hope to achieve in your job?

From your perspective, what makes a person successful as a community supervision officer?

Probes: What background or experiences help? Personality or traits? What behaviors or strategies?

Tell me about evidence-based practice training that you have received, such as motivational interviewing or other trainings.

Older Adults under Supervision

As I mentioned, I am interested in learning about older adults' experiences under community supervision. You may have not received any training that relates to aging or specific issues for older people, but if you have, please tell me about any education or training you have attended relating to working with older adults or an aging population. How was this training useful in your job, if at all?

Probes: Was it offered or required in your job or did you find the training on your own? What information did this training cover? How many hours or sessions were/are required? Who was the instructor and/or who designed or developed the material for the training? Why was this training helpful or unhelpful? How have you applied this to your job?

I am interested in learning about the people aged 50 or older that you supervise. Could you briefly describe this part of your caseload?

How old are they (approximately)?

What health conditions or physical limitations do they have?

What are their living situations?

How long have you been assigned to them?

When you were first assigned to these people (or person), what kinds of information did you initially receive about the person's health, social support, preferences, etc.—for example, this information may have been from the jail or prison where they previously were incarcerated or another source? What information did you feel like would have been helpful to you that you did not receive?

With your clients or supervisees that are age 50 or older, what specific things do you consider that might be different from the considerations of a younger person you are working with? What are some of the differences, if any, between the younger people you supervise and the older people?

Probes: How are their needs different? How are their challenges different?

Walk me through a few of your recent interactions with a person (or people) you supervise who is/are age 50 or older. Tell me about your contact with this person/people.

Probes: How long was your contact? What questions did you ask? What issues or concerns did you discuss?

I am going to ask you about some of the barriers or limitations that you may have encountered and that, if eliminated, might improve your ability to work with older adults or would help them be more successful under your supervision.

Tell me about any challenges with their health—including chronic health conditions or cognition.

Tell me about any challenges with housing or finding a place to live that meet the requirements of supervision.

Tell me about any challenges with health insurance or accessing healthcare, including paying for care or finding appropriate care for their needs.

Tell me about challenges with transportation, driving, or getting to and from places.

Tell me about any challenges with social/family support.

Tell me about any challenges they have had in finding a job, issues with their job or working, etc.

Tell me about any mental health challenges or accessing mental health care or support.

Tell me about any experiences with the person having memory loss, trouble with thinking/making decisions, etc.

What other barriers or challenges exist that I did not mention?

Tell me about any experiences or instances where you have referred an older adult in your caseload to an aging-specific organization or resource, for example, an Area Agency on Aging, senior housing, the Alzheimer's Association, etc. How familiar are you with the resources and

agencies in the community who specialize in helping older people or people with disabilities? How did you learn about these resources?

Person-Centered Approach

Next, I am going to ask you about an approach that the GA Department of Community Supervision has adopted, which they refer to as a "person-centered" supervision model. This model was adopted around the end of 2020. Though there is not a specific definition of this model, the Commissioner of DCS described it as, "…rather than define someone by their crime or conviction, we recognize people as unique individuals with their own strengths, needs, and goals."

Are you familiar with this model or approach? How and when did you learn about it? Have there been other models or approaches brought forth by DCS in the time that you have worked with them—if so, can you briefly tell me about those?

When you hear the term "person-centered framework" or "person-centered model", what do you think of?

How do you apply the concept of person-centeredness to your work as a community supervision officer?

Probes: Tell me some examples of how you employ this to your work, including in the interactions you have with

How do you think person-centeredness fits into your job or role? How well does it fit in with your role?

Language is often important in person-centered frameworks, so I'd like to ask you about the words that people use to refer to the people that are on community supervision.

[At this point, they have likely used the word or phrase, i.e., “parolee”, “probationer”, “person on supervision”, “ex-offender”, etc. but if not, ask what word or phrase they use] I notice that you use “x” to refer to the people you supervise—can you tell me more about why you use that term? What terms or words do you most often hear your peers or colleagues use? What about leadership?

Tell me about your thoughts on language—why do you think it is important or not? How do you think it impacts how people view others or behave, if at all?

Is there anything else you would like to add that we did not cover in our conversation today?

Older Adults on Community Supervision

Thank you for your interest and willingness to be interviewed for my research study. As a reminder, you can stop the interview at any time or skip any questions that you do not want to answer. Everything you say in the interview will remain confidential and any information that is published will not be associated with your name or identity. I am interested in learning about the experiences of people who have been under community supervision who are age 50 or older, such as yourself. I am also interested in learning about the supervision practices of the Department of Community Supervision from your perspective. I appreciate your honesty and am eager to hear about your experiences and perspectives. Do you have any questions?

First collect demographics:

- Gender
- Race
- Age
- Highest Educational Level

Background & Criminal Legal Background

Tell me about your background. Please share as much or as little as you'd like. Where are you from? What is your educational or work history? Briefly, tell me about your family of origin (your mother/father/other guardians, siblings) and your current family.

Have you ever been incarcerated in a jail or prison? Have you been on probation or parole in the past (outside of current)?

[If they were incarcerated previously] How long ago were you released from prison or jail? Were you released under supervision or under other conditions for any previous incarceration? For how long?

If applicable, what was your age when you were released from prison or jail?

Health

Tell me about any health conditions or physical conditions that you have.

Probes: Do you have any problems with your heart? Have you or do you currently have cancer? Have you ever had a stroke or heart attack? Any arthritis, diabetes, or other conditions? Do you have any trouble, or have you noticed any changes with your memory, decision making, or thinking? Do you/can you drive?

Tell me about any physical limitations that you have, including any pain.

Probes: Do you have trouble walking or climbing stairs? Do you have any trouble lifting heavy objects or doing certain physical activities? Do you have any trouble with your hearing or vision? Do you use any assistive devices such as a hearing aid, cane, or walker?

Do you need help with any activities or tasks that are important to your daily life, such as cooking, laundry, paying bills, getting dressed, etc.? If so, tell me more about the kind of help you need.

Community Supervision

Tell me about your current experience with supervision. How long were you/have you been under supervision? What were/are the visits with your community supervision officer like? Tell me about those visits, including phone calls and video visits.

Probes: What questions do they ask? How long are the visits or calls usually? What about these contacts are positive? What about them are negative?

What are/were the conditions or rules you have/had to follow under supervision? What are/were the requirements of your parole/probation?

Probes: What restrictions do you have on where you can live, work, visit, travel, etc.? What requirements do you have related to classes, programs, and contacts with your community supervision officer?

How do these interfere with your daily life, including your job, family responsibility, etc., if at all?

Probes: Do they interfere with going to work or fulfilling other responsibilities or commitments? Do they impact where you can live or work? How do they impact your relationships?

How much choice would you say that you have in your life right now? How much do you think you are able to have the things you want in life? To what extent do you feel you are able to work toward your personal goals or hopes for your life?

What role does your community supervision officer play in those preferences or goals?

How do you think your age and/or your health conditions play a role in your ability to be settled in the community and live the life that you choose? How do you think your experience would be different if you were younger? (If they have had a community supervision experience at a younger age, ask how that was different for them)

Tell me about a time when your supervision officer was flexible with you or demonstrated support/understanding of a challenge you were experiencing.

Tell me about a time when you did not feel supported or understood by your community supervision officer.

Person-centered Model

The Georgia Department of Community Supervision has adopted a "person-centered" model of supervision. I am interested in learning more about how they are implementing that model.

How would you define the term "person-centered" as it applies to supervision, such as parole or probation? What would make supervision "person-centered"? How does this definition fit in with your experience on supervision? How "person-centered" do you find your supervision restrictions, conditions, etc.? To what degree do you think your community supervision officer is "person-centered" in their approach with you?

Language is often important in person-centered frameworks, so I'd like to ask you about the words that people use to refer to the people that are on community supervision.

[At this point, they may have used the word or phrase, i.e. "parolee", "probationer", "person on supervision", "ex-offender", "offender", etc. but if not, ask what word or phrase they use] I notice that you use "x" to refer to yourself and others who are on parole or probation—can you tell me more about why you use that term?

What term or word do you hear supervision officers use? How do you feel about their use of that term?

Tell me about your thoughts on language and why it matters to you or not—why do you think it is important or not? How do you think it impacts how people view and treat you and others, if at all?

Appendix B: Invitations to Participate

Dear (Participant),

We invite you to participate in a research study conducted by Georgia State University. The purpose of the study is to learn more about your experience as a person aged 50 or older who is on parole or probation.

You are eligible to participate in this study if you are under community supervision and you are aged 50 or older. This includes parole or probation. We will ask you to participate in an interview that will last about 1 hour (60 minutes). This interview will ask you about your experience with community supervision. We will ask about any challenges you have faced while you have been on parole or probation.

Your participation in this study is completely voluntary. If you choose to participate you may choose to discontinue participation at any time and you may choose to skip any of the interview questions. Feel free to contact the study team if you have any questions.

Dear (Participant),

We invite you to participate in a research study conducted by Georgia State University. The purpose of the study is to learn more about your experience as a community supervision officer.

You are eligible to participate in this study if you are a community supervision officer and you supervise at least one person who is aged 50 or older. We will ask you to participate in an interview that will last about 1 hour (60 minutes). This interview will ask you about your experience as an officer. We will ask about your role as an officer, training you receive, and your perception of the current models of supervision. Our

questions will specifically focus on your experiences with people aged 50 or older who are on parole or probation.

Your participation in this study is completely voluntary. If you choose to participate you may choose to discontinue participation at any time and you may choose to skip any of the interview questions. Feel free to contact the study team if you have any questions.

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Vita

Victoria Helmly is from Savannah, GA, and has lived in Atlanta for almost 15 years. She completed her B.A. in Sociology at Georgia State University in 2013 and her MSW at Georgia State University in 2016. She received undergraduate and graduate certificates from the Gerontology Institute at Georgia State University. During her master's program, she was a graduate research assistant for Dr. Candace Kemp's "Convoys of Care: Developing Collaborative Care Partnerships in Assisted Living" project – a five-year longitudinal study funded by the National Institutes of Health. She contributed to several presentations and one publication for this project. From 2016 to 2019, she worked for the Georgia Department of Human Services Division of Aging Services as the Georgia Alzheimer's and Related Dementias (GARD) State Plan Coordinator. In this role, she worked with governmental, non-profit, and private partners and elected officials and managed a large contract with a healthcare system. She presented this work at various conferences and professional meetings.

In the fall of 2019, Victoria began the Ph.D. in Criminal Justice and Criminology program at Georgia State University and began working under Dr. William Sabol. During her doctoral studies, she has worked on various projects as a graduate research assistant for Dr. Sabol. She has worked on the “Assessing the Effectiveness of the Second Chance Act Grant Program” funded by the National Institute of Justice since 2021. She has contributed to developing semi-structured interview guides, conducting interviews, and writing manuscripts and reports. She co-authored one publication, *Addressing Barriers to Housing in Reentry Programs: A Qualitative Study of Second Chance Act Grantees*, from data collected on this project.

Victoria's research interests center on the experiences of older adults within the criminal legal system, including incarcerated and formerly incarcerated populations. She is specifically interested in the experiences of dementia and end-of-life in prison and the unique experiences of older people in re-entry. With the mentorship, collaboration, and contributions of Dr. Benjamin Howell, Dr. Brie Williams, and Marisol Garcia, she authored the paper, *A Review and Content Analysis of U.S. Departments of Corrections End-of-Life Decision-Making Policies*. Victoria successfully defended her dissertation in November 2023 and will graduate in May 2024.