RELEASE

A student news collaborative focusing on the impact of incarceration in Connecticut

[FOCUS ON] Healthcare



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welcome to RELEASE

Welcome to Release, a publication devoted to collecting stories about citizens with criminal histories and the organizations that serve them. Produced by the Institute for Municipal and Regional Policy (IMRP) and created by students from Central Connecticut State University, the newsletter provides profiles, general features, interviews, videos, informative graphs and more. Our goal: to empower ex-offenders and to educate the larger Connecticut community on what it can do to stem recidivism. Release covers employment, housing, education, children of incarcerated parents and other subject areas that relate to building a productive life with a criminal history. For your free subscription to Release, which will be distributed online on a monthly basis and also published in print on a quarterly basis, please register at www.releasenews.org.

caring for THE INCARCERATED

Caring for the Incarcerated Hospice Correctional Health Care in a Rocky Hill Residential Neighborhood

By Jesse Duthrie

Between 1980 and 2013, Connecticut's incarcerated numbers skyrocketed from roughly 4,000 to 16,000 men and women. Tough on crime policies filled up correctional institutions not just in Connecticut, but also across the United States. 95 percent of men and women incarcerated finish their sentences and are released back to the public. Providing end of life care for the other five percent has proven to be an ethically and legally challenging problem. Over 2,500 prisoners die annually of natural causes in this country. This national issue has moved right to the heart of Connecticut. This January, SecureCare won a Bill to develop and house 95 end-of-life

inmates from correctional facilities across the state of Connecticut. The nursing home, a hospice center for the incarcerated, began development after a 2011 General Assembly Bill. Now, commotion has erupted from the townspeople, corrections union leaders, and town officials.

The Department of Mental Health and Addiction Services (DMHAS) has laid out a clear and concise plan for the development of the building. According to DMHAS, "Nursing homes can provide the level of medical care needed while receiving over 5.5 million dollars in federal Medicaid reimbursement annually." The DMHAS plan goes on to say that the location was chosen because of its prior use as a nursing home, therefore it would need only minimal modifications. 24-hour onsite security would be provided to control patient movement.

Residents of Rocky Hill remain fearful of housing close to a hundred prisoners near their homes, even if they were to remain under close security. In a December 20, 2012 article by David Drury of the Hartford Courant, a Rocky Hill resident named Tony Coco expressed his concerns about having prisoners living nearly 50 feet from his home. His worries were amplified by the recent Sandy Hook shootings. He went so far as to say, "'If the governor was going to do this in Newton what do you think the people of Newton would do after what happened?""

Coco's claim comes without consideration of facts. 0 percent of elderly inmates in endof-life treatment have ever escaped hospice treatment. Furthermore, the shooter at Sandy Hook Elementry School, Adam Lanza, was in no way associated with hospice centers. He was a 20-year-old male. He was not an ex-inmate, and there's no connection of him escaping any form of a correctional institute.

In the yards of pages the Hartford Courant has run on this topic, it's hard to find a citizen of Rocky Hill that has come out to support the nursing home. It's feasible to ask why they should. Ira R. Byock, M.D., the Director of Excellence in End of Life Care and a public proponent of hospice programs for incarcerated citizens, has written a book and several

articles on the topic. He is currently the Chair of Pallative Medicine and a Professor at Dartmouth Medical School. When asked why people should care how prisoners die, he wrote, "There are striking similarities between being given a long prison sentence and receiving the diagnosis of a debilitating or terminal illness." He draws in a connection with the reader and end-of-life prisoners. He goes on to say, "Death has been called the 'great equalizer;' so are its cousins: illness, dementia, physical debility, and advanced age...People who



are most frail and elderly can be made to feel guilty by society, and at times by their own families, for the crime of being seriously ill or debilitated and not dying quickly enough."

Dr. Byock doesn't rely solely on his reader's empathy. In his article "Dying Well in Corrections: Why Should We Care?" Byock cites court cases and legal proceedings over the past thirty years that have led up to the necessity of hospice care for endof-life prisoners. He cites Estelle v. Gamble (1976), a case in which American courts "distinguished punishment from brutality and... affirmed society's responsibility to provide a community level of care for prisoners." Still, there is an ongoing struggle waging to provide excellent health care to all Americans, and this challenge is not being met. National agencies like the National Hospice Organization Standards and

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Accreditation Committee and the Last Ask Task Force have banded together to rethink the way hospice operates in our country. Byock's challenge is to figure out where incarcerated citizens fit in to the puzzle.

One state proponent of the nursing home, prison reform champion Allison Bassett, claims the vocal rejection speaks to the nature of "Not in My Backyard" (NIMBY). In an article for Rocky Hill Patch by Jeffrey Gebreu, she says, "'NIMBY is far too prevalent in a lot of areas in Connecticut."" The argument suggests that there is resistance from affluent communities to fight "unwanted" projects in their towns, so that they may be "redirected" to less affluent parts of the state. She goes on to say, "[The prisoners] get placed in unsafe, impoverished neighborhoods where under funding actually does create a safety risk."

For the end-of-life patients the stay at the proposed nursing home will offer an opportunity for family visitation before they die. Bassett's sentiments, as well as those who proposed the bill, are to offer humane treatment to those in their final days of life. The individuals expected to receive care at the nursing home will be transitioned from DMHAS or from the infirmaries at Department of Corrections. According to the DMHAS outline, these patients will have "serious or chronic medical impairment that may include dementia, strokes, paralysis, and cancer. Some individuals may be

for mobility or self-care."

The nursing home is scheduled to open in February of 2012, but legal action and public outcry will likely halt that start. Officials in Rocky Hill are attempting to sue the company that would operate the nursing home, iCare management and its subsidiary SecureCare Realty, for not getting the local zoning approvals needed to open the nursing home and hold inmates. On December 20th, the same day of the announcement of the lawsuit against iCare and SecureCare Realty, a local town hall meeting was canceled by state officials

"Bassett's sentiments, as well as those who proposed the bill, are to offer humane treatment to those in their final days of life"

dealing with conditions such as Parkinson, Huntington or Multiple Sclerosis. Individuals may be confined to wheelchairs or require walkers, or other adaptive devices at the last minute. The town hall meeting was anticipated to draw in hundred of Rocky Hill residents. Rocky Hill Mayor Anthony LaRosa, State Senator Paul Doyle, State Representative Tony Gurerra, and the Town Union all oppose the nursing home. It was political chess, out in the open for everyone to see. The town takes the state's

cause legal backfire from city attorneys.

In 1995, the University of Connecticut took over for all Correctional Managed Health

"It was political chess, out in the open for everyone to see. The town takes the state's pawn, so the state takes a rook"

pawn, so the state takes a rook.

A similar issue occurred in Connecticut almost twenty years ago that dealt with caring for the incarcerated in a residential area.

John Dempsey Hospital sits near Route 4 in Farmington, Connecticut. To an average passerby, nothing unique stands out about the hospital. Yet seventeen years ago, a deal was brokered between Governor Rowland and the Department of Corrections that would go on to infuriate the townspeople of Farmington and Care for the state of Connecticut. Department of Correction's medical wards were soon staffed with UCONN nurses and doctors. Yet one issue had not been resolved: what would happen with emergency patients? Prior to the contract with UCONN Medical Center, correctional inmates needing emergency treatment had been shipped out of their prisons, escorted to nearby hospitals, and put under 24 hour surveillance while they received emergency care. This process was not only laborious but also expensive.

A solution was put up by Department of Corrections and the Governor's office: make John Dempsey Hospital the center for all emergency correctional health treatment. Department of Correction's spokesman William Flower summed up the fiscal benefits in a November 30, 1995 Hartford Courant article, saying, "The consolidation would save more than \$2 million a year in transportation and other costs."

Representative Demitrios Giannaros, a state legislator from Farmington, voiced concerns for the safety of his constituents. In an October Hartford Courant article, he says, "The hospital is right in the middle of our community. To have so many prisoners transported to the hospital and held in the special quarters is of great concern to us." Giannaros was backed by Representative Kevin Sullivan of West Hartford, who added that the hospital had neither "the appropriate design nor the proper location to house such a facility."

By November of 1995, residents of Farmington took legal action to stop the development of the correctional medical ward at John Dempsey Hospital. In the same November 30, 1995 Hartford Courant article, town attorney John McGee was working on a complaint seeking temporary injunction against the ward to be filed by week's end. If the junction would be granted, he would seek permanent injunction. The article, written by Courant staff writer Michael Greenwood, tells how signs protesting the ward "popped up along Route 4 and more than 100 residents attended Tuesday's council meeting to voice their opposition."

McGee's injunction, and the complaints of over 100 Farmington residents, would go unheard. There was no temporary injunction formed and by the beginning of 1996, John Dempsey Hospital took over as the main center of emergency medical health treatment for the state. And since it's opened as the center of all emergency correctional medical care, there hasn't been once security threat to the town of Farmington.

When it comes to opening the nursing home in Rocky Hill, there are a lot of invested parties: the town officials, the corrections officers, the townspeople, and the prisoners who will be receiving care. There are also the prison reform advocates who see the opening of the nursing home in a residential neighborhood as step away from the perspectives of NIMBY. Certain risk is involved in transporting incarcerated men to residential areas. Still, driving down Route 4 in Farmington, it's impossible to tell who's occupying the tan hospital building that once caused so much commotion.



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tasting the worst: A CELLBLOCK LUNCH

By Dave Baker

On paper, dining in the American prison has come a long way. Common portrayals of inmates shuffling down chow lines to have slop and gruel heaped on to their trays seem archaic. In 2011, the Connecticut Department of Corrections served over 20,750,000 meals at a minimal cost to the taxpayer of roughly \$2.30 for three square a day. Meals for all 18,500 Connecticut inmates are prepared at a single kitchen housed in the York Correctional Institution, an all-women's facility, and in addition to accommodating specific dietary and religious restrictions, the D.O.C also supports the state economy by purchasing locally grown fruits and vegetables.

Sounds wholesome enough. But taste is inextricably tied to memory. It elicits visceral reactions, and when former inmates rehash their worst experiences in lock up, food is never far from the top.

Andrew Barton refused to eat the food at first. "I didn't eat for the first three days," Barton explained. A former inmate at Cheshire and Enfield Correctional awhile,but you get used to it." Barton adjusted to his new diet over the course of a grueling first month. "The food was hell on my stomach. I couldn't keep anything down at first, so I eased into it." Cheshire C.I's cafeteria followed a steady rotation of meals easy enough to prepare for over 1,400 inmates.

Breakfast included oatmeal

"I didn't eat for the first three days," Barton explained. A former inmate at Cheshire and Enfield Correctional Institutions, Barton quickly recognized his options: eat or starve.

Institutions, Barton quickly recognized his options: eat or starve. "One of the older guys told me, 'Listen, man you gotta eat. I know it sucks.' It took me or cereal, and powdered eggs. Lunch presented a little more variety; bologna sandwiches and hotdogs were mainstays, with chicken patties or cheeseburgers offered two days a week – something to look forward to. Rice and pasta were heavily featured at dinner along with popcorn chicken, and beef was served on occasion. "They called it beef, but you knew exactly what you were getting. They weren't fooling anyone," Barton said. Many former inmates say settling into a routine is a major part of coping with life on the inside. For Barton, stomaching the food was as much an endurance test as it was a routine.

Barton found prison food tolerable, at best. It was hardly home cooking, but Connecticut's D.O.C appears to be a cut above other state penitentiaries when it comes to food. In 2008, *The Huffington Post* reported on a class action suit brought against the state of Vermont by inmates claiming that nutraloaf – a mixture of whole wheat bread, nondairy cheese, raw carrots, spinach, seedless raisins, beans, vegetable oil, tomato paste, powdered milk and dehydrated potato flakes – was more punishment than sustenance. In fact, Vermont prison officials agreed. Vermont Corrections Commissioner Rob Hofmann told the *Post's* Wilson Ring that nutraloaf was often served to alleviate violent and destructive behaviors. "It usually has the desired outcome," Hofmann said.

Prisons using food as punishment has been carefully monitored in the United States for decades. In 1978, the U.S. Supreme Court ruled against the state of Arkansas serving its inmates "grue," a high-protein oatmeal concoction, citing that "["grue"] might be tolerable for a few days and intolerably cruel for weeks or months." Inmates from around the nation occasionally lobby the National Prison Project of the American Civil Liberties Union to address the ever-present food issue, but it rarely comes up in litigation.

I wanted a taste of this. I wanted to shock my taste buds, bite into authentic D.O.C fare and take in the same food Connecticut's inmates choke down every day. The only catch: limited access. Overcoming the mountain of paperwork to get into a penitentiary can be as difficult as trying to escape one. Get permission from this person, talk to that person. Fill out paperwork. What's your purpose in this facility? No, I'm sorry we can't discuss that. It's only a \$2.30 meal. They couldn't spare something for a curious party?

Politicians, pundits, and average people describe the offender population in a myriad of ways. A key phrase that



continually gets lost in the scrum, however, is resourceful. Enter *The Convict's Cookbook*. A collection of cellblock-inspired meals by neuropsychiatrist and former Florida Department of Corrections consultant Dr. K. Sham, *The Cookbook* contains numerous recipes inmates can make with limited ingredients and appliances. A reoccurring favorite is mofongo.

Traditionally, mofongo is a Puerto Rican dish made with beef or pork cracklings, bits of bacon, and vegetables encased in a fried plantain. No commissary offers plantains or fresh vegetables, so inmates get creative. Under the guidance of fellow *RELEASE* staffer and former corrections officer Keith Dauch, we made a sampling of this prison staple. We made our own mofongo.

Dauch worked for the Connecticut D.O.C for ten years, serving primarily in the Hartford Correctional Center. For the inmates there, preparing mofongo was a nightly culinary project. "The second we hit lights, the guys would start pooling their commissary [items] and make this stuff," Dauch explained. The recipe called for three clear garbage bags, one bag of generic potato chips, three packages of chicken flavored Raman noodles, a stick of pepperoni, and a can of squeezable cheese.

Most inmates boil water using a stinger, a contraband item that can potentially short-out entire cellblocks or function as a weapon, according to Connecticut D.O.C policy. We boiled water on a kitchen stove, sidestepping any potential for blowing a fuse or electrocuting ourselves, otherwise we stayed true to the process. We smashed up the Raman noodles and potato chips on the floor. We poured the crushed bits of Utz into a garbage bag along with a cup of water. Next, we mashed the crumbs into a salty paste consistent with ground beef well past its expiration date. We spread the paste over the counter like pizza dough, and sliced up pepperoni with an expired driver's license – inmates use their I.D. cards as cutlery. We substituted canned cheese with Kraft shredded cheddar and added it into a third bag with boiled Raman noodles and chunks of pepperoni, mixing all of



A homemade mofongo

it together by hand. We smeared Raman-pepperoni-cheese filling over the soggy, potato chip dough and folded over like an omelet. The old license cut through it with ease. The moment of truth: it was time to taste it.

Any hopes of salvaging our dish with some extra cheese flat-lined after my first bite. This wholesale food medley, this thing, blitzkrieged my senses; I barely got down a mouthful. Brackish, bland, and miserable, mofongo epitomized a shame meal, but what did I honestly expect from something made in a garbage bag? The verdict was in. Mofongo was disgusting. I rinsed out the salt and plastic aftertaste a few dozen times.

"These guys ate this every night?" I asked Dauch.

"Every night."

Mofongo's key ingredient isn't Raman noodles or processed meat. It's sodium. According to the Mayo Clinic, *The 2010 Dietary* Guidelines for Americans advised limiting one's sodium intake to less than 2,300 mg a day. Three packages of Raman noodles already placed mofongo's sodium count at 5,106 mg – one package alone accounts for 71 percent of the daily value. Add an additional 570 mg from Utz potato chips, 1,653 mg in a stick of pepperoni, 180 mg from Kraft shredded cheddar, and mofongo checks in at 7,509 mg of sodium, well over three times the recommended amount. All told, one bag of mofongo contains 2,617 calories, 1,333 from fat. Given these statistics, it's safe to assume that even a portion of this inmate delicacy is horrifyingly unhealthy.

Sodium does perform an essential role in maintaining a balance of fluids in the body, but its adverse affects pile up: high blood pressure, increased risks of heart failure, stroke, liver and kidney disease, all of these can result from ingesting excess sodium. In recent years, researchers also discovered links between sodium imbalances and mental health problems like bipolar disorder, dementia, and a litany of mood disorders, leaving inmates with salt-heavy diets incredibly vulnerable.

From public schools to prisons, institutionalization and good food rarely go hand-in-hand. Generating enough funds to support the sheer number of incarcerated citizens in the United States is task enough, so it makes sense for flavor and quality to plummet down the list of priorities. Try as we might, we will never fully understand life on the inside. Only the men and women who have done time can grasp the nuances and comprehend the ebb and flow of living behind stonewalls and barbed wire fences. But for a few seconds, I could say I had a taste of it; that I, tasted the worst.

raising awareness

An Interview with Co-occurring Disorders Specialist, Dr. Roger H. Peters

By Ashley Gravel

Dr. Roger H. Peters is a professor at the University of South Florida's Department of Mental Health Law and Policy, serving as Principle Investigator for research projects on co-occurring disorders. He is a member on the editorial boards for the Drug Court Review and the Journal of Dual Diagnosis. Dr. Peters has published his research and was a contributing author to the 'Co-Occurring Disorders Treatment Manual.'



Dr. Roger H. Peters

Ashley Gravel: How did you become involved with treatment for inmates with co-occurring disorders?

Dr. Roger H. Peters: I got into this area through work with the Florida Department of Corrections and the National Gaines Center, a group that works closely with the population of offenders with co-occurring disorders. We've been working with the Florida Department of Corrections on different projects, such as screenings, assessments, and treatment services. They called on us to help develop a curricular as a part of a Residential Substance Abuse Treatment [RSAT] grant they received for that particular year. In addition to creating the curriculum, they wanted help training their staff. We also provided technical assistance to help set up several programs across the state, one for men and one for

female inmates. We've developed a treatment curriculum that's been used in several other states. That program was in place for 14 years, but budget cuts eliminated both the men's program here in the Tampa area, and the women's program in the Fort Lauderdale area. However, the curriculum is still there. It's been used in other programs related to substance abuse within the Florida Department of Corrections. **AG:** In *Assessing Dependence*, Comorbidity, and Trauma: Importance of Jail Screenings for Mental and Substance Use Disorders, you discussed the importance of early identification of inmates with mental and substance abuse disorders to ensure they receive proper treatment. What is the biggest obstacle to this?

RP: In most settings within the justice system, one of the biggest issues we find is that the institutions don't use standardized screening instruments for mental health, substance abuse, or trauma. Those are the three primary areas addressed in that essay, and we've found that sometimes there isn't any screening at all. If they do have a screening in that particular area, often times it's a home grown instrument or a non-standardized **RP:** I think that's part of it. There's really a shortage of staff that have the advanced training to provide those types of screenings. For example, let's say a probation officer administering a screening asks a question such as, 'have you ever had mental health treatment' or 'are there any psychiatric medications that you've taken?'

"What it comes down to is state agencies dealing with offender populations advocating for improved services. A U.S. congressman or a U.S. senator would have to take it on to develop an initiative focusing on prison reform."

instrument. There isn't much evidence about the psychometric properties of their instrument; how well it identifies disorders, whether or not it over-identifies people, or other potential negative consequences etc.

AG: Is not having enough staff properly trained to do screenings ever an issue? The officer may not know how to follow up on the responses they receive. They also may not provide a comprehensive number of questions to get at the underlying disorders. Individuals suffering from mental disorders tend to worsen when they are released, due the stressful environment of jail or prison. People with mental



disorders are victimized and taken advantage of in those settings because they're perceived to be weaker by predatory inmates. In fact, other inmates in the general population view treatment of any kind as a sign of weakness. **AG:** Can you discuss in more depth the struggles that inmates with co-occurring disorders face? they've reentered society. **AG:** In *Co-Occurring Disorders in Specialty Courts* you mention that these specialty courts are used to understand what brought the defendant to court in the first place. Can you speak on that subject a little bit? Was it a good solution to the problem?

RP: Specialty courts typically

"In some programs, they're dealing with not just a single disorder like mental health or substance abuse, but they're dealing with related adjunctive issues such as employment, education, and housing support."

RP: People with both mental and substance abuse disorders are much more likely to have relapses and face additional contact with the criminal justice system once they're released. If they're not involved in an intensive treatment program for their cooccurring disorders, it can set these individuals up for failure once address different areas. There are Drug Courts that focus on substance abuse problems, and Mental Health Courts to address individuals with severe mental illness. There are roughly 30 different specialized sockets or court programs around the United States that focus on co-occurring disorders. In each of these cases, they're addressing a holistic set of issues linked to the risk of recidivism. In some programs, they're dealing with not just a single disorder like mental health or substance abuse, but they're dealing with related adjunctive issues such as employment, education, and housing support. **AG:** Would you say that setting up these courts, along with better quality screenings, would be a major step toward reducing recidivism?

RP: Absolutely. Research shows that Drug Courts reduce recidivism by an average of fifteen to twentysix percent during a one-year follow up period.

AG: Where do you think the agent of change needs to come from for better screening processes?

RP: There are not many advocates for people with these stigmatized problems. The typical stereotypes attached to this population are

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violent, unruly, and intractable to treatment. That is not the case. We have come to realize that these people are often times warehoused in jails and prisons much longer than other inmates; simply because they have mental disorders and co-occurring substance abuse problems. We have standards that have been developed by national organizations, like the National Commission on Correctional Health Care, for dealing with these issues. NCCHC has developed professional standards for mental health and substance abuse



disorders in jails and prisons. Other organizations, such as the American Correctional Association, the American Psychiatric Association, the American Psychological Association, and the American Jail Association have developed professional standards for practitioners in jails and prisons. But, those are essentially voluntary programs. What it comes down to is state agencies dealing with offender populations advocating for improved services. A U.S. congressman or a U.S. senator would have to take it on to develop an initiative focusing on prison reform. One recent example of that is the prison rape initiative. A congressman from Michigan spearheaded a program to investigate prison rape, which is a national epidemic. We have seen some federal agencies take on this issue, such as the Substance Abuse Mental Health

Services Administration, The Center for Mental Health Services, and the Center for Substance Abuse Treatment. Each of these organizations has really done some pioneering work. They've developed better materials. curricular, briefing papers, trainings and technical assistance for those working in prisons, jails, probation, and specialty courts. The National Gaines Center focused on cooccurring disorders within the justice system and produced a lot of important documents and technical assistance training for individuals working with this population. Much more attention has been given to those suffering from co-occurring disorders within the criminal justice system.



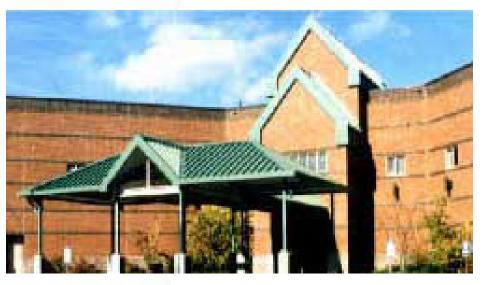
end of LIFE CARE

Hospice in a Prison Setting

By Keith Dauch

In the early morning hours of October 28, 1998, Keith Barile, his heart pounding from a mixture of adrenaline and fear, sat in his car waiting for the morning crew of a Vernon restaurant to arrive. At forty-one years old, he found himself on probation for six criminal convictions, and on this particular morning, he sat in his car, waiting for what would become the culmination of his criminal career. The employees arrived, as they did every morning, to begin preparations for the breakfast rush. Disguised and armed, Keith sprang from his car in an attempt to rob the restaurant.

The attempt failed, and Keith was quickly caught by police. Almost one year later Keith pleaded guilty to, "one count of



MacDougall-Walker Correctional Institution, Suffield, CT

robbery in the first degree, one count of assault in the second degree, six counts of kidnapping in the first degree with a firearm, and one count of operating a motor vehicle while his license was under suspension." He was sentenced to twenty-five years in prison.

Today, Keith is housed at the Niantic Annex Correctional Institution. In an opinion piece he wrote for the *Hartford Courant*, on October 12 of this year, he freely admitted to being the type of person society wanted in prison. He says of himself, "I was selfish and angry and could not be trusted. I cared about nothing and had a propensity for violence." He also recognized within himself a desperate need to change the type of man he had become.

While Keith transitioned into his new life as a small part of a large prison population, a study by the Department of Corrections was in progress to examine the feasibility of starting a prison hospice program. The idea of Hospice migrated from England and settled in Connecticut in 1974, and it provides the overall care to a patient with a terminal illness, ranging from the physical to the emotional and spiritual. Florence Wald, dean emeritus at the Yale University School of Nursing, who played a pivotal role in bringing Hospice to the United States, and Nealy Zimmerman, Chair of the Connecticut Chapter of the National Prison Hospice Association, recognized the urgent need for end of life care for an increasingly older and sicker prison population.

According to a 2010 study by the United States Bureau of Justice Statistics, 26,200 individuals were incarcerated aged 65 or older in the United States. Connecticut currently houses 328 inmates over the age of 60. Colleen Gallagher, Director of Correctional Managed Health Care states that not only does the national trend show an aging prison population, but that, "People are sicker longer in prison." She clarifies that a healthy 45-year-old outside the prison walls would deal with the health issues of a 55-year-old inside.

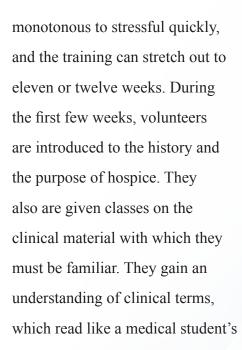
Many studies show that upwards of forty percent of incarcerated offenders report a chronic illness. The prison hospice program has filled a large gap in providing end of life care for offenders.

In the fall of 2000, a little over a year after Keith Barile entered prison, volunteers applied for the first hospice program opening in Suffield, Connecticut. Out of 100 applicants and 40 interviews, 19 volunteers began the training to become hospice workers. Their job would be to fulfill the social and emotional needs of those in the final stages of a terminal illness.

Colleen Gallagher highlights a major difference for the volunteers in the prison hospice program. She explains the prisoner volunteers must deal with their own life and death experiences. They must examine their exposure to death and the feelings the exposure instilled in them. Colleen commented, "We move them to a place of vulnerability, and they have to work through their own issues."

Over time Keith Barile proved himself as an acceptable candidate for the hospice program. He worked on his fight with drug addiction and he worked through his violence issues, learning to deal with situations in a more constructive way. He settled into the monotonous, time-ending routine of daily prison life, and he accepted his situation by coming to terms with his incarceration. After one full year without a class A or B disciplinary report, Keith became eligible for the hospice program.

The training, on average, lasts approximately ten weeks. But prison life can change from



goes on to say, "I've learned to care about someone other than myself, to give freely without expecting anything in return."

During the training Keith had an opportunity for deep reflection on his life. Sitting on his bunk, in his cell, while living through the end result of his negative behavior, Keith recognized the avenue for change

"Some critics do not believe the hospice program for inmates matches up well with the idea that prison is punishment. But this mindset ignores the fact that eventually the majority of those incarcerated will be released."

textbook, and they study the signs and symptoms of the dying.

But it appears that in the third and fourth weeks of training, certain skill sets are studied that reach deeper into their own lives and that have affects beyond just working in the hospice program. Keith says this portion of the training taught him, "to appreciate the fragility and value of life." He that he desperately needed. Keith says the, "activities teach participants how to develop empathy, compassion and pride while practicing honesty, integrity, patience and caring." The hospice program also gives the volunteers the opportunity to put each of these elements into practice each day.

Week three of the training program examines "Compassion

and Effective Communication," skills desperately needed by many who find themselves incarcerated. The volunteers study the "Roadblocks," to effective communication such as arguing, preaching, and threatening. Many of these roadblocks make up the basic elements of prison conversations. But the lesson continues to teach the proper active listening skills that should replace the roadblocks. The volunteers learn empathy; they learn to allow another person to display negative emotions; they learn they do not have to return those emotions in kind

The lesson of empathy allows the hospice workers to attempt to understand where the other person is coming from. By practicing empathy each day they work, the lesson settles deeper into their hearts, and they are able to bring that back to their cell block. Most of those incarcerated know what it is like to feel threatened,

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violent, or they can understand the need to act outwardly their inner feelings of guilt. More than any counselor, they can understand the emotions each other feel, and the lesson of empathy can help break the cycle of violence and anger found in prisons.

Week four dives deeper still with lessons on "Care for the Caregiver." Burnout is a very real issue the volunteers must learn to deal with. Over time, they develop bonds of friendship with those they with the grieving process and ways to care for themselves in order to deal with the impact of loss in a healthy way. Meditation is taught so the volunteers can learn to accept the pain and emotions they deal with while in the hospice program. Breathing in they acknowledge the truth of the emotions they feel, and exhaling they allow those feelings to pass.

Colleen Gallagher concludes by stating, "Connecticut is one of the few states asked to

"Over time, they develop bonds of friendship with those they care for, and inevitable they lose those they have become close to."

care for, and inevitably they lose those they have become close to. Colleen Gallagher says, "Many offenders feel that they can do the program, and as they experience the actual death experiences they have a change of heart sometimes."

To combat burnout, the volunteers are taught ways to deal

participate in developing national guidelines for prison hospice and palliative care." The Connecticut prison system has been fortunate enough to successfully navigate the obstacles for a hospice program in the prisons. With great support from the administration, Connecticut, unfortunately, seems to be one of the exceptions in the country and not the rule.

Some critics do not believe the hospice program for inmates matches up well with the idea that prison is punishment but this mindset ignores the fact that eventually the majority of those incarcerated will be released. People who understand and fully embrace empathy are far less apt to commit crimes.

On February 2, 2001, during one of the many graduations for hospice workers held at the MacDougall-Walker Correctional Institution, State Representative Patricia Dillion read excerpts from inmates who spoke about how the program gave them a chance to atone for their crimes. As Nealy Zimmerman, one of the program's primary architects, said at the event, it gives them a chance to "experience a humane, nurturing alternative to the dehumanizing ethos of the general prison population."



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