Title:

Exploring End-of-life Care during Reintegration from the Perspectives of Correctional Social Workers and Caregivers Providing After-Care Services to Elderly Parolees Released on Medical Parole in eThekwini Metropolitan Municipality

Doctoral thesis submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy (PhD) in Social Work

by

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TABLE OF CONTENTS

DECLARATION OF ORIGINALITY

I, **Sethenjwa Bonny Nduli**, hereby declare that this thesis is the result of my own original research efforts. I affirm that the work presented herein is entirely my own and has not been submitted, in whole or in part, for any academic degree or qualification at any other institution. This declaration underscores my commitment to academic integrity and the principles of scholarly conduct. I acknowledge the importance of originality in research and take full responsibility for the content and findings of this research report.

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DEDICATIONS

This study is dedicated to my beloved twin brother, S'thembele Bunny Nduli, who is no longer with us. Brother, your absence has created an enduring ache in my heart, yet I find solace in the belief that you accompanied me in spirit throughout this endeavour. While I may not have tangible reminders, the memories we created together remain etched in my heart, forever. I often find myself wishing I could have expressed the full extent of my love for you; there are moments when I see someone who resembles you, and I pause, imagining you laughing at the irony of our loss. Regardless of the accolades and achievements I may attain, nothing can diminish the truth that you were, and will always be, my chosen twin and now my guardian angel. I long for the comfort of your presence in my dreams, to hear you reassure me that you are safe and watching over me.

I am pleased to reintroduce myself as **Dr Sethenjwa Bonny Nduli (PhD)**, when the time is ripe. This marks not the conclusion, but rather the commencement of an exciting journey ahead!

Nduli, Khwela Mgabhazi

"Nothing in this world could have ever prepared me to lose my other half."

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"*Although you have been forsaken and hated, with no one traveling through, I will make you the everlasting pride and the joy of all generations.* *16* *You will drink the milk of nations and be nursed at royal breasts. Then you will know that I, the Lord, am your Saviour, your Redeemer, the Mighty One of Jacob".* - Isaiah 60: v15-16

ABSTRACT

Legislation that governs the medical release of offenders in South Africa remains a contentious issue, particularly concerning the reintegration and end-of-life care of elderly parolees. Despite the growing discourse on end-of-life care, there is a critical gap in understanding the lived experiences of elderly parolees and the challenges faced by their caregivers. Guided by Caregiver Dynamics Theory and Ecosystems Theory, this study adopted a qualitative phenomenological approach to explore how end-of-life care is experienced during reintegration from the perspectives of family caregivers and correctional social workers.

Participants were selected through purposive sampling, and data were generated using in-depth semi-structured interviews. The sample comprised 15 caregivers and six (n=6) correctional social workers (who were responsible for delivering social work programmes to parolees). All ethical standards including informed consent, confidentiality, voluntary participation, and sensitivity to participant vulnerability were strictly observed. The data were analysed using thematic content analysis, allowing for an in-depth interpretation of experiential meanings. Based on the interview guide, the researcher was able to gather data which revealed that reintegration is hindered by inadequate institutional care, limited caregiver support, insufficient training, and weak community linkages. The study identifies systemic failures, including the lack of specialised end-of-life care services within correctional frameworks, leading to increased physical confinement, isolation, and emotional distress for elderly parolees. Spiritual practices emerged as an essential coping mechanism, yet they remain an underutilised resource. Family caregivers reported experiencing compassion fatigue, ambiguous loss, and difficulty balancing caregiving responsibilities with personal wellbeing. The absence of training on medication management and polypharmacy further complicated caregiving, leading to ineffective medical support. Many caregivers expressed feelings of resentment and regret, exacerbated by their emotional and physical burdens. Conversely, prior experience in caring for relatives that are now deceased enabled some caregivers to better navigate the demands of end-of-life care, highlighting the role of experiential learning in improving caregiving outcomes.

Correctional social workers were found to be largely ill-equipped to support elderly parolees, with findings indicating a lack of structured aftercare programmes. This deficiency resulted in the exclusion of ill elderly parolees from essential reintegration services, straining family relationships and diminishing the effectiveness of reintegration efforts. Furthermore, inadequate collaboration between custodial and non-custodial correctional social workers severely compromised service delivery, undermining the quality of end-of-life care for elderly parolees. This study underscores significant deficiencies in training, policy, and resource allocation within the correctional system, emphasizing the urgent need for policy reform and targeted advocacy. The findings call for a comprehensive approach that includes specialised training for caregivers and social workers, improved interdepartmental collaboration, and enhanced institutional support for elderly parolees in end-of-life care. Recommendations are directed at policymakers, programme coordinators, correctional social workers, and managers within the Department of Correctional Services to ensure effective reintegration and dignified end-of-life care for elderly parolees.

Keywords: *Caregivers, elderly parolees, end-of-life care, medical parole, reintegration, correctional social workers.*

LIST OF ACRONYMS

BSW	Bachelor of Social Work
CMC	Case Management Committee
CO	Correctional official
COMCOR	Community Correctional Center
CPA	Criminal Procedures Act 51 of 1977
CSA	Correctional Services Act 111 of 1998
DCS	Department of Correctional Services
ELO	End-of-life
EM	Electronic Monitoring
ESA	Execution of Sentences Act
FBOs	Faith Based Organisations
HPSA	Health Professions Council of South Africa
PAJ	Promotion of Administrative Justice Act 3 of 2000
PB	Parole Board
MAB	Medical Advisory Board
SACSSP	South African Council for Social Services Professions
SASSA	South African Social Security Agency
CSW	Correctional Social Worker
WPC	White Paper on Corrections 2005
WHO	World Health Organization
UKZN	University of KwaZulu-Natal
USA	United States of America
VPOs	Volunteer Probation Officers
ID	Identity Document
CSC	Correctional Service of Canada
ETA	Escorted Temporary Absence

CHAPTER 1

SETTING THE SCENE

"*Impossible situations can become possible miracles."*

Robert H. Schuller

1.1. Introduction

In South Africa, the legal framework governing the medical release of offenders has long been contested, especially as the number of elderly offenders and those requiring medical parole continues to rise, drawing concern from policymakers and scholars regarding reintegration challenges. Prior to the amendments enacted on 1 March 2012, the criteria and procedures for early medical release were unclear, particularly because Section 79 of the Correctional Services Act 111 of 1998 did not specify who was permitted to apply for medical parole. This ambiguity became highly visible in the case of Schabir Shaik, a Durban-based businessman whose corporate group, Nkobi Holdings, operated within defence, infrastructure, and IT sectors. In 2005, Shaik was convicted in the Durban High Court on two counts of corruption and one count of fraud, with the judgement finding that his business success was closely tied to political patronage, especially his relationship with then Deputy President Jacob Zuma, which he leveraged to secure state contracts, including defence procurement. After serving two years and four months of his 15-year sentence, Shaik was controversially granted medical parole on 3 March 2009, reportedly due to life-threatening hypertension. The public outrage that followed highlighted deep legislative gaps in medical parole procedures, and occurred against a backdrop of severe national and provincial inequality where Gauteng and the Western Cape record household incomes nearly three times higher than provinces like Limpopo and the Eastern Cape, thereby shaping the social conditions into which medically frail parolees are released (Statistics South Africa, 2023). In addition, broader criminal justice mechanisms relevant to parole, investigation, and sentencing such as Section 205 of the Criminal Procedure Act (CPA) 51 of 1977 (compelling individuals to provide information relevant to investigations), Section 220 (allowing formal admissions by accused persons to stand as sufficient proof), and Section 282 (permitting the antedating of sentences in specific circumstances) illustrate the procedural framework within

which cases such as Shaik's were processed. Together, these legal, socio-economic, and correctional dynamics inform the contemporary debates surrounding reintegration and end-of-life care for elderly parolees.

In September 2021, a similar controversy emerged when former President Jacob Zuma was granted medical parole after serving only 58 days of his 15months sentence at the Escort Correctional Centre in KwaZulu-Natal. This incident underscored several deficiencies, particularly the general lack of understanding regarding medical parole and the functions of the Medical Parole Advisory Board and the Commissioner of Correctional Services. Given that the former President was 81 years old, one could argue that there is a significant correlation between age and incarceration, particularly in relation to severe health issues. Research indicates that older offenders tend to experience worse health outcomes compared to their younger peers (Kendig et al., 2022). Consequently, the reintegration of offenders with serious medical conditions may present greater challenges than those released under standard parole conditions. The rehabilitation framework provides various programs for offenders, including palliative care during incarceration. However, it remains uncertain how correctional social work programs address the specific needs of individuals released on medical grounds.

1.2. Location of the study

The current research was conducted within a community corrections facility, a non-custodial centre located in the eThekwini Metropolitan Municipality in KwaZulu-Natal. The location reflects the complexities of South Africa's socio-economic landscape, which is characterised by stark inequalities, urban-rural divides, rapid urbanisation, high unemployment rates, and a mix of formal and informal economies, all of which are particularly pronounced in eThekwini Metropolitan, where issues such as poverty, crime, and migration intersect with efforts to modernise infrastructure and address social welfare. In South Africa, the legal framework provides two primary alternatives to traditional incarceration namely correctional supervision and parole. Both alternatives are administered by the Department of Correctional Services, which operates under the broader umbrella of Community Corrections. This

framework is designed to offer a more rehabilitative approach to justice, emphasizing the importance of reintegrating offenders into society rather than simply punishing them.

The significance of choosing Community Corrections lies in its holistic approach to managing offenders and their families within the context of the community. This system is not merely about monitoring individuals who are either on parole or probation; it is about fostering an environment that supports their rehabilitation and reintegration into society. By keeping offenders within their communities, the system aims to reduce criminal recidivism rates and promote social cohesion. Community Corrections ensure that individuals on parole and probation are subject to supervision and oversight, which is crucial for maintaining public safety and accountability. This oversight is conducted in accordance with the stipulations outlined in the Criminal Procedures Act 51 of 1977 and the Republic of South Africa Correctional Services Act 111 of 1998. These legislative frameworks provide the necessary guidelines and regulations that govern the operations of Community Corrections, ensuring that the rights of offenders are respected while also safeguarding the interests of the community.

As a vital component of their reintegration strategy, participation in educational and therapeutic social work programmes is mandatory for all parolees released from correctional facilities. These programmes are designed to address the various underlying issues that may have contributed to the offenders' criminal behaviour such as substance abuse, lack of education, and mental health challenges among others. By engaging in these programs, parolees are given the tools and support they need to rebuild their lives, develop new skills, and ultimately become productive members of society. This requirement not only aids in the personal development of the individuals involved but also serves to strengthen the fabric of the community by reducing the likelihood of reoffending and fostering a sense of responsibility and accountability among offenders.

In summary, the research highlights the critical role that Community Corrections plays in the South African justice system, emphasizing its focus on rehabilitation, community engagement, and the importance of structured support for offenders as they transition back

into society. Through this approach, the system aims to create a safer and more inclusive environment for all members of the community.

1.3. Assumption of the study

The research posits that both family caregivers and correctional social workers encounter difficulties in facilitating the reintegration of elderly parolees when they are granted medical parole. Additionally, the lack of comprehension and incorporation of end-of-life care within correctional social work curricula adversely affect the reintegration process and the overall quality of care provided to elderly parolees.

1.4. Statement of the problem

The growing number of terminally ill elderly offenders in South Africa's correctional system has intensified concerns about the adequacy, fairness, and human-rights compliance of existing reintegration and end-of-life care practices. This unprecedented demographic shift has prompted renewed debate on whether current correctional and community-based services are capable of meeting the complex needs of ageing offenders (Brooke et al., 2020). Elderly offenders typically present multifaceted bio-psychosocial challenges requiring sustained, multidisciplinary intervention yet correctional facilities remain chronically under-resourced, creating significant strain on rehabilitation centres (Roberts, 2015). Critical components such as continuous institutional care, meaningful family communication, caregiver training, and coordinated community-based support are often insufficient or absent entirely (Ranieri, 2024). These systemic gaps result in inadequate end-of-life care within correctional settings and heighten the risk of infringing on constitutionally protected rights to dignity, humane treatment, and access to healthcare for elderly offenders (Porporino, 2014).

Although medical parole is intended to protect medically vulnerable offenders, reintegration processes remain fragmented and inconsistently implemented. Community Corrections suffers from shortages of specialised staff including social workers, psychologists, and monitoring officials whose roles are essential for ensuring continuity of care and reintegrative support for terminally ill parolees (Fitz et al., 2024). The absence of adequate personnel and structured support systems leaves family caregivers unprepared and undermines the quality, safety, and ethics of care provided to elderly parolees during the final stages of life. This

situation is especially urgent in South Africa's correctional context, where ageing inmate populations, systemic resource constraints, and enduring socio-economic inequalities converge to exacerbate the vulnerability and marginalisation of elderly offenders released on medical parole. Addressing these challenges is therefore critical for advancing rights-based, dignified, and effective reintegration and end-of-life care services aligned with the aim of this study.

1.5. Overall Aim of the study

The overall aim of this study was to explore the experiences of end-of-life care among elderly offenders who are reintegrating into society after being released on medical parole, as perceived by family caregivers and correctional social workers. Specifically, the study sought to understand the challenges, support systems, and emotional dynamics involved in providing care to elderly parolees during this phase of reintegration, and to identify the roles and perspectives of family caregivers and correctional social workers in facilitating or hindering this process.

1.6. Objectives

To guide this study, the following objectives were formulated to address the key dimensions of reintegration, caregiving, and end-of-life care for elderly offenders released on medical parole:

1. To describe the factors that influence or affect the reintegration process of elderly offenders released on medical parole during the end-of-life care stage, based on the perspectives of family caregivers.
2. To develop an in-depth understanding of family caregivers' experiences in relation to caring for elderly parolees during the end-of-life care stage.
3. To explore how current reintegration social work services promote and improve the quality of care for ill elderly parolees and their caregivers during the end-of-life care stage
4. To identify the challenges that Community Corrections social workers encounter when reintegrating elderly offenders released on medical parole.

1.7. Research questions

1. What factors influence or affect the reintegration process of elderly offenders released on medical parole during their end-of-life care phase, from the perspective of family caregivers?
2. What are the experiences of caregivers taking care of elderly offenders released on medical parole during their end-of-life-stage care stage?
3. How does the current reintegration of social work services promote and improve the quality of care of terminally ill elderly parolee and their caregivers during end-of-life care?
4. What are the challenges that Community Corrections social workers encounter when providing reintegration services to elderly offenders released on medical parole?

1.8. Rationale for the study

When an offender is diagnosed with a terminal disease while serving time in a South African correctional center, it is more probable that terminally ill offenders will be cared for in prisons than hospitals, hospices, or private places (Burles et al., 2016). Their palliative care needs are becoming more widely recognised, and some efforts have been made to develop specialised programs within correctional settings. However, little is known about how palliative and end-of-life care is integrated during reintegration programs for terminally ill offenders released on medical parole. Research suggests that very few offenders who are released from prison achieve successful reintegration without the existence of multiple challenges and long-term difficulties (Lynch & Sabol, 2001; Nelson et al., 2011; Travis et al., 2001).

The Department of Correctional Services is facing the challenge of managing a growing population of elderly offenders who are terminally ill and qualify for medical parole (Boese et al., 2023). Currently, there is a significant lack of scholarly work that examines the experiences of family caregivers and social work service providers within Community Corrections who offer care and support to elderly offenders upon their release. The current research seeks to fill this gap in the existing body of literature by exploring the experiences of Community Correctional social workers and family caregivers who provide care to

terminally ill offenders released on medical parole in the eThekwini Metropolitan area. Furthermore, the study intends to analyse the end-of-life care experiences encountered during the reintegration process of elderly offenders when they are granted medical parole following their incarceration. The difficulties faced by these elderly offenders highlight the urgent need to evaluate the quality of care and reintegration services available to them.

1.9. Background of the study

Correctional systems globally, including in South Africa, continue to experience sustained pressure due to overcrowding and growing health demands. South Africa consistently operates above its official prison capacity, a trend that heightens risks of violence and infectious disease transmission, particularly tuberculosis (Manganye & Phetlho-Thekisho, 2016; Fair & Walmsley, 2024). Similar pressures are evident across African correctional systems such as in Kenya, Uganda, Zimbabwe, and Botswana, where inadequate health infrastructures, staff shortages, and ageing inmate populations challenge the ability of prisons to respond to complex health needs (Kenya Prisons Service, 2019; Uganda Prisons Service, 2020; Zimbabwe Human Rights NGO Forum, 2018; Botswana Prisons Service, 2021). Collectively, African evidence underscores that correctional environment are structurally ill-equipped to manage elderly, chronically ill, or terminally ill offenders.

Within this context, South Africa faces a growing number of elderly offenders whose advanced age and chronic illnesses place additional strain on correctional healthcare services. Elderly offenders have higher rates of communicable and non-communicable diseases than the general population and often receive limited contact or support from family members (Binswanger et al., 2009; Boothby & Overduin, 2007). These vulnerabilities raise concerns about humane treatment, access to health services, and the dignity of offenders, particularly during the end-of-life stage.

Medical parole has therefore become an important mechanism intended to ensure that offenders whose health has deteriorated severely can receive more appropriate and dignified care outside correctional facilities. However, decisions around medical parole must balance the severity of illness, the correctional system's capacity to provide adequate care, and the broader humanitarian implications of continued incarceration (ACTION, 2007; Ddamulira Mujuzi, 2009). Reintegration challenges persist after release, with research showing that

terminally ill parolees face significantly greater health-related difficulties than the general population, while families often bear the emotional and practical burdens of providing care (Greenwood et al., 2024; McKeown et al., 2003; Family Caregiver Alliance, 2019). This constellation of systemic constraints, family strain, and the heightened vulnerability of ageing offenders highlights the urgency of critically exploring medical parole and reintegration processes in South Africa.

1.10. Research approach/ methods

This section offers an overview of the research methodology, which is elaborated in Chapter Five. To explore the experiences and perspectives of family caregivers and correctional social workers regarding end-of-life care during the reintegration process, a qualitative research approach was adopted. The study followed a phenomenological design to gain insight into the lived experiences of participants. Purposive sampling, a non-probability technique, was used to recruit individuals who possessed direct experience with the phenomenon under study. Data were generated through semi-structured interviews, and the analysis was guided by thematic content analysis to identify significant patterns and meanings within the narratives.

1.11. Definition of terms

1.11.1. End-of-life care

End-of-life care refers to the comprehensive medical, psychosocial, and spiritual support provided to individuals approaching death due to terminal or life-limiting illnesses. Its primary aim is to optimise quality of life by relieving suffering, managing symptoms, and supporting both patients and their families through a multidisciplinary palliative care approach (Gomes et al., 2013).

1.11.2. Family caregiver

A family caregiver is an unpaid individual, typically a relative or close associate who provides physical, emotional, and practical support to a person living with chronic illness, disability, or age-related impairment. Responsibilities often include assistance with daily

activities, medication management, and coordination of care, often undertaken alongside personal and occupational obligations (National Alliance for Caregiving & AARP, 2020).

1.11.3. Offender

An offender is any person who has been accused or convicted of a criminal offence and whose details are recorded in the national criminal justice records (Department of Correctional Services, *White Paper on Corrections*, 2005).

1.11.4. Reintegration

Reintegration is the structured and ongoing process through which offenders transition from incarceration back into the community. It includes institutional pre-release preparation, community-based supervision, and support interventions aimed at promoting social adjustment, reducing recidivism, and facilitating successful community re-entry (Griffiths et al., 2007).

1.11.5. Elderly

An elderly person is an individual classified as an older adult, commonly defined in South Africa as women aged 60 years and older and men aged 65 years and older, in accordance with the *Older Persons Act* (No. 13 of 2006). These thresholds reflect typical retirement ages and mark the onset of age-related vulnerability (Gorman, 1999).

1.11.6. Parole

Parole is a conditional release mechanism that allows an offender to serve the remainder of their sentence under supervision in the community after meeting legislatively defined requirements. It is a component of the correctional system's graduated-release strategy rather than a medical model, and its conditions are monitored by Community Corrections (Du Preez, 2003).

1.11.7. Medical parole

Medical parole is a form of conditional release granted to offenders who suffer from terminal, severely debilitating, or chronic illnesses that significantly impair their functioning and cannot be adequately managed in a correctional setting. Its purpose is to ensure access to appropriate care, uphold dignity, and alleviate pressure on correctional health resources (Feucht, 2021).

1.11.8. Parolee

A parolee is an individual who has been conditionally released from a correctional facility and remains under the supervision of Community Corrections, subject to compliance with specified parole conditions in accordance with the *Criminal Procedure Act* (No. 51 of 1977).

1.11.9. Correctional centre/ Prison

In this study, the terms "correctional centre" and "prison" refer to government-operated facilities responsible for the incarceration, care, rehabilitation, and pre-release preparation of offenders. Although the terms may have contextual distinctions, they are used interchangeably in this research for clarity.

1.11.10. Rehabilitation

Rehabilitation is the structured process through which offenders are supported to develop skills, insight, pro-social values, and behavioural change to enable their lawful and constructive participation in society. It is a shared responsibility of the state, communities, and offenders themselves (White Paper on Corrections, 2005).

1.11.11. Correction

Correction refers to the range of programmes and strategies delivered within correctional settings to address offending behaviour, promote accountability, and facilitate personal development in accordance with the *Correctional Services Act* (No. 111 of 1998).

1.11.12. Community corrections

Community corrections encompass non-custodial measures and supervision strategies that manage offenders in the community after release or as alternatives to incarceration. These include monitoring, rehabilitation programmes, and reintegration support provided by the Department of Correctional Services (Correctional Services Act, No. 111 of 1998).

1.11.13. Correctional official

A correctional official is an employee of the Department of Correctional Services appointed in terms of the *Correctional Services Act* and the Public Service Act to perform custodial, supervisory, administrative, and rehabilitative functions within correctional facilities.

1.11.14. Correctional social worker

A correctional social worker is a registered social work professional, accredited by the South African Council for Social Service Professions, who provides assessment, therapeutic interventions, rehabilitation programmes, and reintegration support to offenders within correctional and community corrections environments.

1.11.15. Terminal illness

A terminal illness is a medical condition expected to lead to death within a relatively short period typically six months or less despite therapeutic intervention. Examples include advanced-stage cancers and end-stage organ failure.

1.11.16. Seriously ill

A seriously ill individual presents with severe and potentially life-threatening health conditions requiring intensive medical intervention but not necessarily classified as terminal. Prognosis may vary, with potential for stabilisation or partial recovery.

1.11.17 Life-limiting illness

A life-limiting illness is an incurable condition that significantly shortens life expectancy but may not indicate imminent death. Examples include advanced neurological disorders and

progressive respiratory diseases. In this study, “terminal illness,” “seriously ill,” and “life-limiting illness” are used collectively to describe severe health conditions that necessitate comprehensive care planning and palliative interventions.

1.12. Structure of the thesis

The following section provides an overview of the structure of the thesis, outlining the focus and purpose of each chapter and illustrating how the study progresses from the contextual foundation to the presentation of findings and conclusions.

Chapter	Chapter content
Chapter 1: (Introduction): This chapter provides an introduction and overview of the context of the study.	• Introduction • Location of the study • Assumptions • Statement of the problem • Aims and objectives • Research questions • Rationale and significance of study • Background and context • Research approach/methods • Definition of terms • Structure of the thesis
Chapter 2: (Literature Review): This chapter reviews the existing literature and policies relevant to the study. This chapter also covers the literature related to the release of terminally ill elderly offenders on medical parole.	• The development of offender rehabilitation • Models influencing the correctional systems handling of offenders • Pre and post rehabilitation programmes for offenders • The key role players in the Department of Correctional Services • Correctional health care

	• Parole and social reintegration • The relationship between aging offenders and medical parole • Application of the release of offenders on medical parole in South Africa. • Understanding medical parole in South Africa • Review of the Canadian approach to medical release • The role of Community Corrections in relation to medical parole
Chapter 3: (Literature Review): This chapter is divided into four parts; it first provides an overview of palliative care in the context of gerontology and correctional services. Secondly, it provides a comprehensive presentation of end-of-life care, and thirdly, it presents literature on hospice care and the role of social workers. This chapter concludes with an overview of the literature on family caregivers and their wellbeing.	• Conceptualising palliative care in the context of gerontology • End-of-life care in the context of Gerontology • Hospice care and the role of social workers • Caregiving within the context of elderly care
Chapter 4: (Theoretical Framework): This chapter outlines the theoretical frameworks used in this research, specifically: (1) Caregiver dynamics theory and (2) Eco-systems theory. These frameworks proved to be instrumental in	• Introduction • Caregiver dynamic theory • Ecosystem's theory

understanding and achieving the objectives set forth by the study.	
Chapter 5: (Methodology): The chapter reports on the application of the qualitative methodology and provides a comprehensive overview of how data were collected and analysed. It also includes ethical issues that the study adhered to.	• Introduction • Research design • Population and sampling • Data collection method • Data management and analysis • Ethical considerations • Potential limitations of the study • Timeline
Chapter 6: The chapter presents the findings and key discussions relating to providing end-of-life care during reintegration.	• Introduction • Demographic profile of correctional social workers and family caregivers • Negative factors affecting the reintegration of elderly parolees during end-of-life care stage • Positive factors influencing the reintegration • Emotional and psychological impact of caregiving during end-of-life care stage • Caregiving competence, stress coping, and mental well-being of family caregivers during end-of-life • Caregiver preparedness and confidence in providing quality care to elderly parolees • Conclusion
Chapter 7: (Findings): It presents the second part of the findings and key	• Introduction

discussions relating to providing end-of-life care during reintegration.	• The role of social work services in promoting and improving the quality of care of terminally ill elderly parolees and their caregivers during end-of-life care • Challenges and realities faced by correctional social workers during reintegration • Conclusion
Chapter 8: (**Conclusion**): This is the final section of the thesis; it provides a comprehensive summary of the entire study and brings to light informed conclusions and further provides recommendations for future studies and reformation policies.	• Conclusions • Recommendations

1.13. Summary of the chapter

The chapter established the essential context of the research, articulating the necessity and relevance of the study within the contemporary environment. It described the problem statement and highlighted the specific challenges the research aimed to address. The chapter also outlined the study's objectives, providing a framework for the expected outcomes, and identified the primary research question that guided the investigation, along with the methodology.

Additionally, the chapter offered a concise overview of the methodology, including the research design, data collection strategies, and analytical methods used to address the research question. To aid comprehension, the chapter defined several key terms relevant to the study, such as "reintegration" (the process of returning to society post-incarceration), "adjustment" (the adaptation to new surroundings), "elderly" (older adults facing unique challenges), "medical parole" (conditional release for health reasons), "parolee" (individuals

released under supervision), “department” (the governing authority overseeing parole), “rehabilitation” (the reform process for offenders), “community corrections” (programmes supervising offenders in the community), and “correctional social worker” (a professional aiding reintegration within the correctional system).

CHAPTER 2

LITERATURE REVIEW-PART ONE

Releasing terminally ill elderly offenders on medical parole

"*It is said that no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones.*"

Nelson Rolihlahla Mandela

2.1. Introduction

The high costs of care for medically ill elderly offenders remain a contentious issue, sparking considerable debate. Research shows that the medical expenses for these offenders are twice as high as for younger individuals, and the number of elderly offenders has significantly increased in recent decades (Bezuidenhout & Booyens, 2018). Maschi et al. (2012, p.543) highlight that "older adults in prison have unique individual and social developmental needs" due to cumulative risk factors and prison conditions that hasten aging. As a result, the Department of Correctional Services faces significant healthcare challenges, particularly regarding the implementation of end-of-life care programmes for offenders and parolees released for medical reasons. There is a lack of research on the reintegration of medically ill elderly parolees after incarceration, which this study aimed to address by exploring their end-of-life care experiences.

Health indicators suggest that elderly offenders experience poorer health outcomes than their younger counterparts (Ahalt et al., 2013). Therefore, reintegrating medically ill elderly offenders may pose greater challenges than for those released under parole supervision. The rehabilitation system offers various programmes, including palliative care, tailored to offenders' individual care plans while they are incarcerated. However, it remains unclear how existing social work programmes support the specific needs of medically ill parolees during their reintegration. This chapter reviews prior research on elderly offenders with medical conditions and their reintegration into society. It is divided into three sections. The first discusses rehabilitation programmes in correctional facilities; the second reviews literature on health care for offenders in these settings; and the third explores medical parole and policy alternatives to aid the reintegration of medically ill offenders.

2.2. The development of offender rehabilitation

The purpose of correctional institutions is to reduce crime, counteract criminal recidivism and ensure that offenders are rehabilitated. Similarly, the Department of Correctional Services is committed to providing an efficient correctional system that contributes to a just and safer South Africa through an effective, and humanitarian imprisonment of offenders and the rehabilitation and reintegration of offenders (SA Department of Correctional Services, Service Delivery Charter, 2017). Against this backdrop, the approach to behaviour modification is informed by a diversity of models that inform design, policy, and the practices of correctional service providers (Singh, 2014). This section presents a brief discussion on the contributions of six models which have influenced the modern philosophy of rehabilitation, programmes aimed at rehabilitating offenders and the key role players in the rehabilitation process.

2.2.1. Models influencing the correctional system's handling of offenders

The South African penal system has experienced several important transitions in policy and legislation following the change to democracy in 1994. In this section the researcher provides a brief discussion on the different models that have influenced the modern-day rehabilitation (Dissel, 2002). Each of the five models explains why someone might turn to crime. Every model additionally provides a fix to render this illegal activity invalid (Champion, 2001). The models discussed below include: The Medical Model; the Reintegration Model; the Retributive Justice Model; the Restorative Justice Model and the Rehabilitation Model. Each of these models are discussed within the context of South Africa's rehabilitation system.

2.2.1.1. The Medical Model

The Medical Model views criminal behaviour or deviant behaviour as a consequence of emotional and mental malfunction that are outside the control of the offenders. This approach to incarceration is more focused on the individuals psyche as the cause of criminality rather than external environmental factors (Clear & Dammer, 2000). Similarly, Champion (2001) argues that criminal behaviour is a result of psychological conditions that can be treated. The medical model posits that only medical interventions can be used to address criminal behaviour and links deviant behaviour to psychological, emotional, and internal problems

(Singh, 2014). According to Schwartz and Travis (1997, p. 205), "the idea was that treatment programs should be designed to deal with those shortcomings in personality that caused the offender to commit a criminal act. The strategy central to that kind of treatment almost always included a variant of counselling." Therefore, professions such as social workers, psychologists, and psychiatrists are considered crucial in assisting offenders during their healing process.

Even though the medical model informed offender treatment for many years, it proved insufficient in addressing systemic challenges such as overcrowding, antisocial behaviour, and recidivism (Du Preez, 2008). Within the context of medical parole, this model continues to exert significant influence by foregrounding the offender's physical and psychological health as the primary determinants of release. Medical parole boards therefore rely heavily on clinical assessments, diagnoses, and professional recommendations to determine whether continued incarceration poses a health risk or violates humane standards of care (Singh, 2005). However, when elderly offenders are released under this medically driven framework, reintegration becomes notably complex. Because the medical model prioritises treatment over social support, the responsibility for managing chronic illnesses, frailty, or severe disability shifts largely to families and community caregivers, often with minimal structural or institutional assistance (Bateman, 2012). This results in a release process that is medically justified but socially demanding, raising critical questions about caregiver preparedness, community capacity, and the sustainability of post-release support. These limitations ultimately contributed to the emergence of the Reintegration Model, which sought to align correctional practice with the United Nations Standard Minimum Rules for the Treatment of Prisoners during this period (Singh, 2005)

2.2.1.2. The Reintegration Model

As an alternative to the individualistic Medical Model, the Reintegration Model assumes that "society must also accept responsibility for its problems ... society must render assistance to the released prisoner to facilitate reintegration" (Coetzee, p.l16, 2023). The Reintegration Model is centred on creating programmes that foster strong community ties between the offender and the community. Further, these programmes include but are not limited to providing skills training, employment creation, and other community-based programmes

(Van der Westhuizen, 2002). Advocates of this model support community sentencing for most offenders and believe that prisons should only hold serious offenders who cannot be rehabilitated. Similarly, Griffiths et al. (2007) oppose custodial measures as a rehabilitative approach, claiming that they expose offenders to the harmful impacts of imprisonment such as deteriorating health and disconnecting community and family bonds. These authors also advocate for the use of community-based treatment as an alternative to assist offenders reintegrate into society rather than exposing them to the humiliating and destructive impacts of incarceration. However, determining which types of offenders might benefit from community-based treatment is still a much-debated topic (Liem & Weggemans, 2018). The following presents the philosophical approaches that underpin the reintegration Model (Du Preez, 2003):

- The community plays a key role in reintegrating offenders and providing them with the opportunity to change their behaviour.
- The community should offer support mechanisms to attain social reintegration objectives.
- To promote social reintegration, the community should provide support.
- If an offender is considered as harmful to the community, prison can prevent additional harm and ensure community safety.

Though the above approach emphasises the key role played by the community in attaining successful reintegration, the Department of Correctional Services faces some resistance, which is further exacerbated by the high of number of criminal recidivism cases (Singh, 2014). Communities' reluctance to participate in the reintegration process of offenders make it difficult for offenders to navigate life after imprisonment. Subsequent to this, offenders find it hard to resettle within the community and more than often, they relapse as a result thereof. While this is well documented in literature, little is known about how elderly parolees released on medical parole are reintegrated back into the space of the community and how does this type of release affect the lives of those who render caregiving services to them.

In decisions regarding medical parole, the reintegration model emphasises the availability and suitability of community-based support systems capable of meeting the offender's health and social needs (Van der Westhuizen, 2002). Parole boards are therefore influenced by

considerations such as the presence of caregivers, access to stable housing, and the capacity of families or communities to provide ongoing assistance. For elderly parolees, this model frames reintegration as a shared societal responsibility, but this ideal is often undermined by community resistance, stigma, and the limited resources available to support ageing or terminally ill offenders (Letlape & Dube, 2023). As a result, although the model promotes community inclusion, the reintegration of elderly medical parolees frequently exposes gaps between policy expectations and the realities facing caregivers tasked with providing intensive day-to-day care. The following discussion examines the Retributive Justice Model, which stood in opposition to the Rehabilitation Model subsequently adopted by the Department of Correctional Services in South Africa.

2.2.1.3. The Retributive Justice Model

The Retributive Justice Model has its roots in the early 1970s. It was developed by Hirsch and Singer in the 18th century. This model proposes a more punitive approach to criminal behaviour in contrast to the ideas proposed by the Rehabilitation Model (Champion, 2001). Critical to the Justice Model is the belief that offenders should be removed or excluded from the community as a preventative measure to avoid recidivism (McCarthy & Brunton-Smith, 2018). Therefore, this means that probation and parole and the use of remission to reduce length sentences are no considered ineffective (Loeffler & Nagin, 2022). The Retributive Model posits that everyone has freedom of choice, and those illegal activities are the outcome of one's own decisions, implying a more individualistic view of criminal behaviour (Jonker, 2011).

Critics of the Retributive Justice Model argue that it fails to assist offenders to recognise the negative impact of their offending behaviour, which is a result of their doing. Instead, this model forces offenders to develop exculpatory mechanisms to protect themselves from a severe judgment that it seeks to impose (Osgood, 2017; Wenzel et al., 2008). Similarly, Mtshali (1999) contends that the Retributive Model does not adequately prepare offenders for the world outside; rather, it consequently makes offenders aquatinted to prison life. The overemphasis of this model on lengthy periods of incarceration over the expense of effective treatment has been criticised as the sole cause of prison overcrowding (Du Prez, 2008). The

emphasis on lengthy prison sentences can also be linked to the unintended rise in the number of aging offenders within custodial settings, moreover, this model fails to consider the unique needs that this demography may have such as healthcare. When viewed through the lens of medical parole, the retributive justice model offers minimal support for compassionate release, as its punitive orientation prioritises proportional punishment and community protection over humanitarian considerations. Decision-making under this model often leans toward incarceration, even when offenders are elderly, frail, or medically compromised, because early release may be perceived as undermining justice. For elderly parolees, this model poses significant barriers to reintegration, as prolonged imprisonment accelerates physical decline, disrupts social ties, and creates dependency. Where release is granted, it often occurs late in the illness trajectory, leaving caregivers and families with sudden, intensive responsibilities and little preparation, thereby compounding reintegration challenges.

In light of its clear deficiencies in adequately tackling the fundamental causes of criminal behaviour and the wider consequences of incarceration, the Retributive Justice Model was later modified. These limitations ultimately led to the development of discussions surrounding the Restorative Justice Model, which will be examined in the subsequent section.

2.2.1.4. The Restorative Justice Model

The Restorative Justice Model aims to address the root causes of crime by placing special emphasis on the needs of the involved community, the offenders, and the victims. This model allows all parties involved in the criminal offence to collaboratively work together in address the negative outcome of crime as well as the future impacts of the crime. The Restorative Justice Model is premised on the belief that crime is a violation of people's relationships, rather than merely the violation of the law (Makiwane, 2015). Similarly, restorative justice is described as follows in the United Nations Handbook on Restorative Justice Programs as:

> *Any procedure wherein the victim, the offender, and, if applicable, any other persons or community members impacted by the crime voluntarily collaborate to resolve issues resulting from the crime, usually with the assistance of a facilitator* (Dandurand, & Griffiths, 2006, p.9).

Although the restorative system seems like a new phenomenon, it is a fitting replacement for the retributive system of correction in South Africa, which resonates with a long history of

African traditional conflict resolution techniques grounded in the concepts of Ubuntu (Mangena, 2015; Skelton, 2007). Similarly, it also has philosophical roots that could be traced to several spiritual and religious rites, indigenous aboriginal practices and customs throughout the world (Eschholz et al., 2003). The following restorative justice processes are used in the criminal justice system in South Africa:

A. Victim and offender mediation (VOM): This programme is aimed at providing a conflict resolution process that will benefit all parties involved in the criminal offence (Umbreit, 1998). The process is facilitated by a mediator who first meets with all the parties separately. These preliminary meetings are critical in fostering rapport and trust with among parties (Umbreit, 1998). More than often this process might take place at either at a South African Police Services (SAPS) referral level or pre-trial stage where the case is referred to mediation by the prosecutor.
B. Family group conferencing: This programme offers the victim the opportunity to pose questions to the offender during the conference proceedings and to allow both the victim and offender to explain the extent to which the crime has impacted on them (Maxwell & Morris, 2001). The community impacted by the offender's acts decides on a reparation arrangement rather than just one individual deciding on the form of punishment. The community impacted by the offender's acts decides on a reparation arrangement rather than just one individual deciding on a penalty. This meeting is usually informal and may occur at any stage of the trial.
C. Victim offender dialogue: The programme is targeted at offenders who have committed serious violations. It is a guided process between the victim and offender, which is undertaken as a dialogue. This programme provides an opportunity for the victim to understand what occurred and why, and for the offender to accept responsibility and show remorse, usually it is the offender who invites the victim to this process and more than often facilitated by a trained social worker (Littman et al., 2024).

Currently, there is a slow but steady growth in literature that suggests that the Restorative Justice Model is effective in facilitating healing and ameliorating trauma among victims who have been harmed (Do Nascimento Ritter et al., 2023; Richards et al., 2017; Solon-Biet et al., 2015). In contrast to the punitive system, which keeps offenders out of the society, the

Restorative Justice Model is beneficial since it facilitates community reintegration by bringing the victim and the offender together (Louw & van Wyk, 2016). Nonetheless, the ambiguous institutional role it occupies within the established frameworks of the criminal justice system creates uncertainty. This ambiguity hampers its reliable implementation and assimilation into conventional correctional practices, thereby prompting inquiries regarding its feasibility as a systemic alternative (Fox & Duggan, 2013).

The interplay between the Restorative Justice Model and the Rehabilitation Model continues to be a topic of theoretical debate. Advocates of Restorative Justice assert that it fosters significant reintegration of offenders, thereby decreasing recidivism through the promotion of accountability, healing, and community participation (Morris, 2002; Shabangu, 2021)). Conversely, detractors question these claims, arguing that Restorative Justice may lack the requisite structure and consistency to effectively address the underlying psychological and behavioural factors contributing to criminal behaviour (Ward & Langlands, 2009). They contend that in the absence of professional therapeutic interventions, offenders may not experience authentic behavioural transformation, and victims could face additional harm if the process is inadequately managed. Given these considerations, I personally advocate for a hybrid approach that synthesizes both models. While Restorative Justice presents significant opportunities for healing and community involvement, particularly in less severe instances, the Rehabilitation Model offers a more systematic framework for tackling criminogenic needs through evidence-based practices. The primary points of contention revolve around the perceived efficacy of community-oriented justice compared to professional, treatment-focused rehabilitation; the adequacy of informal processes in curbing reoffending; and the potential dangers associated with victim-offender mediation.

In relation to medical parole, the restorative justice model encourages decision-makers to consider broader relational impacts, including the offender's accountability, the victim's needs, and the community's role in supporting reintegration. When elderly offenders apply for medical parole, restorative principles guide decision-making toward reconciliation, open dialogue, and the rebuilding of social bonds that may facilitate compassionate reintegration. However, the emphasis on victim participation and community involvement can complicate release for offenders with serious or violent histories, where stakeholders may resist early release despite declining health. For elderly parolees, reintegration under this model can be

more holistic, promoting dignity, closure, and community acceptance-but only when facilitated appropriately and when victims or communities are willing to engage constructively.

Ultimately, I posit that harnessing the strengths of both restoration and rehabilitation presents the most promising avenue for achieving sustainable offender reintegration and enhancing public safety. Expanding upon this discussion, the subsequent segment of this section provides a comprehensive overview of the Rehabilitation Model, elucidating its fundamental principles and examining its relationship with the Restorative Justice framework, whether in contrast or in harmony.

2.2.1.5. The Rehabilitation Model

The Rehabilitation Model rejects the practice of inflicting aimless punishment on offenders and the administration of a merely custodial operation. It views the offender as capable of reformation. This model aims at modifying the offender's behaviour and creating deterrence that will restore the individual to being a law-abiding citizen in their communities. The overall purpose of rehabilitation is to shield society from the negative impacts of criminal activity (Lancelevée & Scheer, 2023). In understanding this model, there is need to properly conceptualise it.

Following the dismantlement of apartheid in South Africa, prisons had to also undergo a "new turn" towards a rehabilitative imprisonment (Gillespie, 2008). This transition was presented as a civilising projected that aimed at shifting from corporal punishment to transforming the mind. As a subsequent result thereof, prisons became correctional centres, which aim at preventing crime through rehabilitation.

Rehabilitation is the term used to describe a range of psychological services intended to help offenders deal with difficulties related to their offending behaviour and to live a non-deviant life (Wormith et al., 2007). It is a planned process of managing offenders who have been found guilty and are serving their sentences (Falshaw et al., 2004). These authors further state that the aim of rehabilitation is not only limited to preparing offenders for life outside of prison but also encompasses a variety of trainings and psycho-social support programmes to equip offenders with a multitude of skills.

Similarly, Muntingh (2005) asserts that the Rehabilitation Model for incarceration is viewed as an approach aimed at achieving human growth and fostering social responsibility by rectifying deviant behaviour. Against this backdrop, for the Rehabilitative Model to be successful, it must consider the unique needs of offenders who access correctional programmes inside and outside the prison doors.

Some of the shortcomings of the traditional Rehabilitation Model include the assumption that offenders must be treated for psychological issues, an emphasis on mechanistic processes at the expense of agency, the adoption of negative intervention goals, the perception of people as a bundle of risk factors rather than as unique individuals, and the failure to recognise that risk is as much a contextual/social factor as a psychological one (Ward & Maruna, 2007). Moreover, the use of a 'one size fit all' approach to rehabilitating offenders remains a major shortfall for the Department of Correctional Services in South Africa (Herbig & Hesselink, 2012).

Within medical parole processes, the rehabilitation model influences decision-making by focusing on whether the offender has engaged meaningfully in correctional programmes and demonstrated behavioural change. For elderly offenders, however, rehabilitation-based criteria often intersect uneasily with the realities of ageing, illness, or cognitive decline, which may hinder programme participation despite genuine need for medical release (Nduli & Mthembu, 2024). Consequently, parole boards must balance programme compliance with humanitarian considerations. In terms of reintegration, the Rehabilitation Model promotes structured support and targeted interventions, yet many rehabilitation programmes are not designed with elderly or medically fragile parolees in mind. This creates a mismatch between institutional expectations and the practical needs of ageing offenders and their caregivers, highlighting an urgent need for age-responsive rehabilitation and reintegration strategies. The next section delves into the different South African programmes aimed at rehabilitating offenders.

2.2.2. Pre and post rehabilitation programmes for offenders

The Department of Correctional Services is mandated to ensure that offenders are reintegrated successfully and are rehabilitated in a secure, safe, and humane environment (Department of Correctional Services, 2005b). In meeting up to this mandate, the Department

of Correctional Service is responsible for implementing programmes that promote a just, peaceful, and safe society, and reintegrating offenders back into communities as law-abiding citizens. This mandate is in alignment with the set international standards for an effective correctional system (Singh, 2005). Moreover, the Department of Correctional Services must also account for the ongoing provision of innovative, affordable, and high-quality services, such as the development, treatment, and reintegration of offenders into the community (Motala & Ramaposa, 2002). In doing so, this section focuses on the roles and functions played by education and vocational, social work, psychological and spiritual care as the nucleus of all the recovery programmes presented by the Department of Correctional Services in South Africa.

2.2.2.1. Education and vocational programmes

Education programmes offered by the Department of Correctional Services are considered effective in reducing and delaying recidivism rates as compared to offenders who do not enrol for these programmes. Providing education and training programmes in correctional institutions affords offenders an opportunity to gain the necessary skills and knowledge required by the job market. Some of the noted benefits of this programme include but not limited to higher chances of employment and a reduced rate of recidivism.

Furthermore, education and vocational training programmes, including adult basic education and training (Grades 1–10), secondary education (Grades 11–12), life skills, occupational and entrepreneurial skills training, and computer-based training, are provided in all South African prisons (Annual report 2000/01:90). Other programmes offered by the Department of Correctional Services include carpentry, woodwork, bricklaying, electrical appliances skills, catering, upholstery, fabric painting, mechanical skills and sewing. Such programmes in prisons fill in the isolation gap created because of confinement by ensuring that offenders continue to increase their level of education while in custody (Harris et al., 2021).

When viewed within the broader African context, similar educational and vocational initiatives exist, though their reach and quality vary significantly across countries. In Kenya, the Kenya Prisons Service offers literacy programmes, agricultural training, tailoring, and carpentry, yet these are often hindered by insufficient resources and overcrowded facilities (Omboto et al., 2013). In Uganda, the Uganda Prisons Service incorporates formal schooling,

literacy programmes, and farming skills, with evidence suggesting improvements in behavioural change and post-release productivity; however, limited funding and an overreliance on manual labour restrict the range of vocational offerings (Turyasingura, 2016). In Nigeria, vocational programmes such as welding, textile production, and agriculture are available, but scholars note that inconsistent funding, outdated equipment, and poor staffing undermine their effectiveness (Awofeso & Odeyemi, 2014). Comparatively, South Africa's structured curriculum, national certification systems, and collaboration with educational authorities place it ahead of many African states in terms of programme organisation and accessibility.

Similarly, Correctional Services Canada provides educational programmes for those incarcerated and parolees who remain under supervision (Correctional Services Canada, 2017). Despite such efforts, the available employment opportunities for offenders are restricted, and those that do exist tend to be low waged, without benefits, and are often temporary positions that offer little growth opportunity for future progress (Harding et al., 2019; Holzer et al., 2003). Moreover, it is worth noting that educational programmes are of little to no benefit to offenders approaching or already within their retirement age; and those who are preparing for their end-of-life care stage (Yates & Gillespie, 2000). Building on the discussion above, the following section explores the social work programmes currently available to support offenders.

2.2.2.2. An overview of social work programmes in the Department of Correctional services

Correctional social work programmes in both custodial and non-custodial settings aim at facilitating individual behaviour change and promoting successful reintegration (Ndlovu, 2017). In measuring the effectiveness of these programmes, correctional social workers rely on indicators such as the ability of the offender to stay out of prison after release or going for a longer period without reoffending, improving behaviour in prison and staying in general population housing units; attempting fewer suicides; continuing education or finding employment; upholding healthy personal and familial relationships; and fulfilling court requirements or finishing treatment (Young, 2014). These indicators assist correctional social workers to measure the impact of their programmes on offenders.

The comprehensive social work programmes developed by the Department of Correctional Services aim at providing services to all types of offenders; offenders sentenced to long-term imprisonment, female or male offenders, parolees, probationers, young or old offenders, able-bodied and offenders living with a disability (Department of Correctional Services, 2006). In meeting the complex needs of the distinct categories above, the Department of Correctional Services has several social work programmes that offer a range of professional services, including empowerment, support, development, and crisis intervention (Maschi et al., 2013). Nevertheless, it is worth noting that both locally and globally, there is scarce evidence on correctional social work programmes' involvement with terminally ill elderly parolees during end-of-life care.

The following sub-sections outlines key social work programmes implemented by the Department of Correctional Services, South Africa. These programmes

- Orientation and Responsibility Programme

The programme is not merely informational but operates as a behavioural conditioning tool. It introduces offenders to the normative and institutional logics of correctional life, shaping their understanding of personal responsibility, institutional authority, and the relationship between compliance and reintegration prospects. However, its effectiveness is contingent on how well these values are internalised by offenders and consistently reinforced by institutional actors. As such, the programme's impact should be assessed not only by its content delivery but also by its capacity to foster agency, moral reasoning, and readiness for reintegration.

- Life Skills and substance abuse programme

The life skills programme is a rehabilitative intervention aimed at enhancing offenders' decision-making capacity and interpersonal competencies. Through a focus on individual and interpersonal development, this programme contributes to a deeper understanding of the behavioural patterns that led to incarceration and encourages pathways toward personal transformation and social reintegration (McCauley et al., 2011).

The substance abuse programme on another hand targets offenders and parolees whose criminal conduct is linked substance use disorder. The aim of this programme is to reduce

use and or harm associated with use; by doing so, it empowers offenders to take control over their lives (Department of Correctional Services, 2018). Both programmes contribute to a rehabilitative framework that views crime not solely as a legal transgression but as a manifestation of broader social, psychological, and behavioural dysfunctions. As such, their efficacy lies in the extent to which they address underlying criminogenic needs and promote sustainable behavioural change within and beyond the correctional setting.

- Family and Marriage Enrichment

The diverse impact of imprisonment on families heightens the risk of divorce for offenders who are married. Research has revealed that after their release, parolees are confronted with the loss of trust that makes it is difficult for them to assimilate into the family system (Sholihah et al., 2021). Therefore, this programme focuses on preserving the family structure and ensuring that parolees and their families are well supported during reintegration.

- Anger Management

The Anger Management programme aims at equipping parolees or offenders with the requisite skills to manage their behaviour when confronted with internal feelings of anger. Social workers use the cognitive behavioural approach to assist offenders to understand the triggers and causes of anger and aggression (Department of Correctional Services, 2018). This programme targets offenders who have committed violent crimes resulting in physical or bodily harm.

- Sexual Offender Treatment Programme

The sexual offender's treatment programme aims to assist offenders to gain control over their sexually abusive behaviour perpetrated without the person's consent. This programme addresses factors that contribute to offending behaviour, victim empathy, self-image, communication, conflict resolution, and relapse prevention.

- Resilience Enhancement Programme (Youth Programme)

This programme aims at equipping youth offenders with the requisite skills to develop resilience and attitude to overcome life challenges whilst inculcating habits geared towards the exploitation of all available self-development opportunities.

Though these programmes offered by correctional social workers cover a range of criminogenic risk factors across all special categories, younger parolees may benefit more than their elderly counterparts (Maschi et al., 2012). Due to the lack of specialised correctional social work programmes, elderly parolees requiring an integrated clinical and geriatric care during end-of-life may experience additional challenges during reintegration as compared to those without a life-limiting illnesses. The next section focuses on the programmes provided by psychologists in the Department of Correctional Services.

2.2.2.3. An overview of the psychological programme in Correctional Facilities

Psychological programmes focus on emotional and mental ills that may have influenced the offender's behaviour, through the assistance of registered psychologists. This programme enables offenders to acquire coping skills and strategies to adjust to the prison environment. These programmes consist of two approaches, which include but not are limited to individual psychotherapy and group therapy (Muthaphuli, 2008). According to Magubane (2016, p.15),

> "…individual therapy, group therapy and family therapy are the methods used by psychologists to ensure the effective treatment of offenders, which will in turn strengthen their rehabilitation. These methods are applied to various forms [categories] of offenders, ranging from ones with suicide [sic] tendencies to ones who request these services themselves."

Some of the prioritised programmes rendered by psychologists include the following:

- Suicide-related risks
- Court referrals
- Persons who have previously received psychiatric or psychological treatment and /or who have a mental illness
- Youths and females
- Aggressive and/or sexual offenders; and
- Persons who request to see a psychologist

Scanty research exists on the effectiveness of psychological programmes meant to rehabilitate and reintegrate elderly offenders (Brooke et al., 2020). An additional point to note is the relationship between advanced ageing, reintegration after incarceration and limited social support available, which are considered as factors linked to mental health support (Dobmeier et al., 2017; Western et al., 2015; Wyse, 2018). Against this backdrop, a report drafted by the Commission for Gender Equality (CGE) in 2017 suggests that psychological services and programmes offered by the Department of Correctional Services were found to be inadequate and failed to meet the mental health needs of both offenders and parolees. The following section focuses on spiritual care programmes in the Department of Correctional Services.

2.2.2.4. Spiritual Care Programme

A paucity of literature documented by criminologists suggests that spiritual care programmes play a critical role in the rehabilitation and reintegration of offenders (Johnson & Larson, 2003; Kleiman & Hollander, 2011; Maruna et al., 2015). Spiritual care programmes deal with the rendering of faith-based programmes as part of the offender's rehabilitation. Religious organisations are permitted to provide spiritual care to those offenders who align with their religious philosophy. Research has shown that religious teaching and education promote healing and wholeness that empowers offenders to be able to locate themselves in the world, thus fostering a sense of group identity (Dunn et al., 2023). The figure below illustrates how local churches benchmark social work interventions and programmes at Community Corrections.

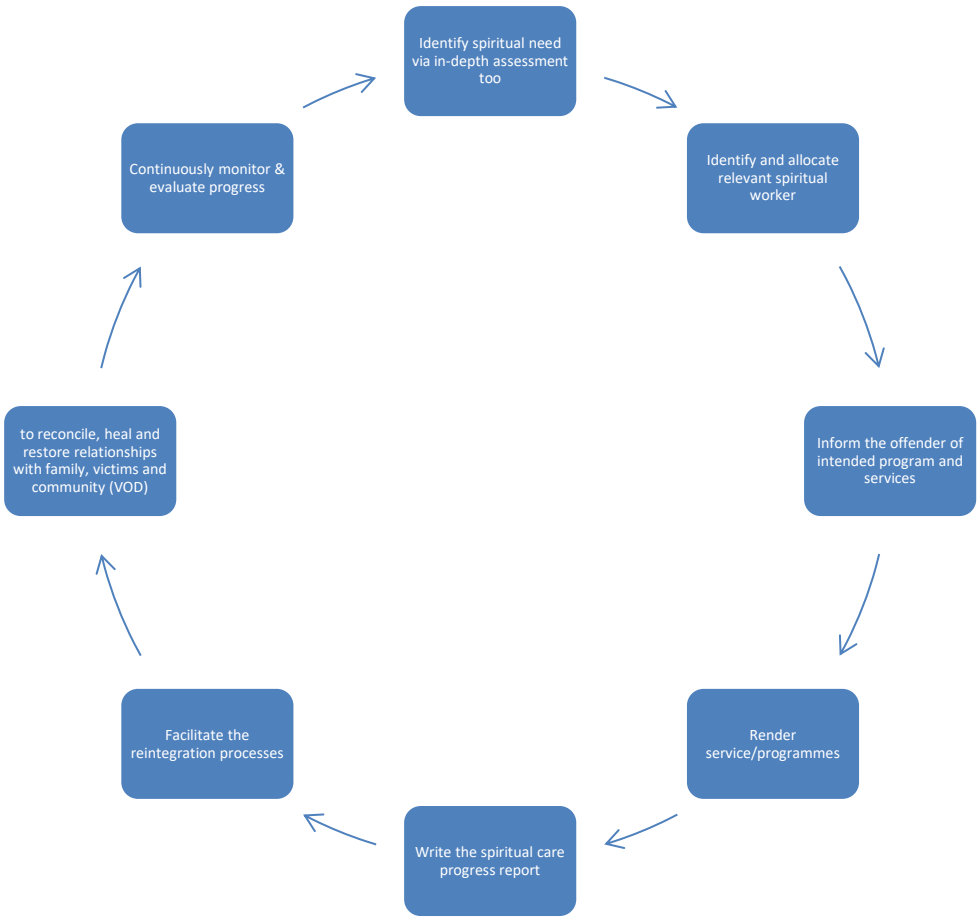

Figure 2.1: The process guiding spiritual services and programmes for parolees at Community Corrections

Source: Okoro (2024)

Moreover, the available research also points to spiritual care programmes as an effective vehicle for reducing the rate of recidivism (Okoro, 2024). While this is so, offenders or parolees seeking protection use religious programmes as a shield from negative experiences of being considered as the out-group; this is common for sexual offenders, homosexuals, and offenders who are HIV positive (Dammer, 2013). Similarly, Tlale (2022) note that offenders who are considered physically weak or effeminate are more likely to be part of spiritual care programmes as a form of protection. Noticeably, the relationship between end-of-life care and spiritual programmes is still unknown, which is also the case with the meaning that it has for terminally ill offenders. The next section introduces the role players in the Department of Correctional Services (in South Africa).

2.2.3. The key role players in the Department of Correctional Services

Several key stakeholders within the Department of Correctional Services (DCS) play an integral role in the delivery and implementation of rehabilitation and reintegration services in South Africa. This section critically examines the primary role players involved in this process, namely: the offender, the correctional official, the correctional social worker, the victim of crime, and the broader community. Each actor occupies a unique position within the rehabilitative framework and contributes to the dynamic interplay that underpins effective reintegration.

Du Preez and Luyt (2006, p. 156) emphasise the importance of external stakeholders in facilitating offender rehabilitation, highlighting that reintegration cannot be achieved solely through institutional efforts. Instead, a collaborative, multi-sectoral approach is essential one that bridges the gap between custodial interventions and community-based support systems. This underscores the necessity of inclusive, participatory models in correctional rehabilitation that extend beyond institutional confines and actively engage civil society, victims, and community structures in the reintegration process.

2.2.3.1. Offender

Successful rehabilitation depends on the offender's changed behaviour, which includes but is not limited to accepting their disposition and attitude (Cilliers, 2008). This simply implies that rehabilitation requires offenders to be willing and fully committed to changing their behaviour as a step towards healing from the past (Muthaphuli, 2008). Offenders are expected to use the duration of their imprisonment productively by equipping themselves through participating in developmental programmes (Labane, 2012). Offenders are often categorised based on the type of offence they have committed, age and gender markers. This form of categorisation allows the Department of Correctional Services to render suitable programmes for them. The White Paper on Corrections (2005) highlights the following special categories of offenders:

- *Children in detention*: The Department of Correctional Services recognises children in detention as those who require different service delivery and must be accommodated separately from other offenders. Similarly, the White Paper on

Correction (2005) contends that children should be kept out of correctional facilities and steered away from the criminal justice system wherever feasible. If this is not possible, children should be placed in a secure facility specifically intended for them. Furthermore, The White paper asserts that children under the age of 14 should not be placed h in correctional facilities. Instead, it advocates for their placement in diversion programmes administered by the Department of Social Development, in alignment with child-centred and rights-based approaches to juvenile system

- *Youth offenders*: The crime rate among young offenders between 12 and 18 years old is considered the highest as compared to other categories of offenders (Morey, 2023). The available research also indicates that young parolees face several challenges upon release such as a lack of employment (Langa & Masuku, 2015).

- *Female offenders*: According to the Maruna et al., (2022), the population of female offenders in South Africa significantly increased over the years from 2.5% in 2002, to 2.6% in 2015. Agboola et al. (2022) argue that due to the low population of female offenders in correctional centres, the available research focuses more on male offenders than on their female counterparts. The Correctional Services Act (No. 111 of 1998) outlines specific provisions aimed at safeguarding the rights and well-being of female offenders. These include the mandatory separation of female and male inmates, prioritisation of adequate nutrition for pregnant women, and the development of gender-sensitive infrastructure, policy, and planning. Moreover, the Act places an obligation on the Department of Correctional Services to implement programmes that are attuned to the distinct psychosocial, health, and rehabilitative needs of women. These measures reflect a broader commitment to a gender-responsive correctional framework that recognises the intersectional vulnerabilities experienced by female offenders within the criminal justice system

- *Offenders living with disability*: Disability is defined as a person who suffers from an impairment or loss of any psychological or anatomical function, as a result they are restricted from performing tasks like anyone else in the general population (Kaplan, 2000). The White Paper on Corrections [South Africa] (2005) considers offenders

living with disability as a special category of offenders and encourages correctional institutions to design suitable programmes to accommodate and cater for their needs.

- *Elderly offenders*: This category consists of offenders aged 55 and above is noticeably the fastest growing population of offenders in correctional institutions (Carson & Sabol, 2016). Elderly offenders are associated with adverse health needs, which require frequent medical attention. According to the White Paper on Corrections [South Africa] (2005), the Department of Correctional Services must ensure that appropriate medical care is integrated as part of the case management system in correctional centres.

- *Mentally ill offenders*: Gaffney et al. (2024) argue that poor mental health is more prevalent among offenders who are incarcerated as compared to the general population. It is worth noting that, the intricate interplay between mental health illnesses and criminal behaviour presents a barrier for mental health service providers when dealing with offenders who suffer from psychiatric disorders (Krona et al., 2017). Therefore, the White Paper on Corrections [South Africa] (2005) provides that employees under the Department of Correctional Services must be trained to recognise signs of poor mental health and should under strict orders immediately report to the head of the correctional centre.

- *First-time offenders*: This category of offenders consists of those who are sentenced for the first time, usually such an offender is sentenced for a short duration and must be separated from those who are considered repeat offenders. During their adjustment period to prison life, first time offenders are more likely to experience severe stress and this is largely due to prevailing personal and/or correctional conditions, which are linked to depression, anxiety, suicidal ideation, social withdrawal, self-mutilation, and hostility (Asberg & Renk, 2012; Dachs & Santos, 2006; DeVeaux 2013; Peacock, 2008; Picken, 2012; Tomar et al., 2017).

- *Offenders with long-term sentences*: The prison population is mostly composed of offenders who are serving lengthy sentences for serious offences which include but not limited to murder. The available research suggests that offenders who have severed lengthy sentences tend to experience complication when returning to the

community (Khwela, 2014). This concern is linked to poorer mental health as an inevitable consequence of being in behind prison bar for a prolonged period (Naidoo & Mkize, 2012). It worth noting that offenders serving lengthy prison sentences tend to be appear older than the population outside prison (Khwela, 2014)

- *Detained offenders who are foreign nationals*: Foreign nationals who are detained in correctional centres are treated as any South African citizen. The Department of Correctional Services is responsible for identifying foreign nationals who are detained in its facilities and reporting such individuals to the Department of Home Affairs (Singh, 2017). Though prison demographics reveal a continued increase in detained foreign nationals, little is known about the experiences of foreign detainees released on parole.

Offenders contribute to the medical parole process by providing accurate information regarding their health status, functional limitations, and daily living challenges. Their willingness to participate in medical assessments, disclose symptoms, and comply with treatment recommendations enables medical professionals and the Parole Board to determine eligibility for medical parole. The offender's conduct, disciplinary record, and level of cooperation also inform the Board's evaluation of risk and readiness for supervised release. Having outlined the special categories of offenders and the programmes designed to meet their unique needs, the next section examines the critical role played by correctional officers in facilitating rehabilitation and supporting the reintegration process.

2.2.3.2. Correctional officer

Correctional officers play a critical role in guiding, mentoring, and facilitating rehabilitation services in the Department of Correctional Services. Scott et al. (2006) aver that one of the responsibilities of correctional officers is to provide care. They also have to oversee the transfer of prisoners from prison to reintegration offices, register and admit new offenders, assign offenders to community service, and handle complaints and forward them to the appropriate office. Under community corrections, correctional officials serve as liaisons between the community and the institution, helping released offenders settle into halfway houses or treatment centres, find jobs, and reintegrate successfully. It is apparently clear that correctional officers spend most of their time working with offenders and been identified as

having a positive impact on treatment and illness (Applebaum et al., 2004; Dvoskin & Spiers, 2004). Therefore, it is not surprising that correctional officers are at risk of physical harm and or experiencing a traumatic event that has adverse psychological effects on their mental health. Moreover, the available literature reveals that correctional facilities remain understaffed, which compromises the quality of rehabilitation services. A study conducted by Mthethwa and Sibanyoni (2020) found that the shortage of correctional officers was a contributing factor to sexual assault among male prisoners. It is worth noting that correctional officers not only view their working environment as hostile, but they also perceived it as being stressful (Gutfraind, 2010). The next part of this section highlights the role of social workers in the Department of Correctional Services.

2.2.3.3. Correctional social worker

Correctional social workers play a vital role in the implementation of rehabilitation services and assisting offenders to transition in and out of prison. The critical role played by social workers is well captured in the following definition of social work by the International Federation for Social Workers (2014), which stipulates that:

> "Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing."

Guided by this definition the role of social workers was expanded to provide:

- Community-based rehabilitation services,
- Diversionary programmes,
- Assistance for reintegrating offenders into society,
- Psychosocial support to offenders,
- Social services for the families of parolees,
- Victim advocacy.

The above social work services are executed through the methods of casework, group work and community work (Murhula et al., 2019). The social worker's goal is to assist the offender in altering their behaviour patterns so they can fit in society. This is accomplished in two ways: (1) by working with individuals to recognise and value their skills and resources, and (2) by altering the surroundings to produce a very favourable social environment in which they reside (Skidmore et al., 1961, as cited in Shakil, 2015). Shenk (1991, p. 91) argue that the main goal of social work is "to utilize the knowledge and skills of the profession in a corrective manner, to rehabilitate individuals, to assist them to help themselves so that they can return to and become part of society." Although social workers are well known for their role played in juvenile services, little is known about their role in working with the families of offenders. After release, social workers become the primary coordinators of ongoing support. They monitor compliance with parole conditions, provide ongoing counselling, mediate family tensions, and link parolees to social grants, palliative care services, or old-age homes. A lack of adequate social work aftercare can lead to caregiver strain, breakdown of support structures, or re-victimisation, making the monitoring role essential in preventing reoffending and ensuring dignified end-of-life care.

In fulfilling their rehabilitative duties and responsibilities, social workers encounter a range of institutional and systematic challenges that impede the effective delivery of services. Mnguni and Mohapi (2015) highlight that a significant constraint stems from the predominantly generic nature of social work training in South Africa which lacks specialised curriculum tailored to the correctional context. This training gap limits practitioners' capacity to respond adequately to the complex and evolving needs of incarcerated populations. The growing presence of elderly offenders within correctional centres many of whom present with terminal illnesses and age-related mental health conditions further intensifies the demand for specialised interventions (Chapman & Ivanoff, 2017). Consequently, there is an urgent need to integrate palliative and end-of-life care competencies into correctional social work training. Considering these challenges, it is not surprising that the critical role played by post incarceration social work programmes for parolees do not have a strong focus on post-release support services for ex-offenders (Gupta & Singh, 2016).

Similarly, Nduli and Mthembu (2022) found that not only are social programmes not suitable for elderly parolees, but correctional social workers faced backlash from correctional

officials, making it difficult for them to work collaboratively in facilitating rehabilitation programmes during reintegration. An article written by Wako and Gebru (2020) noted that there is limited awareness from support staff and offenders on the mandate of correctional social workers in Ethiopia. A plausible reason for this could be that fact that correctional officials view social workers as being too soft to work in the correctional environment simply because of their values about people (Shakil, 2015). Nevertheless, it remains unclear how social workers assist the families of elderly parolees released on medical parole during their end-of-life care stage, which this study is seeks to explore. The next section focuses on the role of the victim in the rehabilitation pathway.

2.2.3.4. Victims of crime

The position of victims in the criminal justice system continues to receive considerable attention from policy makers and advocates of victims' rights (Braun & Braun, 2019). Booth (2016) argues that the role of victims of crime has been limited to that of being a witness and are often not regarded as stakeholders by the criminal justice system. This concern has been addressed through several declarations, the most significant of these was the United Nations General Assembly's adoption of the Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power on November 29, 1985, which acknowledged and addressed victims' concerns on a global scale (Müller & Der Merwe, 2006). With a focus on restorative justice in South Africa, the Department of Correctional Services is dedicated to working collaboratively with both victims and offenders in fostering reconciliation and restoring family relations through victim offender dialogues and victim offender mediation programmes under the chaplain.

In alignment with the international declaration, domestic legislative and policy reforms to increase victim participation in the parole process have made great strides in South Africa (Louw, 2021). Against this backdrop, the former Minister of Justice and Correctional Services (Michael Masutha) criticised the parole system for demonstrating insufficient empathy for the victims of crimes. He argued that meaningful engagement with the victims or their families should be a fundamental component of parole decision making (Hales et al., 2015). Therefore, the inclusion of victims in the parole process coincides with the South African Victim Charter of Right Act 2006, which aims at ensuring that victims are afforded

the opportunity to make their voices heard in the criminal justice system (Singh, 2014). Victims contribute to medical parole decisions by providing impact statements, expressing safety concerns, and articulating their views about the offender's release. Their participation helps the Parole Board assess community risk, emotional harm, and the need for protective conditions. Victim input is increasingly recognised as a necessary component of transparent and restorative parole processes.

Therefore,victim concerns influence aftercare conditions such as geographic restrictions, reporting frequency, or no-contact orders. If victims feel uninformed or excluded, community resistance may increase, which can undermine reintegration efforts. Alternatively, meaningful victim engagement can enhance community acceptance and promote safer reintegration environments, provided that confidentiality and safety are maintained. The next section explores the pivotal role the community plays in supporting the reintegration of offenders.

2.2.3.5. Community

Zondi (2012) argues that there is little knowledge from communities regarding the return of offenders in their communities. Yet delinquency is viewed as a result of the failure of both the community and the individual offender (Champion, 2005). This therefore means that communities have a significant role to in ensuring that offenders are rehabilitated and reintegrated successfully. However, a study conducted by Zondi (2012) revealed that community members lacked information on what happens when an offender is incarcerated and often were curious about why an offender would be brought back before they finish the sentence imposed. Although South African laws and policies emphasize the importance of community involvement in the reintegration of offenders, in practice, this involvement is often fragmented and insufficient. Community members are typically engaged only during the initial stages such as reporting the crime or participating in victim-offender dialogues but are frequently excluded from subsequent processes, including decisions about parole, early release, or post-release monitoring. This partial involvement creates a disconnect and fosters miscommunication and mistrust between the community and the criminal justice system.

Community members may feel side-lined when offenders are released without their knowledge or input, especially in cases where they were directly affected. This lack of

transparency and ongoing communication undermines public confidence in the correctional system and impedes the successful reintegration of ex-offenders. As Jonker (2011) points out, reintegration is not solely the responsibility of the Department of Correctional Services it requires meaningful collaboration with communities. Without this, reintegration efforts risk failure, as offenders may return to environments that are hostile, uninformed, or unprepared to support their rehabilitation. Therefore, to truly implement a restorative and inclusive justice model, the Department of Correctional Services must go beyond policy statements and actively foster continuous, transparent engagement with communities throughout the entire correctional and reintegration process. Communities contribute by offering informal support networks, hosting parolees, and participating in restorative justice processes such as victim–offender dialogues. Community institutions including churches, NGOs, clinics, and traditional leaders provide essential resources that complement state services. Their perceptions and willingness to receive parolees influence the Parole Board's assessment of reintegration feasibility.

The available research indicates that offenders released from prison frequently encounter exclusion and social isolation, both of which severely hinder their reintegration into society (Nduli & Mthembu, 2022). Community attitudes play a decisive role in shaping the parolee's reintegration trajectory. Supportive communities can ease this transition by facilitating access to care, reducing stigma, and promoting social inclusion. Conversely, hostile or uninformed communities may further marginalise parolees, restrict their access to essential services, and create barriers that exacerbate poor health outcomes or heighten the risk of reoffending. Continuous communication between correctional services and communities is therefore critical for building the trust and collaboration needed to sustain effective aftercare. When communities fail to play a constructive role, rehabilitation efforts become substantially undermined. Jonker (2011) underscores the potential of community-based social institutions to provide emotional and spiritual support that meaningfully assists offenders as they reintegrate. Similarly, McAlinden (2007) argues that strong social support networks and active community involvement are indispensable to creating a sustainable and effective rehabilitation system. Poor health remains one of the major drivers of early release under the parole system, necessitating a closer examination of the adequacy of correctional health care services. Accordingly, the following section critically explores correctional healthcare

systems and their capacity to provide appropriate medical support to both incarcerated and paroled individuals.

2.3. Correctional Health Care systems and Inmate well-being

Healthcare in the correctional setting is receiving more attention due to the unusually high illness load of those behind bars (Bai et al., 2015; Wangmo et al., 2015). Therefore, this means that it is important to understand the manner in which incarceration affects the health of those who are incarcerated and those who are being reintegrated back into society. Binswanger et al. (2009) found that incarcerated individuals in the U.S. exhibited a higher burden of chronic medical conditions compared to the general population. However, despite these findings, comprehensive data on the prevalence of chronic health conditions in correctional centres particularly in countries like South Africa remains limited. This gap in data makes it difficult to develop targeted healthcare policies and adequately address the healthcare needs of incarcerated populations. A plausible reason for such a high burden of illness could be linked to the circumstances before, and during incarceration (Bai et al., 2023).

Binswanger et al. (2009) emphasise that individuals in prison often come from economically disadvantaged backgrounds and generally have low educational attainment. Many report significant substance abuse issues prior to their incarceration. While imprisoned, they often face poor nutrition and restricted physical activity. Additionally, a considerable number suffer from mental health and neurological disorders, including schizophrenia, depression, and epilepsy, which complicate the treatment of chronic health conditions. Furthermore, their risk of infectious diseases is exacerbated by high-risk behaviours such as intravenous drug use and unprotected sexual practices.

The following section is structured into three subsections, each focusing on a key health concern affecting incarcerated offenders and those released on parole: (1) mental health conditions, (2) communicable diseases, and (3) non-communicable diseases.

2.3.1. Mental health of offenders and Parolees

Overwhelming evidence indicates that offenders and parolees frequently experience poor mental health, which can manifest during incarceration and persist or worsen during the transition to parole (Asberg & Renk, 2014; Fraser et al., 2009; Gavin et al., 2014; Blackburn,

2000; Islam-Zwart & Vik, 2004; Nduli & Mthembu, 2022). In South African correctional centres, empirical research shows a disturbingly high prevalence of mental-health disorders among female offenders, including psychotic, depressive, and trauma-related disorders, alongside a very high HIV prevalence rate of 64.3% (Naidoo et al., 2022). Women now comprise approximately 3.2% of the total incarcerated population in South Africa (World Prison Brief, 2024), underscoring their minority status in a system largely designed for male offenders (Steyn & Hall, 2015).

The combination of elevated mental-health burden, high HIV prevalence, and rehabilitation programmes poorly adapted to female offenders presents significant challenges for medical parole. Many female inmates may be released without having received adequate medical or psychological stabilisation, which increases the risk of deterioration, unsuccessful reintegration, and potential reoffending. In line with the Correctional Services Act (No. 111 of 1998, as amended), offenders with serious health conditions including mental illness may qualify for early or medical parole, highlighting the importance of accurate diagnosis, treatment, and planning before release. This underscores the need for gender-sensitive, adequately resourced health services and aftercare programmes that recognise the unique vulnerabilities of female parolees.

Elderly offenders similarly face chronic and progressive mental health challenges, including dementia, major depression, and schizophrenia, often compounded by comorbidities and underdiagnosis (WHO, 2016; James & Glaze, 2006; Kakoullis et al., 2010; Naidoo et al., 2022). Reports show that older offenders frequently experience death anxiety and elevated suicide risk (Aday, 2005; News24, 2019). Suicide remains the leading cause of unnatural deaths in South African correctional centres, accounting for over 37% of deaths, with 32 completed suicides and 35 attempts reported in 2020/2021 (Judicial Inspectorate for Correctional Services, 2022).

These findings have direct implications for medical parole. Offenders with significant mental-health conditions, particularly those at high risk of self-harm or suicide, require thorough clinical assessment, integrated care plans, and structured aftercare arrangements before and after release. Without these measures, medical parole decisions risk releasing individuals into communities without sufficient psychological or medical support,

undermining both their rehabilitation and broader public safety. Consequently, mental health screening, treatment, and ongoing support are essential components of a medically justified parole process, ensuring that vulnerable offenders receive the care necessary for successful reintegration.

2.3.2. Communicable diseases affecting offenders

Exposure to risk factors for disease has long been recognised by epidemiologists as a crucial factor in the aetiology of health and illness (Massoglia, 2008). The surging number of incarcerated offenders and those serving lengthy sentences has culminated in overcrowding, a persistent challenge for the Department of Correctional Services. The risk of contracting infectious diseases is significantly elevated during incarceration, driven by various contributing factors such as overcrowded living conditions, exposure to sexual harassment, heightened psychological stress, unregulated tattooing or body piercing practices, and poor ventilation within correctional facilities (Marques et al., 2011). As a result, several researchers have highlighted this issue as a health crisis, emphasizing that the spatial limitations, including small prison cells, constitute a significant public health concern in correctional facilities (Legodi & Dube, 2023; Manna et al., 2022; Walmsley, 2003). Madeddu et al. (2019) found that the prevalence of viral hepatitis in European prisons, exceeds that observed in the general population.

Similarly, findings from a systematic review by Baussano et al. (2010) also indicate that the risk of latent tuberculosis is significantly higher among prisoners than the general non-incarcerated. In Portuguese correctional facilities, the prevalence of infectious diseases is significantly higher compared to the general population. Specifically, incarcerated individuals exhibit rates of HIV that are 8 to 10 times higher, hepatitis C (HCV) rates that are 9 to 10 times higher, and tuberculosis rates that are 4 to 17 times higher than those observed in the surrounding community (Marques 2011, p.272). Therefore, this means that correctional services across the globe are presented with a unique opportunity to make quality healthcare services available.

Similarly, in sub-Saharan African prisons, issues of overcrowding not only contribute to airborne diseases such as tuberculosis but were also linked to cases of sexual violence, rape, and unsafe injecting practices (Reid et al., 2012). These circumstances heightened the risk of

sexually transmitted infections (STIs) including human immunodeficiency virus (HIV). Nevertheless, HIV positive offenders are estimated to be 20 times higher than the general population in terms of developing active tuberculosis (Ruger & Yach, 2009). Further, over 70% of offenders with tuberculosis are coinfected with HIV in sub-Saharan Africa despite the provision of antiretroviral therapy (ART), condoms and Pre- and Postexposure Prophylaxis, the Department of Correctional Services is still faced with a growing epidemic (Reid et al., 2012). Noticeably, most of the literature pertaining to communicable diseases in sub-Saharan Africa is still sparse and the available is outdated (Baussano et al., 2010; Massoglia, 2008). The next part of this section focuses on noncommunicable diseases affecting offenders.

2.3.3. Noncommunicable diseases affecting offenders

Globally, noncommunicable diseases are among the leading causes of deaths, amounting to 71% of the global mortality (Samodien et al.,2021, p.51). South Africa is among those countries leading in noncommunicable diseases (NCDs) such as cardiovascular diseases, cancer, diabetes, respiratory illnesses, and mental disorders (de Mestral & Stringhini, 2017). Similarly, some studies documented that several NCD conditions, including cardiovascular diseases (CVDs) and cancer, are among the most common causes of death in prisons (Wang et al., 2017; Manna, 2022). In the context of correctional institutions, offenders are a vulnerable group who, compared with the general population, experience poorer health outcomes (Wright & Allgar, 2019). Even though it has been proposed that pre-existing factors such as demographics, ethnicity, and low socioeconomic status contribute to the effects of incarceration on some NCDs, such as CVDs, certain conditions may be linked to the prison environment itself or they are exacerbated while incarcerated (Brooke, 2023). An estimated 30 million individuals, the majority of whom experience significant social and economic disadvantages, transition between correctional facilities and communities worldwide each year (Brooke, 2023).

Some criminal justice scholars and health researchers argue that incarcerated individuals may experience *premature* or *accelerated aging* due to the cumulative impact of chronic illnesses and exposure to harmful health-related conditions. Within this context, older offenders face a heightened risk of developing chronic or geriatric conditions that may progress to terminal

illness. Yelderman et al. (2018, p. 4) observed that "among older adults in jail with an average age of 59, the prevalence of several geriatric conditions was similar to that found among community-dwelling adults aged 75 or older." Given their compromised health status, medical parole may be a more appropriate response for elderly offenders. However, limited research exists on the experiences of caregivers and correctional social workers involved in the reintegration of those granted medical parole. The following section examines the processes surrounding medical parole placement and its supervision.

2.4. Parole and social reintegration

Parole provides sentenced offenders with an opportunity to serve the remainder of their sentence in the community, under the structured supervision of community corrections, a division of the Department of Correctional Services (DCS) responsible for managing and monitoring parolees' conduct post-incarceration. The underlying objective of parole is to facilitate the offenders' rehabilitation and reintegration into their respective communities and promoting law-abiding and socially responsible behaviour. When effectively implemented, parole has the potential to reduce recidivism by supporting successful re-integration pathways. Consequently, parole serves as a mechanism not only for alleviating overcrowding in correctional centres but also as a critical strategy for fostering greater community involvement in the rehabilitating process (Flesaker & Larsen, 2012). Parole is not only considered when offenders have served a minimum percentage of the sentence, but also when offenders have been diagnosed to be in the final stages of a terminal illness (Ddamulira-Mujuzi, 2007). In such instances, the Republic of South Africa's Correctional Services Act 111 of 1998 provides for the release of terminally ill offender on medical parole with the aim of allowing them to have a consolatory and dignified death (Ddamulira-Mujuzi, 2007). In essence, medical parole is largely concerned with reintegrating an offender who is ill back into society, a process that lies at the core of the current research study.

The available literature suggests that offenders on parole usually have limited work experience, have not completed high school, and suffer from physical and mental health issues as well as drug illnesses (National Commission on Correctional Health Care [NCCHC], 2002; Watson et al., 2004). The incidence and range of health issues experienced by parolees are frequently higher than in the general community (Watson et al., 2004). It is

clear that parolees are confronted with several challenges when released, therefore the perspective of caregivers and correctional services providers constitute a research gap this study aims to address.

While the reintegration phase is ideally about forming strong ties with families and creating job opportunities, this is however not the reality for elderly offenders released on medical parole (Cobbina, 2010; Graffam et al., 2004; Hall et al., 2001; O'Brien & Daffern, 2017). The existing literature indicates that the communities to which parolees typically return are often economically disadvantaged, characterized by limited employment opportunities, inadequate housing options, and weak or absent social support networks (Krivo & Peterson, 2004; Raphael, 2011; Sampson & Raudenbush, 1999; Xu et al., 1995). The available literature is not clear on the manner in which a medical illness may affect the reintegration process, an area this study seeks to explore. The following section explores the relationship between aging and medical parole, shedding light on the unique difficulties faced by elderly offenders.

2.5. The relationship between elderly offenders and medical parole

Elderly offenders represent a particularly vulnerable subgroup within correctional populations, as they are at increased risk for deteriorating health and tend to experience the onset of age-related illnesses significantly earlier than their non-incarcerated peers (Pro & Marzell, 2017). Gerontological literature characterises the ageing process as a period marked by substantial psychosocial challenges, including the loss of income, reduced social status and roles, bereavement, and increasing isolation often exacerbated by disability and cognitive decline. These factors contribute to heightened levels of depression, loneliness, diminished family support, and reduced self-esteem among older individuals (Leshnick et al., 2012). Within correctional settings, these stressors are often intensified by the prison environment, with Chiu et al. (2020) noting that incarcerated individuals tend to exhibit age-related illnesses 10 to 15 years earlier than those in the general community. This accelerated ageing highlights the need to conceptualise older offenders as a distinct category requiring specialised healthcare and psychosocial interventions, both during incarceration and after release. Their unique needs underscore the importance of age-responsive policies, particularly regarding medical parole and reintegration planning.

In South Africa, budget constraints particularly the high cost of housing terminally ill and elderly offenders has prompted the Department of Correctional Services to explore more financially sustainable alternatives. According to Pro and Marzell (2017), these alternatives include early medical parole, community-based palliative care, and partnerships with non-governmental organizations that specialise in hospice services. While these programmes aim to reduce costs, they also raise ethical and logistical challenges regarding adequate care and public safety. Therefore, any discussion of cost-effectiveness must be accompanied by a clear explanation of these initiatives and an evaluation of their broader social impact. The severity of the sickness mostly determines the suitability of medical parole, the competence of the prison medical clinic to treat the disease, and the financial ramifications of continuous imprisonment (ACTION, 2007).

According to the Correctional Services Act No. 111 of 1998 of the Republic of South Africa, an offender serving a custodial sentence excluding those awaiting trial may be considered for release on medical parole or placement under correctional supervision if diagnosed as being in the terminal stage of a life-threatening illness or condition. This determination must be based on the written testimony of the treating medical practitioner. The decision may be made by the National Commissioner, the Correctional Supervision and Parole Board, or the court, depending on the circumstances. The provision aims to ensure that terminally ill offenders are afforded the opportunity to die in a humane and dignified environment (Correctional Services Act, No. 111 of 1998). Despite the ethical rationale underpinning medical parole, there remains limited empirical evidence on whether such placements meaningfully enhance the quality of care or support systems available to terminally ill offenders during the reintegration process. This gap raises concerns about the adequacy of post-release healthcare and the broader societal and family readiness to accommodate medically vulnerable parolees.

Elderly offenders appear to be more likely than younger offenders to be granted medical parole due to their complex needs. This demographic trend/ pattern underscores the need to evaluate the capacity and responsiveness of community correctional centres in facilitating the reintegrating medically ill elderly parolees. The empirical data on how these systems accommodate such individuals remains limited particularly in the South African context. The next following section critically examines the implementation and the application of medical parole, with emphasis on its relevance for ageing and terminally ill offenders.

2.6. Application of the release of offenders on medical parole in South Africa

On the 1st of March 2012, a single central medical parole review board was established to review all the petitions for medical parole, which were now permitted due to incapacitating diseases as well as fatal illnesses (Bateman, 2012). Established under the Correctional Matters Amendment Bill Act 5 of 2011, the new organisation is unaffiliated with the government and is free to consult with as many experts as it wishes. In the past, the 52 general parole boards had the authority to request expert medical advice, but this authority was subject to misuse and selective prejudice due to the influence of the medical officer in each prison district.

2.6.1. Understanding medical parole in South Africa

This section covers the criteria that must be met by an offender to be considered for a medical parole, the process that must be followed to apply for medical parole; the way in which the medical advisory board is structured, and finally a closer review of Section 79 of the Republic of South Africa Correctional Services Act (111 of 1998). According to Regulation 29(A) (3) of the Republic of South Africa Correctional Services Act, the head of a correctional facility is required to forward all applications for medical parole to a correctional medical professional for review in accordance with the provisions of Section 79 of the Act. The Medical Parole Advisory Board (MPAB) should receive a written recommendation from the correctional medical professional about the presence or absence of the requirements outlined in Section 79 of the Republic of South Africa Correctional Services Act. The principal function of the 10 medical professionals that make up the MPAB provide an "independent medical report to the Minister of Correctional Services, the Correctional Supervision and Parole Board, or the National Commissioner of Correctional Services, as the case may be." Therefore, when the MPAB establishes that an offender is terminally ill or incapacitated, medical parole is not automatically granted. The correctional regulations compel the board to issue a recommendation on the "appropriateness of granting medical parole in accordance with section 79" and Regulation 29A (7) of the correctional services department.

Logically, the MPAB is in a position to decide the medical elements of an application and to advise the commissioner on the treatment and circumstances that are consistent with improving the quality of life for offenders. The commissioner should then assess whether the

correctional institution has the resources to implement such guidelines in caring for an offender. As alluded earlier that the release of offenders on medical parole is regulated by Section 79 of the Republic of South Africa Correctional Services Act 111 of 1998. Due to various prevailing controversies, this section was later amended on the 1st of March 2012 by the Correctional Matters Amendment Act 5 of 2011. Before the amendment of Section 79, medical parole assumed that the offender will die soon after release (Ddamulira Mujuzi, 2009), which stipulated that

> "Any person serving any sentence in a correctional centre and who, based on the written evidence of the medical practitioner treating that person, is diagnosed as being in the final phase of any terminal disease or condition may be considered for placement under correctional supervision or on parole, by the Commissioner, Correctional Supervision and Parole Board or the court, as the case may be, to die a consolatory and dignified death".

The amendment of the previous medical parole system intended to address the following shortcomings in the existing statutory framework:

- Restricting the granting of medical parole to offenders who are nearing the end of their lives has the unintended consequence of keeping other offenders who are gravely ill or similarly disabled—for example, from a severe stroke—detained in Correctional Centres despite the Department's lack of the resources—both human and financial—to adequately care for them (Letlape & Dube, 2023).
- Medical professionals found it difficult to verify that a person is in the latter stages of a terminal disease, thus they were hesitant to suggest that an offender be placed on medical parole. Furthermore, because of the media and social pressures surrounding their recommendations, medical professionals were hesitant to recommend placement on medical parole under the narrow definition that was in effect, even though 60% of these inmates did not die after being placed on parole. At the same time, a considerable number of natural deaths occurred in Correctional centres every year due to the medical community's unwillingness to suggest that prisoners be placed on medical parole so they might pass away in peace and dignity outside (Muntingh, 2022).

According to Section 2 of the Act, the correctional system's goals include upholding court orders, keeping offenders in secure custody, and respecting their human dignity in order to help preserve and safeguard a just, peaceful, and safe society. It was suggested that while

implementing medical parole, a balance be made between the need to guarantee that offenders who are gravely sick be treated with respect and making sure that their release does not constitute a substantial risk to society. Considering this mandate, Section 79 was amended to "any sentenced offender may be considered for placement on medical parole, by the National Commissioner, the Correctional Supervision and Parole Board or the Minister, as the case may be, if

> (a) such offender is suffering from a terminal disease or condition or if such offender is rendered physically incapacitated as a result of injury, disease or illness so as to severely limit daily activity or inmate self-care
>
> (b) the risk of re-offending is low; and
>
> (c) there are appropriate arrangements for the inmate's supervision, care and treatment within the community to which the inmate is to be released

The amendment of Section 79 paved the way for a broader discerption and requirements of sentenced offenders who qualified to be released on medical parole. It is also important to note that offenders should not be released simply because of illness (Phela, 2018). If an offender can be treated with dignity in prison, he should not be released. However, Section 79 makes this unclear. The final condition is that the community into which the individual is released can provide the necessary monitoring, care, and therapy [(Section 79 (1) (c) of the Republic of South Africa Correctional Services Act of 1998)]. Mngoma (2023) argues that this might present as a challenge for sentenced offenders simply because most of the offenders comes from economically disadvantaged households that cannot afford the financial burden and care needed to support the parolee. The experiences of families of those who are released on medical parole and the extent to which the Department of Correctional Services provides support to ill parolees remains unknown in the context of South Africa.

2.6.2. Review of the Canadian approach to Medical Release

In Canada, law offenders who are ill may apply for temporal absence provided that it is for medical purposes. Temporal absence is a privilege granted to an ill offender for a certain period time, unlike parole where the offender serves the remaining period of their sentence outside. There are two categories of temporal absence (TA) under the Correctional Service

of Canada (CSC), which oversees all prison sentences lasting more than two years, both escorted and unescorted (Helmus` & Ternes, 2017). Inmates on an escorted temporary absence (ETA) are under the supervision of a correctional officer, another CSC employee, or a volunteer from the community while they are out. The absences are usually not more than a day in length. Escorted temporary absence allows offenders to complete community service, maintain relationships with family, receive medical care, participate in personal growth, and/or attend community-based rehabilitation programmes (CSC, 2012b). Unescorted temporary absences (UTAs) are awarded to inmates who have served a certain amount of time (Erdem et al., 2024) and demonstrated suitable behaviour in the community. In Canada, the National Parole Board is an independent and administrative body responsible for making informed decisions on the date and circumstances of release required for offenders' reintegration (Landry & Sinha, 2008). Only the Parole Board can grant temporal absence on condition that they are convinced that the offender will not reoffender during that time (van Wyk, 2014). This reduces chances of recidivism.

2.6.3. The role of community corrections in relation to medical parole

According to Smith (2004, p.57), the goal of community corrections is

> "To monitor and exercise supervision and control over offenders who have been sentenced directly by a court to correctional supervision, prisoners whose sentences have been converted after serving a certain time in prison and who have now been released from prison under correctional supervision and persons who have been released on parole."

Van der Westhuizen and De Bruyn (2002) argue that community corrections is a community-based prison system that seeks to rehabilitate offenders within their communities while still subjecting the offender to tight correctional monitoring for the remainder of their term. The primary duties and purposes of community corrections are to:

- Submitting pre-sentence reports to the court
- Dealing with individuals not sentenced to correctional supervision but placed under Department of Correctional Services supervision
- Preside over house arrest
- Ensuring the probationer or parolee stays in a specific area and exercising control over the offender

- Fostering victim compensation and community service

The function of community corrections in facilitating the reintegration of offenders granted medical parole remains ambiguous due to inconsistent protocols, limited resources, and the unique challenges posed by the offenders' medical conditions. However, individuals with significant health concerns often necessitate assistance to maintain their medical care within the community following their release from a correctional facility (Hammett et al., 2004). Typically, community corrections oversee the process of reintegrating parolees into society, thereby positioning themselves as crucial contributors to discharge planning and the continuity of care for those released on medical parole.

The next chapter explores literature on the quality end-of-life care and examines the experiences of caregivers involved in this process.

CHAPTER 3

LITERATURE REVIEW- PART TWO

Providing quality care and support towards end-of-life

"*You do not get to choose how you are going to die or when. You can only decide how you are going to live*."

Joan Baez, folk singer and songwriter

3.1. Introduction

In recent years, scholars and researchers have increasingly drawn attention to a series of tensions emerging within the field of gerontology, particularly in relation to policy initiatives aimed at addressing the needs of the ageing population. These tensions are especially evident among practitioners striving to provide holistic yet cost-effective care for older adults and their caregivers. A significant source of these tensions is the growing emphasis on enhancing the quality of life for elderly individuals, with particular concern for those facing economic disadvantages. Furthermore, the inadequate educational preparation of professionals in gerontology, especially within social work and health-related disciplines, has been identified as a pressing issue (Tate et al., 2023). Compounding this challenge is the limited focus within both research and practice on the specific needs of older adults transitioning from incarceration to community life.

It is clear from the available literature search conducted that there is sparse literature on the experiences of caregivers taking care of elderly parolees during end-of-life (Dittborn et al., 2021; Wen et al., 2022). This chapter is divided into four sections. First, it offers an overview of palliative care within the context of gerontology and correctional services. Second, it examines the principles and practices of end-of-life care. Third, it reviews the literature on hospice care and the role of social workers. Finally, the chapter explores the experiences and wellbeing of family caregivers as reflected in existing research.

3.2. Conceptualising palliative care in the context of gerontology

A historical reflection on palliative care reveals that its foundations are not a recent development. Evidence suggests that rudimentary forms of palliative care existed as early as

prehistoric times, when members of tribal communities engaged in communal rituals aimed at alleviating pain and providing comfort to the sick and dying (González & Ruiz, 2012). As human societies evolved, so too did medical and therapeutic practices, eventually culminating in the emergence of the modern palliative care model.

The Hospice Palliative Care Association of South Africa (HPCA) has played a vital role in improving the quality of life for individuals and families confronting life-threatening illnesses (Welgemoed & Lerm, 2020). Despite such national initiatives, access to palliative care remains limited globally. The World Health Organization (WHO, 2021) estimates that more than 56.8 million people require palliative care annually, with 78% residing in low- and middle-income countries (LMICs). However, only 39% of countries report widespread availability of such services, particularly for patients with non-communicable diseases (NCDs). Palliative care encompasses a holistic approach that addresses the medical, psychological, and emotional needs of patients and their caregivers. For many, the end-of-life journey involves sudden immersion into unfamiliar medical environments filled with complex equipment and unfamiliar professionals, often leading to confusion, vulnerability, and emotional distress. Patients may struggle to articulate their needs, as captured in expressions such as, "What do you now need most from me?" (Ndiok et al., 2020), highlighting the importance of empathetic communication and psychosocial support in palliative care practice.

Palliative care is broadly defined as a holistic approach to managing serious illness, emphasizing the physical, psychological, social, and spiritual wellbeing of patients (Ndiok et al., 2020). Clark and Seymour (1999, p. 83) similarly describe it as “total care,” highlighting the integration of pain relief, interdisciplinary teamwork, and the cultivation of trust between caregivers and patients an essential dynamic that promotes mutual respect and autonomy. Expanding upon these conceptualizations, the World Health Organization (WHO, 2009, as cited in Callahan et al., 2014) outlines the goals of palliative care as follows: (a) affirming life while recognizing dying as a normal process; (b) providing relief from pain and distressing symptoms; (c) integrating psychological and spiritual care; (d) supporting patients in living as actively as possible until death; (e) assisting families during the illness and bereavement; (f) neither hastening nor postponing death; and (g) employing a multidisciplinary team approach to address patient and family needs. These principles form

the foundation of high-quality palliative care, as illustrated in the following figure, which captures the multidimensional nature of this care model. The figure below illustrates the different dimensions of what quality palliative care encompasses.

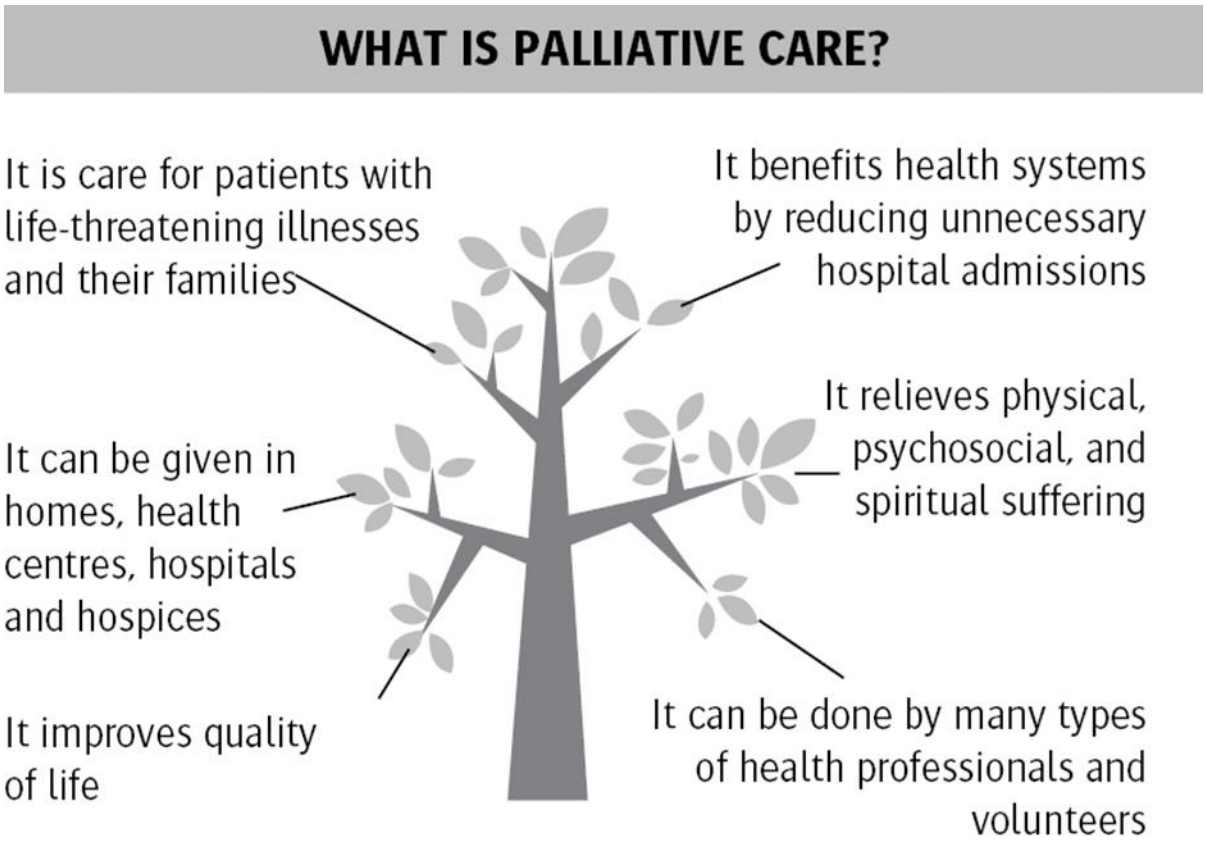

Figure 3.1: The different dimensions of defining palliative care

Source: Adapted from World Health Organization (2002)

Financial constraints and the rising costs of healthcare services have contributed to patients missing follow-up hospital visits (Bacon et al., 2013). Inadequate/ poor follow-up can significantly disrupt the effective management of chronic conditions and increase the risk of disease progression. Among the terminally ill particularly elderly individuals nearing the end of life—care is often provided by family members or, when financially possible, by hired professionals such as private nurses (Chukwuneke, 2015). However, in low-income households, especially across African contexts, caregiving responsibilities are predominantly shouldered by family members (Adedeji et al., 2022).

A critical component of home-based care is palliative care. Current trends in health and social care delivery reveal a shift toward providing long-term care within home environments (Ndiok et al., 2020). Nonetheless, evidence from South Africa indicates that the successful implementation of palliative care is contingent upon effective collaboration between the ministries of health and social services (Hunt & Maasdorp, 2022).

The following section explores the provision of palliative care in correctional facilities, with particular focus on elderly incarcerated populations.

3.2.1. Palliative care in correctional centres and the elderly

Cancer and other serious illnesses are among the most prevalent health concerns affecting elderly offenders in prison (Burles et al., 2021). In high-income countries such as Canada and the United States, individuals over the age of 50 account for approximately 87% to 89% of all cancer diagnoses in prison populations (Bally et al., 2021; Burles et al., 2021). By contrast, in South Africa, natural deaths in correctional facilities are primarily due to human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) (Stevenson et al., 2020). Accurate national statistics on the prevalence of HIV/AIDS in South African prisons remain limited (Sarkin, 2021), although regional data suggest prevalence rates between 20% and 25% among incarcerated populations (Dlamini, 2024). Comparable trends are observed in other African countries: in Kenya, HIV prevalence among prisoners ranges from 14% to 18% (Ngugi et al., 2018), in Uganda it is approximately 12% (Mutagamba et al., 2017), and in Nigeria, estimates indicate 10%–15% (Adejumo et al., 2019). These figures underscore the critical need for palliative care and medical parole for seriously ill offenders across the continent, as overcrowding and limited healthcare infrastructure exacerbate health risks.

The ageing prison population often presents with chronic and advanced illnesses, placing tremendous pressure on already limited palliative and end-of-life care services, particularly in low- and middle-income countries (Fares et al., 2021). Within the South African Department of Correctional Services, the increase in elderly offenders is particularly concerning because many may not complete their sentences due to declining health, making medical parole an essential mechanism for ensuring access to appropriate healthcare and continuity of care (Bezuidenhout & Booyens, 2018). Older incarcerated adults face distinct

physical, psychological, and social challenges, intensified by harsh prison conditions that accelerate the ageing process (Maschi et al., 2012). Despite ongoing efforts, there is limited knowledge regarding how correctional social work programmes address the palliative and post-release needs of elderly parolees.

Palliative care initiatives in South Africa were initially introduced to respond to the HIV/AIDS crisis in correctional facilities. Between January 2008 and March 2009, 219 sentenced offenders died in custody due to illness (Sithole & Dempers, 2010). Partnerships between the Department of Correctional Services and organisations such as the Hospice Palliative Care Association of South Africa (HPCA) aim to provide palliative services depending on resource availability, particularly in KwaZulu-Natal correctional centres (Sithole & Dempers, 2010). However, progress in improving the quality of life of seriously ill offenders has been limited (Welgemoed & Lerm, 2020), and community correctional centres responsible for reintegration are often excluded from these partnerships, despite their critical role in supporting parolees.

Globally, challenges persist in delivering palliative care within correctional systems. In high-income contexts such as the United Kingdom and the United States, elderly offenders continue to experience inadequate access to treatment, delayed diagnosis of life-limiting illnesses, and unmanaged suffering (Enders Boisclair & Roy, 2005; Wahidin, 2011). In Africa, similar constraints exist due to insufficient funding, understaffed medical units, and limited integration of parole mechanisms with healthcare services. Research indicates that elderly offenders often encounter mishandled pain management and insufficient healthcare (Iftene, 2017; Annaheim et al., 2018; Scaggs, 2017; Wangmo et al., 2016). These gaps highlight that while medical or compassionate release exists globally for offenders with life-threatening illnesses, insufficient attention is given to their reintegration and continuity of care, emphasizing the importance of linking palliative care with medical parole programs.

It is also important to clarify that palliative care extends beyond end-of-life care; it involves holistic support for individuals with serious illnesses regardless of prognosis (Callahan et al., 2014). In the context of gerontology and correctional services, integrating palliative care with medical parole mechanisms ensures that elderly offenders with chronic or terminal illnesses

can safely reintegrate into society while receiving appropriate healthcare and psychosocial support, a practice that is increasingly critical across African correctional systems.

3.3. End-of-life care in the context of gerontology

End-of-life care is a specialised component of palliative care that focuses specifically on preparing for death and providing supportive care to individuals in the final stages of life (Huffman & Harmer, 2019). In South Africa, end-of-life care has been actively developed since the 1980s, enabling healthcare providers to offer meaningful support to patients and their communities (Gwyther et al., 2018). Despite this progress, existing research suggests that elderly individuals nearing death particularly older women with limited social networks and those living with dementia are often less likely to receive adequate treatment or have their care needs met (Ahronheim, 1997; Clare et al., 1997; Cuevas et al., 2021; Ross & McDonald, 1994; Thomé et al., 2004). Unlike other health conditions that affect only specific populations, end-of-life is a universal stage in the human life course that every individual will inevitably face (Huffman & Harmer, 2019).

Undoubtedly, elderly individuals are living longer, and it is estimated that by 2030, there will be 74 million deaths per year related to the elderly, of which 85% will be in developing countries (Van Den Block et al., 2015). This also suggests that there will be an increased number of people affected by death and dying every year (Van Den Block et al., 2015). Considering that we have witnessed an increase in chronic diseases, especially among geriatric patients living longer, this also suggests that more people will be living with the effects of their chronic illness and, as a result, are likely to die from them (Cohen & Deliens, 2012). Therefore, it is essential to understand the issues and concerns around end-of-life care to mitigate serious systemic issues and improve the standard of services.

The definition of end-of-life in the available literature varies, especially those in the healthcare discipline. According to the National Hospice and Palliative Care Organization (NHPCO), end-of-life care or hospice care begins when a person is diagnosed with a terminal illness and has fewer than six months to live, and no curative therapies are available (Huffman

& Harmer, 2019). Some define end-of-life care as being the patient's quality and advocating for treatment at the time of Death (Boucher, 2016; Novelli & Banerjee, 2017). Others view end-of-life care as a way to optimise comfort and prevent possibly pointless and onerous treatments (Fleming et al., 2016). According to the American National Cancer Institute, end-of-life care consists of:

> "Care given to people who are near the end of life (likely to die within the next 12 months) and have stopped treatment to cure or control their disease. End-of-life care includes physical, emotional, social, and spiritual support for patients and their families. The goal of end-of-life care is to control pain and other symptoms so the patient can be as comfortable as possible. End-of-life care may include palliative care, supportive care, and hospice care. Also called comfort care."

It is worth noting that end-of-life care differs from person-to-person, and it must be brought to our attention that some may receive end-of-life care for months while others receive it for days.

Nevertheless, elderly patients nearing the end of their lives require complex care, and meeting those demands requires a multidisciplinary team's cooperation (Pless Kaiser et al., 2019). Extant literature highlights major concerns affecting patients and their caregivers during end-of-life care. These areas of concern include "communication, cultural considerations, plan of care, ethics, pain and symptom management, and termination of care" (Huffman & Harmer, 2019, p.2). Cultural competence has been highlighted as necessary when communicating during end-of-life care. In this regard, cultural competence refers to the ability to understand, communicate with, and effectively interact with people across different cultures. It involves recognizing and respecting cultural differences, being aware of one's own cultural biases, and adapting practices to meet the cultural needs of individuals. At end-of-life, one of the barriers to effective communication and decision-making is cultural taboos around death and dying as well as ambiguity about when and how to start conversations; therefore, a lack of understanding of the patient's belief may harm the relationship between patient and provider (Givler et al., 2018). A plausible reason for this could be that cultural beliefs tend to influence the way patients perceive and interpret pain during end-of-life (Givler et al., 2018). For example, in some African cultures, such as the context of Nigeria, planning for the end of life is seen as a blasphemous act which competes with the divine powers of God (Agbawodikeizu et al., 2019; Kirby et al., 2018).

Though there are qualitative studies that focus on end-of-life experience and terminal illness, there is relatively little research exploring the lived experiences of caregivers and correctional social workers during the end-of-life care phase of elderly offenders released on medical parole. This is not surprising as social work educators reiterated that the social work curriculum exposed students to little content on care of the dying and the bereaved (Head, 2019). This also means that social workers lack the necessary preparedness to provide effective and ethical practice during end-of-life care (Dziegielewski & Holliman, 2019). The available evidence underscores that offender released from prison have a heightened risk of premature death, especially in the initial few weeks after their release (McNeeley et al., 2023). Yet so, little is known about end-of-life care during reintegration. The end-of-life care process is not just focused on the quality of life but also considers the quality of Death (Flaherty & Meurer, 2023); in the following part, we focus on the phenomenon of a good death.

3.3.1. The phenomenon of a "Good Death"

Euthanasia is commonly referred to as "good death" (from the Greek word εύqanasía, meaning "good death") (Krikorian et al., 2020). When Herman Weisman initially proposed the idea of a "good death" in 1972, it was described as "a transitional stage in which everyone involved knows and accepts the proximity of death and resolves the socio-emotional and material concerns of the dying person" (Weisman, 1988, p.35). Leland (2012) argues that death and dying should not be understood as the failure of medicine but should be viewed as a developmental stage that is associated with a sense of meaning and transcendence. Early integration of end-of-life care programmes in terminal and life limiting illness impacts the quality of care (Leland, 2022). Nel (2007) suggests that Africans' conception of death is strongly tied to their sense of kinship, with death being seen as not fully severing ties to one's family. Alongside this claim, there are three important characteristics that, in the African setting, set forebears apart. It is believed that the familial bonds that persisted prior to the family members' departure have been maintained rather than destroyed (Sithole, 2022). In African contexts, death is associated with continuation, in contrast to the Western understanding of death as an end.

Talking about a good death is part of end-of-life care and a significant commitment towards addressing questions and counteracting the fear of loss (Cubides, 2022). According to the

Wijeyaratne et al., (2025, p.2), "death" is defined as "the act or fact of dying, the end of life, the final cessation of the vital functions of an animal or plant or individual." Chamsi-Pasha and Albar (2017) argue that the determination of death can only confirmed through a neurological criterion instead of the traditional cardiorespiratory criteria.

Nevertheless, the End-of-Life Care Committee of the Institute of Medicine of the National Academies (IOM) describe a good death as "one free of avoidable suffering for patients and their families, by their wishes, and reasonably consistent with clinical, cultural, and ethical standards" (Bellamy et al., 2022, p.31). Other scholars define the phenomenon of a good death as pertaining to managing pain and symptoms, making clear decisions, preparing for death, completing it with dignity and respect, being near loved ones, and finding peace (Cubides, 2022). Considering that discussions about death are often viewed as bad luck and or in a prohibitive manner, it impacts the quality of death as it allows the patient to share their values and preferences on what is important to them during end-of-life. According to Becker et al. (2020, p.3), a "good death" has the following characteristics:

- Controlling symptoms and pain
- Respecting the dying patient's wishes for treatments
- Encouraging contact with healthcare providers
- Providing a safe environment for emotional expression
- Respecting the dying patient's wishes regarding death

Seifart et al. (2020) found that 30-40% of dying patients discuss end-of-life options with their clinicians. A plausible reason for a dwindling number could be attributed to a clinician's fear of hurting the dying patient's feelings or ruining their hope. Against this backdrop, one may argue that the ability to provide a meaningful 'good death' for those nearing end-of-life and their families allows them to experience therapeutic healing and rewards social workers and nurses an opportunity to self-actualise (Watson, 1999). Currently, no study distinguishes between early and late symptoms of death, nor has it examined the multidisciplinary team's collective experiences with these indicators. The next part of this chapter presents a robust discussion of the various stages that a person nearing death may experience.

3.3.2. The stages of death

Dying from old age or a chronic condition can cause protracted agony and diminished function, making it challenging to observe signs of impending death (Murray et al., 2005). In the context of medical parole, recognising these signs is critical, as early identification of terminal decline can inform decisions about the timing of release and the level of care required in the community. Hall et al. (2011) argue that recognising the physical, psychological, and other changes in an elderly person allows caregivers and social workers to plan care based on individual preferences and values, which is especially relevant for parolees whose care transitions from a correctional facility to community-based or home-based care. Predicting when someone will pass away remains difficult (West, 2002), making continuous monitoring and assessment crucial for elderly offenders on medical parole.

Despite the individual receiving some form of medical attention for a terminal diagnosis and a timeframe for dying, the dying process remains unpredictable (Hohler, 2011). Although the person's corporeal capacity may decline drastically or gradually, there may be certain signs that give clues that a person is nearing death experience (Poss, 2021). Providing older people with information and preparedness might reduce anxiety misconceptions and allow them to express their desires around the dying process (Bollig et al., 2016; Lloyd et al., 2016; Ronaldson & Devery, 2001). Some of the changes noted during the end-of-life stage are depicted in the diagram below (Figure. 3.2).

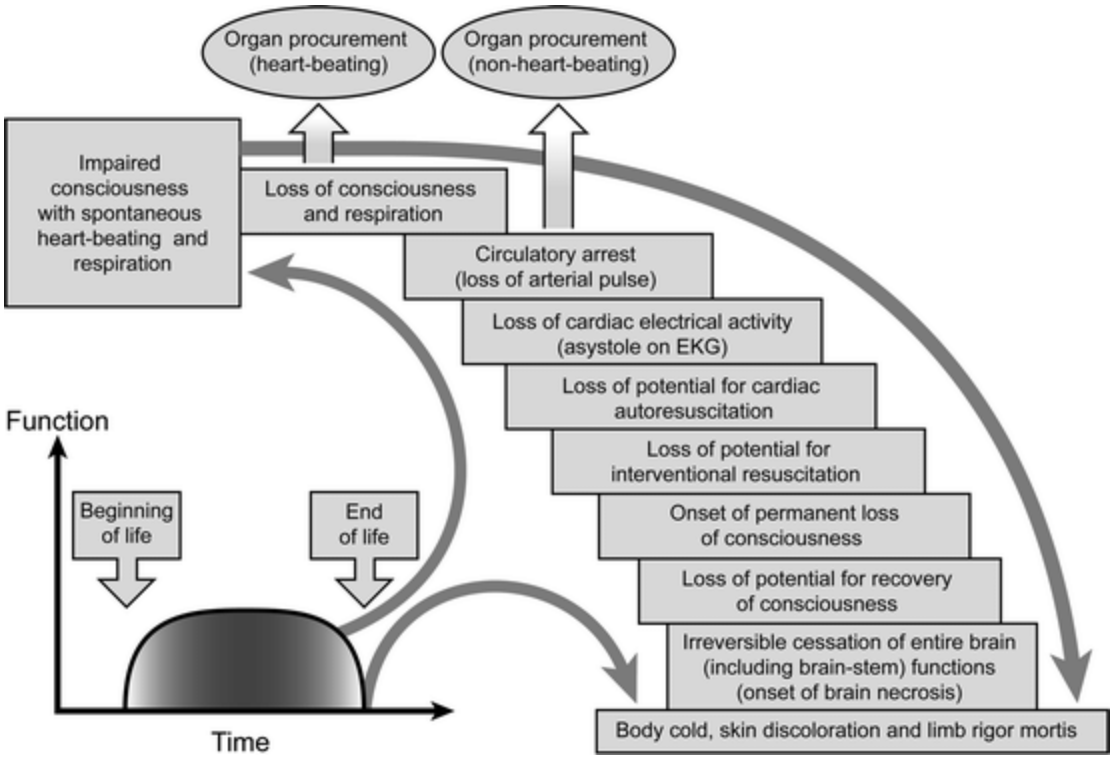

Figure 3.2: The clinical stages of the dying process

Source: Verheijde et al. (2009)

Human death is a singular phenomenon. The dying process occurs in clinical stages over time. There is a gradual loss of capacity for somatic integration of the whole body because of an irreversible cessation of all vital and biological functions, including circulation, respiration (controlled by the brainstem), and consciousness (Lloyd et al., 2016). The irreversibility of circulatory and respiratory function cessation is interlinked with the onset of whole-brain necrosis, which is the premature death of cells or tissue in the body, often caused by factors like injury, infection, or lack of blood supply, leading to inflammation and tissue damage. The loss of capacity for consciousness is irreversible when the necrosis of the whole brain, including the brainstem, is complete.

> "There is no accurate clinical test to ascertain the absence of self and/or environmental awareness in unresponsive patients following severe brain injuries. Arbitrary neurological and circulatory criteria redefining human death enable heart-beating and non-heart-beating procurement of transplantable organs, respectively. Scientifically flawed criteria of death can harm donors because procurement procedures are performed without general anaesthesia" (Verheijde et al., 2009, p. 412).

Some of the physical changes that suggest that a person is dying could be the fluctuation of the blood pressure and body temperature; the completion of the skin may also tend to change, considering the fluctuating temperature (Atwood, 2017). Irregular breathing is also a signal of the person approaching death-usually breathing tends to be slower and may stop for a fleeting period. Older individuals may experience higher daytime sleepiness while sitting in areas such as the dining room or armchairs (Åvik Persson et al., 2018). It is expected that persons nearing end-of-life are likely to experience changes in their mental state; some may experience terminal delirium, which is a state of being confused, restlessness, disorientated, illusional, shouting, or even physically assaulting caregivers. An older person's mood alteration, such as depression, irritability, or bad mood, may be an early indicator of death (Greer et al., 2020).

Moreover, the physical and mental changes associated with end-of-life, such as terminal delirium, depression, irritability, or reduced appetite (Åvik Persson et al., 2018; Greer et al., 2020), underscore the importance of integrating medical, psychological, and social support services into medical parole plans. These considerations highlight that medical parole is not merely a legal mechanism for early release but a critical intervention to ensure that terminally ill offenders receive humane, comprehensive, and continuous care outside correctional facilities. Surprisingly, it is unclear how long an elderly person may survive without fluids because it is widely agreed that they do not appear to suffer without them (West, 2002). Throughout the end-of-life process, caregivers are equally impacted by all these physical, clinical, and mental health changes. However, little is known about their unique experiences in providing care during this critical time.

While dying is not a pleasant experience, it is important to discuss it honestly. Identifying and discussing the causes of death might ease the transition. Crawford et al. (2021) argue that nurses and social workers are crucial in end-of-life care as they provide a safe environment for a "good death". Social workers are obligated to look after their clients' psychological and emotional wellbeing. Therefore, thinking about the client's corporeal capacity and utilising knowledge of the body or body cognisance is vital to selecting and executing therapies relevant to emotional wellness during end-of-life-care.

3.4. Hospice care and the role of social workers

The hospice movement's initial focus was to treat cancer patients, but as time passed, HIV and AIDS became a greater threat to countries throughout the world. Hospice care is an approach that requires a multidisciplinary team to provide care to patients nearing death (Wajid et al., 2021). Approaching death and dying in the right manner is crucial, and this could be achieved through hospice care, which provides comprehensive palliative care that has a positive effect on the feeling of death (Møller & Skinhøj, 2000). It is worth noting that most developing countries, including India, have failed to create hospices; as a result, a substantial number of terminal cancer patients in their latter stages of life are denied palliative treatment (Palat & Venkateswaran, 2012).

Annually, hospice care professionals in South Africa service over 150 000 individuals with life-limiting and terminal illnesses. It is worth highlighting that 84% of hospice care is given in places that are part of the community (HPCA, 2020). A strong collaboration is needed between hospice care professionals and community correctional centres to facilitate positive and holistic reintegration services for offenders released on medical parole. This is because hospice care prioritises both the living and the dying, and it is the pinnacle of palliative care. For social work practitioners to meet the needs of terminally ill patients, specialised training is required (Lilley & Reid, 2024). Social workers are integral to the palliative care team, offering support to patients and families throughout the illness (Institute of Medicine, 2014). Some of the services that they offer range from care/case management, behavioural health counselling and psychotherapy, support groups, advance care planning, consulting services, involvement on ethical committees, tangible services, and grief and bereavement counselling (Meier & Beresford, 2008; National Association of Social Workers, 2018; Terry Altilio & Otis-Green, 2011). Even though social work has a long-standing history and prominence in hospice care, the roles and responsibilities of social workers remain largely misunderstood by other professionals (Taels et al., 2021), as it is in the case of correctional social workers reintegrating seriously ill parolees.

Often, patients often receive hospice care too late, resulting in social workers having to deal with a build-up of resentment as well as caregiver and resource issues (Curd & Hong, 2024). Further, caregiver fatigue and waiting lists for limited community resources are often reported (Curd & Hong, 2024). It is not surprising that Alcide and Potocky (2015) reported that hospice social workers recorded higher levels of fatigue and death anxiety in addition to

certain challenges with interdisciplinary practice. The findings highlight the emotional and professional toll that hospice social workers experience as they navigate the complex and often distressing nature of end-of-life care. This underscores the need for better support systems, coping mechanisms, and resources to address the mental and emotional well-being of hospice professionals in their challenging work environment.

Introducing palliative care in the Department of Correctional Services is challenging. The current pitfalls in providing quality palliative care are also linked to the shortage of well-trained social workers required to address the demands of hospice and long-term care facilities, as well as hospital and community-based palliative care programmes, which are extensively becoming even more critical as these services do not appear to meet the growing demand needed to promote quality care (Stein et al., 2019). In the South African context, social workers involved in providing palliative care have made considerable progress in increasing the number of social workers who are trained and qualified to provide psychosocial care (Centre to Advance Palliative Care, 2015; Coalition to Transform Advanced Care, 2018; Institute of Medicine, 2008). However, to date, little is known about the extent to which palliative and end-of-life care are infused in post-incarceration programmes aimed at supporting medically ill parolees, which the present research seeks to explore. In the next section, caregiving complexities and role negotiation are critically discussed.

3.5. Caregiving within the context of elderly care

Caregiving for someone who is terminally ill presents substantial psychosocial, economic, and emotional challenges for families, communities, and healthcare workers. For elderly offenders released on medical parole due to life-limiting illnesses, these challenges are particularly pronounced, as care responsibilities often shift from correctional facilities to families or community-based support structures. Family caregivers providing prolonged end-of-life care for parolees may experience major physical, social, and emotional disruptions, resulting from witnessing the decline in their relative's health (Mystakidou et al., 2013). The coexistence of chronic non-communicable comorbidities with the long-term provision of care can exacerbate caregiver burden, potentially leading to work overload and decreased quality of life, especially for older caregivers (Bailon Almeida et al., 2018). Jeyathevan et al. (2020)

reported that caregiver burden increases with age, and the alleviation of such burden is often linked to the duration and adequacy of care. Akintola (2006) further highlights that prolonged stress can result in anxiety, depression, hypertension, psychological distress, social isolation, and weakened immunity among caregivers.

In the context of medical parole, these findings underscore the need for targeted support systems that prepare families and community caregivers for the complex demands of end-of-life care. Despite these challenges, there is limited literature exploring caregiver experiences specifically in relation to elderly offenders released on medical parole. Understanding these experiences is crucial for ensuring that medical parole not only facilitates humane early release but also provides continuity of care, psychosocial support, and community integration for parolees with life-threatening illnesses.

3.5.1. Who is the typical caregiver?

Most caregivers consist of relatives, spouses caring for their partners, children caring for parents, and siblings caring for siblings (McDaniel & Pisani, 2012). In Sweden, one of the countries with the highest public spending on long-term care, a significant portion of informal care, care provided by friends, relatives, or neighbors without compensation is still relied upon to supplement formal care services, highlighting the importance of community support and the challenges of balancing public resources with personal caregiving responsibilities (Jegermalm & Torgé, 2023). In the United States, an estimated 66% of caregivers are female, and 65% of care recipients are female (Sullivan & Miller, 2015). Similarly, in Africa, caregiving is heavily gendered, with 91% of caregivers in South Africa being women, and 68% in Uganda providing the majority of care (Mathai, 2022). This disproportionate burden on women may reflect dominant cultural norms that associate caregiving with feminine social roles (Mathai, 2022).

As life expectancy increases globally, there is growing concern for family caregivers who are ageing alongside their care recipients and may themselves require support (Ebimgbo et al., 2019; Iwuagwu & Kalu, 2021). This challenge is particularly pronounced in rural settings, where reciprocal care for elderly family members is common. Within this context, most existing caregiving data focuses on terminally ill patients or children with special needs, leaving a significant gap in knowledge regarding episodic caregiving for elderly parolees

released on medical parole. Families and communities are often unprepared for the sudden responsibility of caring for a medically fragile parolee, highlighting the need for post-release support structures, social work interventions, and policies that address the unique psychosocial and logistical challenges associated with medical parole.

3.5.2. The role of family caregivers during end-of-life

Considering the strong links that may exist between patients and their family members, Gallagher-Allred (2009) notes that a growing number of patients prefer to pass away at home rather than in a hospital or any other healthcare facility. This may put an intolerable amount of strain on certain families. As mentioned earlier, the end-of-life experience is challenging to maneuver for both the dying patient and the family (Hughes et al., 2021). It is worth noting that family caregivers are reported to provide an estimated 75-90% of home-based care for those in their end-of-life (Dunbrack, 2005). Nevertheless, the available research indicates that the strained relationship between parolees and their families after incarceration is often complicated (Hairston, 1991; Visher & Travis, 2003; Niven & Stewart, 2005; Travis, 2005). This happens because of the physical separation and emotional trauma caused by incarceration that places significant strains on familial relationships (Comfort, 2019; Listwan et al., 2013). As a result of a stained familial relationship, this could complicate caregiving, which necessitates the present research that aims to explore the experiences of caregiving during the transition of elderly parolees released on medical parole.

Family caregivers typically carry a significant emotional burden on their work (Rabow et al., 2004). While some family caregivers may feel privileged and satisfied in their roles, they may also experience despair, remorse, wrath, resentment, and feelings of inadequacy (Dunbrack, 2005). Caring for a person at home involves the most immediate and intimate needs, such as physical aspects of care: giving baths and helping them to eat, get dressed, use the bathroom, or even breathe (Stajduhar et al., 2017). Similarly, Hudson (2009) avers that the responsibilities and duties of caregivers are complex and sophisticated, which include aspects of physical and medical care duties, including but not limited to symptom assessment and management, personal hygiene, administration of medication, and consulting with medical professionals. Moreover, caregivers must still provide emotional support, handling finances, patient advocacy, making decisions, providing social and practical assistance, and

coordinating medical treatment (Stajduhar et al., 2017). In the case of caregivers providing care to elderly parolees, this may be difficult considering the strain on family members and might lead to the unintended impacts of ambiguous loss. Therefore, supportive therapies meant for the families of dying patients should be able to meet the emotional, cognitive, spiritual and financial needs as shown (Figure 3.3) below.

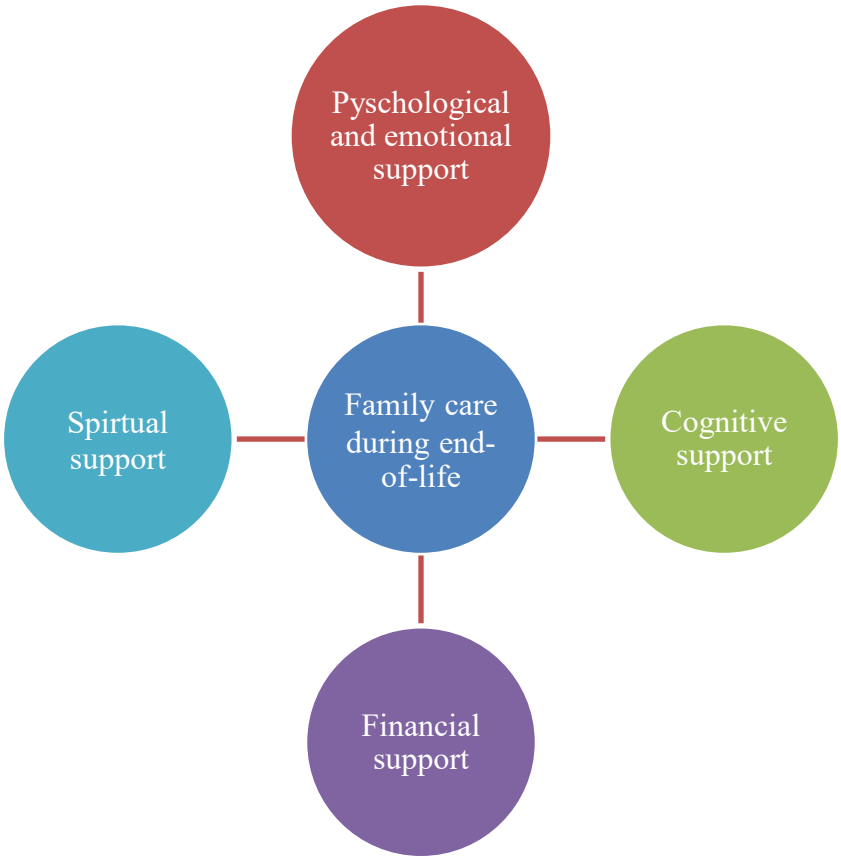

Figure 3.3: Supportive intervention for the family during end-of-life care

Source: Noome et al. (2016)

3.5.2.1. Financial support during end-of-life care

It has already been established that family caregivers manage all the financial burdens that arise during end-of-life. Studies from the United States, Australia and New Zealand suggest that family caregivers are substantially the most disadvantaged when it comes to accessing financial support (Aoun et al., 2005; Emanuel et al., 2000; Gott et al., 2015). Similarly, a recent Eurobarometer poll suggested that informal caregivers ranked financial compensation as their top support requirement in Europe. Even though government policies widely

recognise the role of family caregivers, accessing financial support from the state during end-of-life remains a key challenge in South Africa (Govender et al., 2015). The lack of financial support for family caregivers during end-of-life for elderly patients was identified as a risk factor for elderly abuse (Liu et al., 2017).

3.5.2.2. Psychological and emotional support during end-of-life care

Extant literature highlighted that family caregivers experienced emotions such as helplessness, guilt, loneliness, fear, and a loss of control over day-to-day living (Vanderwerker et al., 2005). Kübler-Ross (2014) postulates that due to anticipatory grief, family caregivers of those nearing end-of-life are likely to experience similar stages of bereavement as the dying family member, which can range from feelings of denial, anger, bargaining, sadness, and finally accepting the loss. Though these feelings can be recurring among family caregivers, Kübler-Ross (2014) argues that as family caregivers attempt to adjust to this new reality and search for meaning in existence during the end-of-life stage, they will eventually return to the normalcy experienced before the end-of-life stage.

3.5.2.3. Spiritual support during end-of-life

Over the years, various international studies highlighted that the spiritual needs of those nearing end-of-life and their families remain unmet (Dá Mesquita et al., 2024; Delgado-Guay, 2014; Lunder et al., 2011). Yet, it is well known that spirituality at the end-of-life (EOL) has even greater relevance and is one of the most crucial aspects of quality of life (Puchalski et al., 2009). A plausible reason for this could be drawn from Staton et al. (2001), who argued that persons nearing end-of-life are likely to seek a deeper connection beyond the dying body, as a way to confirm their belief in the continuity of life after death. This implied hope provides reassurance that they will continue to exist even if they are not physically present. Canda and Furman (2019, p.59) state that spirituality is "a universal and fundamental human quality involving the search for a sense of meaning, purpose, morality, well-being, and profundity in relationships with ourselves, others and ultimate reality". However, some of the reasons for incorporating spiritual care in end-of-life services are to enable healthcare and social work practitioners to engage with the dying person and their families, listen to their concerns,

dreams, and pain, participate as partners in care, and facilitate recovery through therapeutic relationships (Balboni et al., 2017). Due to the lack of a framework for incorporating spirituality into social work practice, social workers may be forced to discuss this subject with clients at their own discretion (Carrington, 2013). Yet, in most African families, spirituality is central to restore harmony and healing in families (Agyekum & Newbold, 2016; Bhikha & Glynn, 2013).

The role of ancestors in shaping cultural practices around caregiving is significant, as many communities continue to draw on ancestral traditions to guide the ways in which care is provided within families and local networks. Mbiti (1990) asserts that ancestors inhabit the spiritual realm, serving as intermediaries between their descendants and the divine. Ancestors are regarded as guardians and are invoked during times of crisis (Marumo & Chakale, 2018). Their support and blessings are typically granted when appropriate rituals are performed and sacrifices are offered (Thabede, 2008). While they provide guidance, protection, and blessings, they may also impose penalties if familial rituals are neglected (Kübler-Ross, 2018). Although Nduli and Mthembu (2022) identified spirituality as a beneficial factor aiding elderly parolees in their reintegration post-incarceration, there is limited understanding of how social work reintegration programmes integrate spirituality into their aftercare assessments and initiatives.

3.5.2.4. Cognitive support during end-of-life care

A longitudinal study on caregiver death-preparedness in the American context reported that caregivers who were inadequately death-prepared reported a higher subjective caregiving burden compared to those who were sufficiently death-prepared (Teno et al., 2022). Similarly, reports suggest that cognitive support for the family is crucial in helping them accept the impending death of their loved ones nearing end-of-life (Scheinfeld & Lake, 2021). It is worth highlighting that a lack of understanding can also contribute to irritation and stress-related issues. Caregivers must understand the behavioural patterns associated with each special need. Considering the high caseload among social workers within the South African context, providing the cognitive support required by caregivers at end-of-life care may be difficult.

Similarly, in the case of seriously/terminally ill elderly parolees, the emotional complexities associated with death preparedness are unclear, considering that a person released on medical parole may potentially be at a dying stage. In a research project aiming to bridge the knowledge gaps of caregivers during end-of-life, findings revealed that feelings of loneliness and hopelessness were linked to a lack of cognitive support (Varik et al., 2024). This finding underscores the importance of involving family caregivers during end-of-life care. Nevertheless, it remains the intention of this study to uncover the way the Department of Correctional Services include caregivers when reintegrating elderly offenders released on medical parole, as well as explore how correctional social work programmes integrate end-of-life during reintegration to foster a positive transition.

3.5.3. Family caregiving in the context of offenders on medical parole

Generally, caregiving is characterised by many stressors that contribute to caregiver burden. As the person's health deteriorates, the responsibilities of the caregiver increase. Once an offender is released on medical parole, they disorganise the entire family's life, alter the family's general lifestyle, and upset the established equilibrium (Naser & La Vigne, 2006). It is worth mentioning that family members may have both positive and negative influences on released parolees as they face numerous problems related to their reintegration into society (Naser & La Vigne, 2006). While families are often expected to provide continued personal support to their relatives upon release from prison, research indicates that many families are reluctant to welcome parolees back into the community (Denckla & Berman, 2001; Roberts et al., 2004; Nelson & Trone, 2000). Therefore, caregiving in the case of offenders released on medical parole is rather complex, and the lack of suitable transitional correctional programmes that include caregivers contributes negatively to this complexity.

Extant literature indicates that parolees commonly depend on family caregivers for support upon release (Dumont et al., 2012; Fleisher & Decker, 2001). Family caregivers are responsible for providing care for ill parolees. They also offer parolees identity, social position, and support during reintegration (McCleary & Blain, 2013). The quality of life of a family caregiver is influenced by the availability of resources to mitigate the effects of caring (Blum & Sherman, 2010; Northouse et al., 2012; Sercekus et al., 2014). Due to inadequate healthcare and a lack of government assistance during reintegration, the enormous need for

care falls mainly on family caregivers. Doshmangir et al. (2022) argue that following diagnosis, most patients and their families are ill-prepared about the illnesses or palliation; as a result, most patients do not show up for follow-up appointments because they are not well-informed, and no follow-up programmes are in place to keep track of these patients. Therefore, correctional social workers should be at the forefront of preparing family caregivers during the reintegration of offenders released on medical parole to address some of the complications that might arise as a consequence of ill-preparedness.

3.5.4. Caregiver burnout

Recognising family caregivers' contributions and analysing their needs in practice has been acknowledged (Ferris et al., 2002). Various studies have reported that caregivers, especially those who might fail to care for themselves in specific ways, are at elevated risk of caregiver burnout (Akintola, 2006). Burnout is a state of mental and physical exhaustion that includes unfavourable views about one's work and a loss of empathy and care for one's clients (Van Dyk, 2001). Some studies have reported a close relationship between burnout and characteristics of the caregiver such as age and presence of illness. The emotional needs of caregivers vary depending on their relationship with their loved one as well as the amount of time and responsibility invested. Available research illustrates that caregivers who are tasked with caring for people suffering from geriatric diseases such as dementia, Alzheimer's, and Parkinson's have a threefold higher rate of emotional distress (Hailu et al., 2024). This could be linked to the reality that caregiving is more complicated and difficult for those caring for elderly people with chronic illness and deteriorating mental and physical health (Davis et al., 2011). Consequently, caregivers experience a range of shifting emotions that make providing care mentally and physically exhausting.

It is not surprising that caregiver burnout is also linked to family relationships and conflict, which heighten the burden of caregiving. Some families become more united or break apart amid a catastrophe (Hohler, 2011). It is uncommon for one family member to provide care, although others in the family may express strong concerns or disagreement (Podgorski & King, 2009). Sometimes, everyone appears to have an opinion on what should be done and how things should be handled, but few desire to do it. Keeping this in mind, this study seeks to explore the manner in which caregivers are regularly assessed and provided with support

to become knowledgeable about end-of-life and provide timely and efficient care to those nearing death experience.

3.5.5. Coping with grief and bereavement

Grief and bereavement are common experiences when working with the aged and their families. Caregivers of those with life-threatening illnesses, such as cancer or dementia, experience a range of losses, including the loss of loved ones, shared hobbies, and future aspirations (Noyes et al., 2010). Sanders and Corley (2003), observe that family caregivers of elderly persons diagnosed with a life-threatening illness tend to experience predeath grief as the disease progresses. Nevertheless, predeath grief is not easy to identify among caregivers and may be frequently overlooked or even misunderstood. The process of grief and bereavement is different for everyone (Wangliu & Che, 2025). During terminal illness, caregivers may experience shock, denial, numbness, or dismissing the gravity of the diagnosis. Several studies suggest that family caregivers (FCGs) with pre-existing health issues, such as mental or chronic disease or drug addiction, have a lower chance of coping with bereavement well (Brazil et al., 2006; Kendall et al., 2002; Stroebe et al., 2007). While some psychiatric literature views grief beyond the six months as associated with pathology (Tsai et al., 2016), this is a controversial debate as some researchers and practitioners argue that the process of grief and bereavement takes its own time. In contrast, Schulz et al. (2007) revealed that caregivers who were said to have experienced a subjective caregiving burden were less likely to experience prolonged grief. Considering the strain that caregivers experience, we assume that the reason for them not suffering the brunt of prolonged grief could be attributed to the explanation that they may have felt that the caregiving burden had been alleviated by death.

One of the implications for social work practice that this literature underscores is the need to screen caregivers for prolonged grief symptoms to prevent and enhance their perceived social support.

3.5.6. Caring for the caregiver

As mentioned previously, caregivers must cope with their feelings of loss and anger, as well as take care of the person at end-of-life who may be in excruciating pain and frightened. This

responsibility comes with great sacrifice and significantly contributes to caregivers' quality of life. Yet, it is not really clear who takes care of the caregiver in their time of need. The question of who cares for the caregiver has received little attention, and the available studies remain neutral on this subject. Dyck (2009) notes that the healthcare system may be forced to take on more of the load when carers are unable to handle the responsibilities of providing care for an elderly person nearing death experience. Considering that globally, the geriatric population of persons over 65 will double over the next 20 years (Nduli & Mthembu, 2024), the question "Who cares for the caregiver?" becomes even more pressing. Santos (2019, p.18) comments that "caregivers neglect their health after taking a caregiving role because of the relatively high rates of exhaustion, being overwhelmed, and not having enough time for themselves". Therefore, it comes as no surprise that caregivers are prone to poor health outcomes such as high blood pressure, heart disease, diabetes and arthritis as compared to non-caregivers (World Federation of Mental Health, 2017). The question of who takes care of caregivers or how caregivers take care of themselves remains the focus of the present study, which aims to unveil how caregivers of elderly parolees' self-care during the end-of-life phase.

3.6. Summary

The exponential growth of the elderly population and its connection to end-of-life issues represents one of the most significant social changes in recent times. This chapter has highlighted that elderly offender released on medical parole often face severe, progressive illnesses requiring specialised treatment due to their complex medical needs. In addressing this complexity, the chapter has contributed to a deeper understanding of the experiences of caregivers, palliative care, and end-of-life care. It has become clear that the provision of specialized care is often influenced more by a patient's diagnosis, physical symptoms, age, ethnicity, socioeconomic status, and location than by the complexity of their actual healthcare needs. Given these disparities, this study specifically explores the unique experiences of caregivers who care for elderly parolees in their end-of-life phase, as well as the role of correctional social workers during this critical transition. The following chapter introduces the theoretical framework that underpins the perspectives of correctional social workers and caregivers, who form the core participants in this study.

CHAPTER 4

THEORETICAL FRAMEWORK

"He who loves practice without theory is like the sailor who boards ship without a rudder and compass and never knows where he may cast"

Leonardo da Vinci.

4.1. Introduction

A theoretical framework serves a critical role in qualitative research, providing a structured lens through which data patterns are discerned, interrelationships among data points are systematically organized, and findings are coherently interpreted considering existing theoretical paradigms. It enables researchers to interrogate data meaningfully and elucidate underlying conceptual insights. Moreover, theoretical constructs guide both scholarly inquiry and professional practice by informing analytical perspectives, framing research problems, and shaping methodological choices (Maxwell, 2013). Grounding research within such frameworks fosters rigorous contributions to scholarly discourse. In this study, the Caregiver Dynamic Theory and the Ecosystems Theory were employed to gain a deeper understanding of the lived experiences of family caregivers and correctional social workers engaged in the reintegration of terminally ill elderly offenders released on medical parole in South Africa.

The analysis of systems related to end-of-life care for elderly parolees requires a theoretical framework to help researchers interpret data. This study identifies two suitable frameworks: (1) Caregiver Dynamics Theory and (2) Ecosystems Theory, both of which are essential for meeting the study's goals. The Caregiver Dynamics Theory, a middle-range theory, explains the positive and negative factors influencing the caregiving relationship and its evolution over time. Recognising these factors allows correctional social workers to develop effective strategies to improve caregiver relationships. Together, the Caregiver Dynamics Theory and the Ecosystem Theory provide valuable insights into the complexities of caregiving, especially for elderly offenders on medical parole, highlighting the various experiences and challenges that caregivers encounter.

The Caregiver Dynamic Theory enhances our understanding of caregivers' experiences at the end of life. Concurrently, the Ecosystems Theory emphasizes the complex interactions between individuals and their environments, which is crucial for analysing the challenges faced by elderly parolees requiring end-of-life care. By considering not only the individual but also their various systems such as family, healthcare, and social support the Ecosystems Theory facilitates a comprehensive examination of factors influencing reintegration, including healthcare access and social support. Consequently, this theory significantly enriches the study when reflecting on the environmental and social influences on the reintegration of medically vulnerable elderly parolees. Ultimately, both theories are well-suited for this research, allowing for a nuanced interpretation of the data.

4.2. Caregiver Dynamic Theory

Caregiving is primarily a shared duty among family members, and this caregiving process is characterised by increasing complexity and responsibility (Fox et al., 2021). To explore the experiences of caregivers for elderly offenders released on medical parole, the study adopted the caregiver dynamic theory to gain insights into the challenges they face in their caregiving roles and to gather their recommendations for social support. In this context, family caregivers include relatives, partners, friends, or neighbours who provide unpaid assistance to elderly parolees dealing with physical, mental, or cognitive impairments (NASEM, 2016).

The Caregiver Dynamic Theory is a middle range theory adopted from Loretta Williams (2003) in the United States, emanating from the field of nursing. According to Simpson (2013) (cited in Yegidis et al., 2018, p.15) the adoption of theory outside of the social work terrain is an uncommon practice. In this study, Caregiver Dynamic Theory was applied to family caregivers in South Africa it provided insight into the caregiving challenges, relational dynamics, and support needs specific to elderly parolees released on medical parole.

The Caregiver Dynamic Theory is composed of three primary conceptual building blocks: commitment, expectation management, and role negotiation. Each of these core concepts is associated with a corresponding sub-concept that provides further explanatory depth specifically, self-care in relation to commitment, new insight linked to expectation management, and role support within the domain of role negotiation. These interrelated

components collectively inform the evolving nature of caregiver relationships over the course of the illness trajectory (Smith & Liehr, 2018). As an extension of the theoretical model, each major and supportive concept is further subdivided into distinct dimensions that allow for more nuanced analysis (Smith & Liehr, 2008).

A logical method was used to analyse and categorise the qualitative data on the caregivers' lived experiences, and the Caregiver Dynamic Theory, which is presented in Figure 4.1. below.

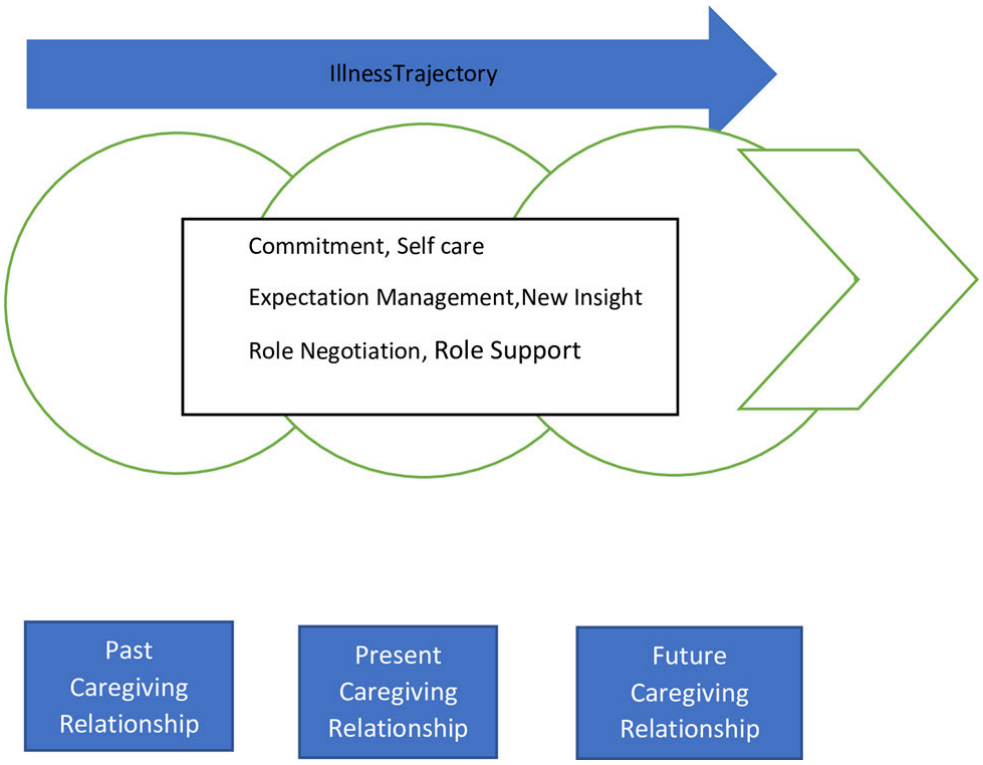

Figure 4.1: Illness Trajectory (Caregiver Dynamic Theory)

Adapted from Corbin and Strauss (1991), "A Nursing Model for Chronic Illness," in Research in Nursing & Health.

4.2.1. Commitment

This discourse, although rooted in extensive literature, presently tends to be more descriptive than critical. The referenced studies (e.g., Cohen et al., 2002, USA, family caregivers of terminally ill patients; Stajduhar et al., 2010; Vitaliano et al., 2003) offer significant insights into the emotional and practical aspects of caregiving; however, a more analytical approach

uncovers potential gaps and limitations in the conceptualisation of commitment and caregiving especially within the varied cultural and socio-economic contexts represented in this research.

For example, while the existing literature portrays caregiver commitment as a manifestation of moral and relational duty, it frequently neglects to critically assess the structural or systemic limitations that influence caregivers' abilities to fulfil these roles. Emotional distress, physical fatigue, and financial pressures are well-documented, yet the frameworks rarely consider how social inequalities or the presence (or absence) of institutional support impact these challenges. In the context of this research, the experiences of some participants indicate that commitment was not solely relational or moral; it was also influenced by necessity, a lack of alternatives, and deeply rooted social expectations, particularly among female caregivers. Moreover, while the literature often emphasises the dual nature of caregiver experiences anticipatory grief and relational enhancement, the subtleties of cultural interpretations regarding duty, sacrifice, and resilience remain insufficiently examined. The current framework, although beneficial in outlining emotional trajectories, does not adequately encompass the collective, intergenerational, and frequently gendered aspects of caregiving that are evident in the narratives analysed here.

Applying this framework to my data has critically revealed that commitment frequently intersects with ambivalence caregivers conveyed profound love and a sense of moral obligation while simultaneously experiencing feelings of entrapment or resentment. This complexity poses a challenge to a strictly normative perspective of commitment as being inherently positive or sustaining. Instead, it necessitates a more nuanced understanding that perceives caregiver obligation as dynamic, context-dependent, and at times, contested. This analysis indicates the necessity to broaden current theoretical models to more accurately represent the realities of caregiving within environments that are structurally constrained or culturally specific.

Existing empirical research on caregiving indicates that family caregivers often grapple with intense emotions such as anger and anxiety, which may be indicative of mental health challenges (Farran et al., 1997; Haley et al., 1995). Within this theoretical context, self-care

is positioned as a vital dimension of commitment, signifying the caregiver's recognition of personal well-being as integral to the sustainability of care. It encompasses a range of intentional practices aimed at preserving physical and psychological health, including the development of adaptive routines and the articulation of emotional responses both constructive and adverse arising from the demands of caregiving. It also includes the necessity of stepping back from caregiving pressures when needed (Smith & Liehr, 2018). Winslow (1997) argues that the demands of caregiving can hinder caregivers from participating in self-care activities. Consequently, this concept aided the researcher to explore how caregivers manage their own wellbeing while providing care and support.

4.2.2. Expectation management

This concept entails anticipating the future and expressing a desire for a return to normalcy. When the future is unpredictable, it entails taking each day as it comes, assessing behaviour based on prior interactions with the patient, and balancing actual treatment outcomes with predicted therapy detours (Willaim, 2007). Expectation management within the caregiver dynamic is essential for ensuring a balanced and sustainable caregiving experience. Caregivers frequently approach their roles with established expectations regarding their duties, the intensity of care needed, and the anticipated outcomes. However, these expectations may be influenced or challenged by the emotional and physical strains associated with caregiving, particularly during end-of-life scenarios (Gaugler et al., 2009). Successful expectation management necessitates effective communication, the establishment of realistic goals, and psychological readiness for the inherent challenges of caregiving, which can alleviate feelings of frustration, burnout, and resentment (Schulz et al., 2003).

Expectation management encompasses five key components: future planning, reestablishing normalcy, embracing the present, evaluating behaviours, and adjusting treatment strategies. Investigating the influence of caregivers' expectations on the caregiving experience, particularly within the context of elderly parolees in the end-of-life phase, is critical for understanding the complex interplay of interpersonal and contextual factors that shape caregiving in such challenging circumstances. A central concept related to expectation management is the acquisition of new insights. The process of assimilating new information

requires a transformation in awareness, often facilitated through personal growth, the development of trust in a higher power, and the recognition of positive treatment outcomes.

As the end-of-life nears, the consequences of these expectations can become especially evident. Caregivers may find it difficult to align their expectations regarding the dying process with the actual decline of a loved one (Kastenbaum, 2000). This disparity between expectation and reality can significantly affect caregivers' levels of commitment, as they may experience emotional turmoil, confusion, or feelings of inadequacy, particularly if they perceive themselves as unable to fulfill the expected demands (Kramer, 1997). Conversely, having clear and realistic expectations about the end-of-life journey can enhance a caregiver's sense of preparedness and emotional resilience, allowing them to navigate the transition more effectively and maintain their commitment to caregiving (Stajduhar et al., 2010).

4.2.3. Role negotiation

Role negotiation is characterised as the caregiver's strategic advocacy for the patient's recovery and autonomy following the assumption of complex care responsibilities that demand collaborative efforts (Williams, 2007). Caregivers engage in role negotiation by identifying actions while considering patient feedback and diligently facilitating communication between patients and the healthcare system (Williams, 2007). This negotiation process is crucial within the caregiver dynamic, as it enables both caregivers and care recipients to effectively navigate their respective responsibilities and needs, particularly during the end-of-life phase. In caregiving relationships, the roles of caregiver and care recipient are subject to frequent changes, necessitating continuous negotiation of responsibilities, boundaries, and expectations (Biegel & Blum, 1988). Caregivers often assume various roles, including emotional supporter, physical caretaker, and financial manager, which requires considerable flexibility and adaptability. The negotiation process aids caregivers in balancing these diverse roles, fostering effective communication with the care recipient, and addressing the inherent challenges of caregiving (Funk et al., 2009).

As individuals approach their end-of-life, the process of role negotiation becomes increasingly significant due to the heightened demands associated with caregiving, which

may lead to an expansion or alteration of caregivers' roles. Family caregivers often encounter a dilemma between their commitment to fulfilling these responsibilities and the emotional, physical, and psychological burdens that such duties can impose (Hirschman et al., 2004). The expectation to provide care during this critical period can intensify feelings of stress and role overload, particularly if caregivers perceive themselves as inadequately prepared or unsupported (Kramer, 1997). Furthermore, the dynamics of role negotiation can influence caregivers' emotional investment, as they may feel a sense of obligation while simultaneously grappling with feelings of helplessness or frustration when they are unable to meet the escalating needs of their loved ones (Pinquart & Sörensen, 2003). Effective communication and well-defined role boundaries are crucial for sustaining a balanced caregiving experience during this pivotal time.

Role negotiation encompasses five dimensions: appropriate pushing, getting a handle on it, sharing responsibilities, attending to patient voice, and vigilant bridging. This study aims to explore how caregivers navigate their roles and responsibilities to promote the autonomy of elderly parolees, as well as how social work reintegration programmes can enhance the caregiving relationship. The concepts of role negotiation and role support are interconnected. Role support refers to receiving skilled and compassionate care, practical assistance with tasks, and access to relevant information (Williams, 2007). It embodies the understanding that others are invested in the caregiver's wellbeing. Support may come in the form of help with financial obligations, or caregivers may devise innovative solutions to address these challenges. The study seeks to identify the specific roles caregivers assume to ensure that medically ill elderly parolees receive adequate support.

One significant factor that drives caregivers' engagement with those they care for is the awareness that their efforts are recognised and valued by others, alongside their genuine experiences of receiving such support (Amendola et al., 2011; Goodhead & McDonald, 2007; Williams, 2014). Consequently, the application of caregiver theory enabled the researcher to explore the experiences of caregivers who provide care for medically ill elderly individuals released on medical parole, as well as to comprehend the contributions of reintegration services in supporting caregivers throughout the illness trajectory.

4.2.4. Caregiver Dynamic Theory: A critique

The Caregiver Dynamic Theory, similar to other theoretical frameworks, is subject to critique. It is important to recognise that although this theory offers a significant lens through which to examine the intricate interactions between caregivers and those receiving care, it may fall short by concentrating primarily on the "dynamic" aspects of the relationship (Shrestha et al., 2023). This focus can overlook critical elements such as power imbalances, the impact of wider social influences, and the varied experiences of caregivers that arise in different circumstances and cultural settings (Methi et al., 2024). A notable criticism of the Caregiver Dynamic Theory pertains to its inadequate consideration of the influence exerted by policies, laws, and institutional frameworks on the caregiving process. The theory fails to thoroughly investigate how macro-level elements, including healthcare policies, social services, and legal regulations (such as medical parole), affect the experiences of caregivers. For instance, policies such as medical parole can impose distinct challenges on family caregivers by transferring the responsibility for caring for elderly individuals on parole to their families, who may not possess the necessary resources or training to deliver effective end-of-life care (Hochschild, 2011). Research conducted by Gaugler et al. (2005) underscores that caregiving is not an isolated phenomenon; rather, caregivers are significantly shaped by the overarching structural systems, something that the Caregiver Dynamic Theory tends to neglect.

4.3. Ecosystems Theory

The Ecosystems Theory, a fusion of systems theory and ecological theory, provides a complex framework for understanding human development. Originally proposed by Urie Bronfenbrenner in 1979 and later refined by scholars such as Darling (2007), Neal and Neal (2013), and Paat (2013), the theory offers a lens through which to explore the intricate relationships between caregiving, reintegration, and the outcomes of transitions into end-of-life care programmes. At the core of the Ecosystems Theory lies the assumption that human development cannot be understood in isolation; rather, it is deeply influenced by the dynamic

interconnections between individuals and their surrounding environments. The theory emphasizes the significance of these interdependent systems ranging from physical settings to social structures, cultural contexts, and institutional frameworks, and highlights the ways in which individuals are shaped by and, in turn, shape these environments. However, while the ecosystems approach underscores the importance of connectivity, it raises critical questions about the clarity of its theoretical assumptions, especially when it avoids making explicit claims regarding the nature of individuals or the environments that influence them. This reluctance to address the underlying principles of human nature or the specifics of environmental factors challenges the applicability of the theory, particularly when considering its role in complex transitions like end-of-life care (Paat, 2013). The reliance on interconnection without a deeper explanation of causality or the fundamental properties of these interactions leaves room for ambiguity in understanding how caregiving outcomes are shaped and what interventions might be most effective in such intricate processes.

The work of Bogenschneider (1997) underscores that the Ecosystems Theory is a comprehensive framework and a contextually aware way to comprehend families and the systems in which they are embedded. Therefore, the Ecosystems Theory was used in this research to assist us to understand the influence of and the role played by social structural context and social work programmes to influence the outcomes of transition to providing end-of-life care (Pardeck,1998).

The Ecosystems Theory conceptualizes the relationship between individuals and their environments as a dynamic interplay, highlighting the reciprocal influence they exert on one another. This perspective necessitates social work interventions to consider both the individual and the various dimensions of their environment. It is essential to maintain a dual focus on the person and their surroundings throughout the support process. Presently, the ecosystems approach equips social workers with strategies to engage at multiple system levels (Pardeck, 1998). This framework underpinned the current study, which explored the experiences of correctional social workers and caregivers involved in end-of-life care.

The Ecosystems Theory posits that the environment encompasses not only the natural geographical context influencing individuals' psychological and social functioning but also

various systems such as familial, economic, educational, religious, and political factors that shape human development and behaviour (Pardeck, 1998). Consequently, applying this framework enabled the researcher to examine how available reintegration social work services enhance the quality of life for medically ill elderly parolees and their family caregivers during end-of-life care.

This theoretical perspective argues that human behaviour results from environmental influences (Pardeck, 1998). It situates medically ill elderly individuals and their caregivers within a subsystem that forms part of a larger system, including family, peer groups, institutions, cultural groups, churches, and broader society (Meyer, 2008). The framework comprises four environmental levels: the microsystem, mesosystem, exosystem, and macrosystem (see Figure 4.2 below). Pardeck (1998) further suggests that current thinking highlights the complex interplay of psychological, social, cultural, political, and physical forces interacting with individuals, as depicted in Figure 4.2.

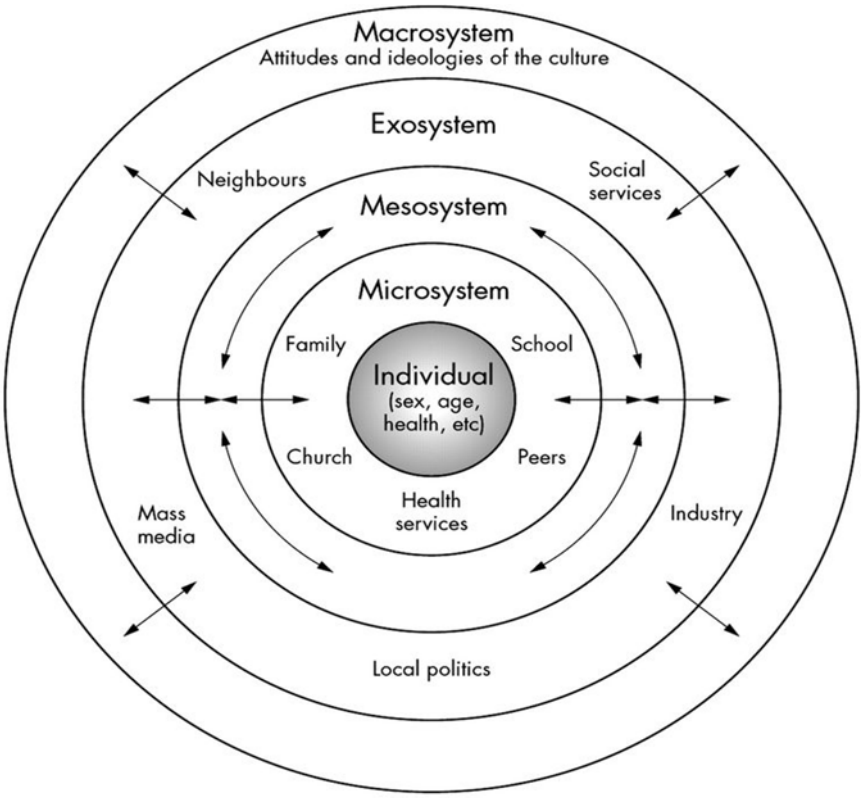

Figure 4.2: Bronfenbrenner's (1979) levels of the ecosystem

Source: Bronfenbrenner (1979)

The Ecosystems Theory posits that alterations within any component of a system will reverberate throughout the entire system (Krieger, 2001). Consequently, the transition of medically ill elderly parolees from incarceration to community living will influence all facets of the system, particularly the family caregivers tasked with their support during this reintegration process. Therefore, the involvement of correctional social work programmes is crucial in sustaining homeostasis, defined as a state of equilibrium where the system adapts to changes (Kirst-Ashman et al., 2002; Alexander, 1985; Preston-Shoot & Agass, 1990). The Ecosystems Theory was pertinent to this study as it highlighted the significant role of correctional social workers during the transitional phase of medically ill elderly parolees. From an ecosystems perspective, this transition impacts parolees through the application of planning activities, policies, psychotherapy, and various micro-level interventions (Payne, 2005).

According to the Ecosystems Theory, despite that an individual is part of the broader system, they also need other people and resources to survive (Du Bois & Miley, 2005). Within this theory, which comprises different levels of the system (micro, macro, mezzo, and exo systems), there is constant interaction between risks and protective factors. These interactions can have either a good or negative impact on an individual's life. In this study, the Ecosystems Theory was used as a theoretical lens to study terminally ill elderly parolees facing numerous transitional challenges that demand a strong social support system to help them adjust as they re-enter the family and the community, enduring several health-related issues.

4.3.1. Micro system

The Ecosystems Theory provides a comprehensive framework for analysing the diverse functions of family caregivers and correctional social workers in the care of elderly parolees during their end-of-life stage. The microsystem, which encompasses the immediate environment that interacts directly with the elderly parolee (Bronfenbrenner, 1977, 1979; Teater, 2014) is particularly significant in examining the relationships among family members, parolees, and correctional social workers. This theoretical approach facilitated an

investigation into how these stakeholders' family caregivers and correctional social workers manage the intricate challenges associated with reintegration and end-of-life care.

Existing research consistently demonstrate that family caregivers frequently endure substantial emotional, psychological, social, and physical stress as they adapt to the complexities of caregiving especially when attending the multifaceted/ specific needs of elderly parolees facing terminal conditions (Denckla & Berman, 2001; Jacksonville Community Council, Inc., 2001; Nelson & Trone, 2000). Schulz and Sherwood (2008) highlighted the significant burden placed on family caregivers, particularly in end-of-life care, where they must manage not only medical needs but also the emotional challenges and complexities associated with reintegration after incarceration. Similarly, studies by Gaugler et al. (2005) and Li et al. (2019) underscore the heightened stress experienced by caregivers supporting individuals with complex backgrounds, such as elderly parolees, as well as the challenges they face in balancing their own personal lives while ensuring the well-being of the parolees.

The contribution of correctional social workers is equally vital. Their role, particularly during the transition from incarceration to medical parole, involves evaluating the health needs of the parolee and coordinating resources for end-of-life care. The correctional social worker serves as a link between the parolee's institutional history and their reintegration into the community, collaborating closely with family caregivers to establish suitable care plans (Roberts, 2011).

4.3.2. Mesosystem

The mesosystem, as articulated by Bronfenbrenner (1977, 1979) and further developed by Teater (2014) encompasses the interactions and relationships among various elements within the microsystem, including the dynamics between family caregivers and correctional social workers. This analytical level is particularly significant when investigating the interactions among elderly parolees, their family caregivers, and correctional social workers within the context of their wider community, especially during the critical phase of end-of-life care.

Empirical evidence suggests that the relationship between family caregivers and correctional social workers is essential for ensuring that elderly parolees with terminal conditions receive the necessary care and support (Nduli & Mthembu, 2022). Research conducted by Lindquist (2013) underscores the importance of effective communication and collaboration between these two groups in addressing the multifaceted needs of elderly parolees throughout their reintegration and subsequent care. Family caregivers, who often endure significant emotional and physical stress, require support and direction to manage the medical, emotional, and logistical complexities associated with caring for a terminally ill family member. Kuo et al. (2009) assert that correctional social workers can play a vital role in connecting institutional care with community resources, thereby enhancing the coordination of health services, offering emotional support, and assisting families in comprehending the medical and legal requirements of the parolee during this transitional period.

In the context of community dynamics, the function of the correctional social worker transcends mere direct intervention, encompassing the facilitation of connections with various community resources. These resources, including hospice care, home health aides, and mental health services, are crucial for delivering holistic support to elderly parolees during their final life stages (Freedman et al., 2009). Nevertheless, caregivers frequently encounter obstacles in accessing these services, which may stem from structural impediments, insufficient financial means, or a lack of awareness regarding available support networks (Patterson & Lampley, 2014).

Family caregivers play a vital role in the wellbeing of elderly parolees; however, they often grapple with feelings of isolation, guilt, and frustration, especially when they have limited access to support services or feel inadequately prepared to meet the challenges of end-of-life care (Harris et al., 2015). The mesosystem perspective highlights that the quality of interactions between family caregivers and correctional social workers significantly influences the caregiving experience. Research indicates that when correctional social workers actively engage with caregivers, offering both emotional and practical support while connecting them to pertinent resources, caregivers report increased confidence and reduced feelings of being overwhelmed (Nduli & Mthembu, 2022; Wolff et al., 2010).

The context of the community significantly influences the dynamics of interactions involving elderly parolees. Elements such as local perceptions of parolees, the accessibility of social services, and the readiness of community members to assist families caring for elderly parolees with terminal illnesses are critical in determining the success of reintegration efforts. These factors also affect how caregivers manage their responsibilities. Research conducted by Maruna and LeBel (2003) indicates that communities characterised by robust social support networks and favourable reintegration experiences yield improved outcomes for both parolees and their caregivers, especially during difficult times such as end-of-life care.

Moreover, the mesosystem as outlined in the Ecosystems Theory offers a pertinent framework for examining the relationships among family caregivers, correctional social workers, and the wider community in the context of caring for terminally ill elderly parolees. This perspective emphasizes the significance of interactions and support mechanisms among these essential entities, underscoring the necessity of collaboration and community resources in alleviating the caregiving burden, facilitating a dignified end-of-life experience for elderly parolees, and enhancing the overall quality of life for their caregivers.

4.3.3. Macrosystem

The macrosystem, as described by Bronfenbrenner (1977, 1979) and further examined by Teater (2014) refers to the extensive societal elements that affect human development, including cultural norms, socio-economic factors, legal frameworks, and public policies. This overarching system significantly impacts the quality of care available to elderly parolees, especially during their end-of-life stages, as well as the experiences of family caregivers and correctional social workers. The macrosystem's effects encompass the societal and policy structures that determine individuals' access to essential resources and their overall quality of life. These considerations are particularly vital when analysing the influence of medical parole policies on the reintegration of terminally ill elderly parolees and the difficulties encountered by their caregivers.

Medical parole policies, aimed at facilitating the release of incarcerated individuals suffering from severe, often terminal, health conditions can immensely affect the caregiving landscape

for elderly parolees. Research indicates that these policies present both advantages and challenges for families and correctional social workers (Willis, 2025). On the one hand, medical parole offers elderly parolees the opportunity to receive palliative or hospice care within a community environment, which may alleviate some pressure on prison healthcare systems (Hochschild, 2011). On the other hand, these policies can impose significant challenges on family caregivers, who may lack the necessary resources, training, or support to address the intricate needs of a terminally ill family member transitioning from incarceration to community living (Martinson & Berridge, 2014).

Research examining the effects of medical parole on family caregivers indicates that the transition from institutional to home-based care can induce considerable emotional and physical strain (Haley et al., 2014; Mabuto et al., 2024). Family caregivers, particularly those lacking access to professional training or healthcare resources, may find it challenging to manage pain relief, medication regimens, and other critical components of end-of-life care (Quinn & Daunhauer, 2016). Additionally, these caregivers may experience feelings of isolation, as the reintegration of the parolee often evokes stigmas associated with their criminal background, complicating the caregiving relationship (Pettus-Davis & Epperson, 2013). Investigations, such as those conducted by Harris et al. (2015), reveal that family caregivers frequently feel unprepared for their roles and have limited formal support systems to assist them, a situation that becomes particularly concerning when medical parole permits individuals to return home during their final life stages.

For correctional social workers, medical parole policies offer both advantages and challenges. These professionals are essential in facilitating the parole process, evaluating the medical needs of parolees, and collaborating with healthcare providers and family members to ensure a seamless transition. However, they often encounter significant obstacles, including insufficient training in end-of-life care, a lack of resources to assist families, and bureaucratic hurdles that impede the timely provision of medical care and services for parolees (Maruna, 2001). The broader legal and healthcare frameworks can restrict the resources accessible to both parolees and their families, complicating the social worker's responsibilities (Berk, 2015). Research by Roberts (2011) underscores that correctional social worker frequently

face difficulties in reconciling institutional protocols with the specific needs of elderly parolees, particularly in the context of end-of-life care.

The macrosystem encompasses cultural values and socio-economic conditions that influence societal perceptions and care practices for terminally ill elderly parolees. Cultural factors are pivotal in shaping caregiving approaches, particularly within family dynamics. For example, in cultures that emphasize strong familial ties, caregivers may bear substantial responsibilities for end-of-life care, which can heighten emotional strain (Choi et al., 2025). Conversely, societal attitudes towards incarceration and parole can also affect the quality of care received. In communities where parolees or individuals involved in the criminal justice system are viewed negatively, families may face social stigma, complicating their access to community resources and social support (Wolff et al., 2010). The interplay of these cultural norms and societal perceptions with macro-level policies, such as medical parole, significantly impacts the experiences of caregivers and social workers, often intensifying the difficulties they encounter in delivering adequate care to terminally ill elderly parolees.

In summary, the impact of the macrosystem on the caregiving experience and the function of correctional social workers is significant, particularly when examining the convergence of medical parole policies, cultural values, and socio-economic factors. Medical parole policies can profoundly influence the caregiving landscape, while simultaneously presenting considerable challenges for caregivers and social workers alike. These challenges highlight the necessity for more robust support systems and the critical importance of considering socio-political and cultural contexts when assessing the experiences of those caring for elderly parolees in their final stages of life. A comprehensive understanding of the broader societal elements within the macrosystem is essential for identifying the systemic barriers and opportunities that affect the quality of care for terminally ill elderly parolees.

The Ecosystems Theory postulates that discrepancies between personal and environmental attributes reduce positive outcomes and may lead to problematic behaviour or negatively affect the person, psychologically (Germain, 1973). Throughout the reintegration process, family caregivers who have not been prepared may find it difficult to be effective in their caring role. In addition, the lack of supportive services further exacerbates caregivers'

dissatisfaction with life which may lead to desperation and depression among them (Doherty et al., 2014). The Ecosystems Theory emphasizes the need for family caregivers to benefit from resources and social support programmes offered by social workers for them to help alleviate the burden of caring for an ill elderly parolee.

Additionally, the Ecosystems Theory requires social workers to concentrate on understanding elderly parolees and caregiver surroundings. This entails being aware of all the systems the client engages with and how those interactions affect the reintegration process during end-of-life care. This framework is pertinent to social work because it improves the knowledge of common social issues and facilitates the development of solutions that guarantee a better match between clients and their surroundings. Furthermore, the Ecosystems Theory is suitable to understand the needs of elderly parolees and their caregivers. This assists the present research to understand their transactions and relationships across many ecological systems and the different factors, which impede or enable successful reintegration during end-of-life care.

4.3.4. A critique of the Ecosystems Theory

Notwithstanding the fact that the ecosystems viewpoint has commonly been acknowledged in the social work profession, there are unavoidable limitations which have been helpful in refining the various concepts that make up the Ecosystems Theory. The Ecosystems Theory suggests that human behaviour can be predicted by assuming a “cause-effect relationship” (Berger et al.,1999, p. 49). According to some of the proponents of the Ecosystem Theory, which argue that systems have an innate ability to maintain homeostasis by restructuring their constituent parts to preserve balance. This might be seen as systems of people or groups that oppose change to maintain the equilibrium of the system. However, at times, these "harmonious relationships" are neither “equal nor mutually agreed upon.” According to some theories, power struggles inside and across institutions can lead to inequality since power is allocated according to aspects like “gender, ethnicity, and socioeconomic status” (Berger et al., 1999, p. 48). Thus, whilst applying the Ecosystems Theory, it is essential to consider questions of power and chaos in rendering end-of-life care during reintegration.

4.4. Integration of Theories in Medical Parole Context

Combining the Caregiver Dynamics Theory and the Ecosystems Theory provides a nuanced and comprehensive lens through which to understand the multifaceted challenges of caregiving and reintegration for elderly parolees in South Africa. While Caregiver Dynamic Theory focuses on the relational, emotional, and practical dimensions of caregiving, Ecosystems Theory situates these experiences within broader social, cultural, economic, and policy contexts, enabling a more holistic understanding of the factors influencing both caregivers and elderly parolees.

From a Caregiver Dynamic Theory perspective, caregiving is understood as a dynamic process involving commitment, expectation management, and role negotiation. In the context of elderly parolees on medical parole, this theory highlights how family caregivers navigate complex emotional landscapes, balancing their sense of moral duty and love for the parolee with practical constraints, fatigue, and psychological stress. Caregiver Dynamic Theory provides insight into the micro-level experiences of caregivers, including the ambivalence they may feel between commitment and resentment, the strategies they adopt to manage expectations during unpredictable end-of-life trajectories, and the negotiation of evolving roles to ensure the parolee's autonomy and dignity. For example, a caregiver may struggle to maintain commitment while simultaneously coordinating medication administration, arranging medical appointments, and advocating for the parolee within healthcare and social services systems.

Conversely, Ecosystem's theory situates these caregiving experiences within a broader social ecology, accounting for interactions at multiple system levels: microsystem, mesosystem, exosystem, and macrosystem. At the microsystem level, caregivers' interactions with parolees and social workers are shaped by the immediate home environment, the health condition of the parolee, and family dynamics. At the mesosystem level, the quality of collaboration and communication between family caregivers, social workers, healthcare providers, and community organizations directly influences the success of reintegration and the ability to provide effective end-of-life care. At the macrosystem level, cultural norms, socio-economic conditions, and medical parole policies create structural opportunities or

constraints, affecting access to resources, social support, and caregiving expectations. For instance, policies governing medical parole in South Africa place considerable responsibility on families to provide care, often without formal training or adequate resources, which may exacerbate stress and affect the quality of care provided.

The integration of Caregiver Dynamic Theory and Ecosystems Theory is particularly valuable for social work practice. It enables correctional social workers to adopt interventions that address both the relational-emotional aspects of caregiving and the systemic-environmental influences on reintegration. For example, by applying Caregiver Dynamic Theory, social workers can identify areas where caregivers need emotional support, respite, or guidance on role negotiation, while ET informs strategies to mobilize community resources, coordinate healthcare services, and advocate for policies that facilitate smoother transitions for elderly parolees. This dual perspective ensures that interventions are not only person-centered but also contextually grounded, acknowledging the reciprocal influence between individual behaviours and environmental conditions.

Moreover, integrating Caregiver Dynamic Theory and Ecosystems Theory allows researchers and practitioners to identify risk and protective factors that influence caregiving outcomes. Risk factors, such as caregiver isolation, limited financial resources, or stigma associated with parolees, can be mitigated through Ecosystems Theory-informed interventions like community-based support groups, partnerships with healthcare providers, or policy advocacy. Protective factors, including strong family bonds, supportive social networks, and access to social work programs, can reinforce caregiver resilience and enhance the wellbeing of elderly parolees.

Ultimately, the combined application of Caregiver Dynamic Theory and Ecosystems Theory in the context of elderly parolees on medical parole underscores the complex interdependence between individual experiences and systemic conditions. It facilitates a comprehensive understanding of how caregiving responsibilities, social support structures, institutional policies, and cultural expectations converge to shape the reintegration experience. By leveraging insights from both theories, social workers can design more effective, evidence-

informed interventions that support caregivers, improve the quality of end-of-life care, and promote the successful reintegration of elderly parolees into the community.

4.5. Summary

This chapter provided a thorough exploration of two significant theoretical frameworks namely the Ecosystems Theory and the Caregiver Dynamics Theory. The Ecosystems Theory emphasizes the intricate interplay between individuals and their environments, highlighting how various systems such as family, community, and societal structures impact the experiences and wellbeing of elderly parolees. This perspective encourages correctional social workers to consider not only the individual needs of elderly parolees but also the broader contextual factors that influence their lives.

On the other hand, the caregiver dynamics theory focuses on the relationships and interactions between family caregivers and the elderly parolees they support. It examines the emotional, psychological, and social aspects of caregiving, recognising that the wellbeing of caregivers is intrinsically linked to the quality of care provided to older adults. Understanding these dynamics is essential for correctional social workers, as it allows them to address the needs of both family caregivers and care recipients, fostering a more holistic approach to intervention.

A comprehensive understanding of these aging and caregiver theories is vital for correctional social workers who engage with elderly parolees released on medical parole. Such knowledge shapes their perceptions during the helping process, guiding them in recognising the multifaceted challenges faced by this population. It also informs the selection of optimal intervention strategies, enabling social workers to tailor their approaches to enhance the overall wellbeing of elderly parolees and their caregivers. By integrating these theoretical frameworks into their practice, correctional social workers can develop more effective support systems that address the unique needs of elderly parolees and their family caregivers. In the context of the current study, these theories were instrumental in the data analysis process. They provided a lens through which the data was interpreted, allowing for a deeper understanding of the experiences and challenges faced by elderly parolee and their caregivers

during end-of-life. By applying these frameworks, the researcher was able to uncover nuanced insights that might otherwise have been overlooked.

The next chapter delves into the methodology adopted in this study, offering a detailed overview of the research design, data collection methods, and analytical techniques used. Additionally, the chapter addresses the ethical considerations that guided the research process, ensuring that the rights and wellbeing of participants were prioritised throughout the study. This comprehensive overview lays the groundwork for understanding the findings and implications of the research, further contributing to the field of social work and the support of elderly parolees nearing their end-of-life experience.

CHAPTER 5

METHODOLOGY

5.1. Introduction

This chapter presents and critically discusses the study's research design and methodological underpinnings, including the research paradigm, the methodological approach, and the data generation and analysis techniques used to address the research questions. A qualitative methodology was employed to explore the complex and subjective experiences of elderly offenders navigating end-of-life care while reintegrating into society following their release on medical parole. This approach was particularly suited to capturing the depth and variability of perspectives offered by family caregivers and correctional social workers engaged in this multifaceted process.

Furthermore, this chapter offers a comprehensive account of the ethical consideration and challenges encountered throughout the research process. Ethical approval for the study was obtained from the Human Research Ethics Committee of the University of KwaZulu-Natal (Protocol number: HSSREC/00006622/2024) (Appendix G).

5.2. Epistemological and ontological assumptions of the study

The interplay between ontology, epistemology, and the selected methodological framework is crucial in guiding the trajectory of this research, as it directly informs both the research design and the interpretation of the findings. This study is grounded on an interpretive ontological perspective, positing that reality is not a static or objective entity but is shaped by human experiences (Guba & Lincoln, 1994). These philosophical foundations substantiate the selection of semi-structured interviews as a data collection method, enabling a comprehensive examination of the intricate lived experiences of family caregivers and correctional social workers involved in end-of-life care during reintegration.

The choice of semi-structured interviews as a data method reflects the necessity to capture participants' personal and subjective realities while offering a flexible yet organised framework for data collection (Kvale, 2007). This method is consistent with the epistemological premise that knowledge is co-constructed through the interaction between

the researcher and the participants, thereby fostering a deeper comprehension of how individuals interpret their caregiving roles within complex environments. Furthermore, the alignment of ontological and epistemological assumptions with the selected methodology ensures that the study's philosophical framework is congruent with practical data collection methods, essential for establishing the trustworthiness of the findings (Lincoln & Guba, 1985). Therefore, maintaining coherence among the ontological, epistemological, and methodological elements is essential for preserving the integrity of the research process and ensuring that the outcomes are meaningful and a reflection of the participants lived experiences. This philosophical consistency is foundational to the relevance and credibility of the study's contributions.

5.3. Research paradigm

The theoretical, philosophical, and methodological framework that underpins this research is rooted in interpretivism. According to Bezuidenhout, Davis, and Du Plooy-Cilliers (2014), interpretivist research seeks to profoundly comprehend the subject matter, often necessitating the researcher engaging extensively with participants. This engagement allows the researcher to grasp how individuals navigate their daily lives and discern what holds significance and meaningful. Within this study, the interpretive paradigm underpinned the inquiry into the lived experiences of family caregivers and correctional social workers involved in supporting the reintegration of elderly parolees released on medical parole. By privileging participants' perspectives, this paradigm facilitated an in-depth exploration of the subjective meanings attached to caregiving and professional support in complex and often emotionally charged contexts.

From an interpretivist's perspective, the social work researcher aimed to understand the meanings that individuals ascribe to their interactions with other humans and to the broader society in which they live (Pulla & Carter, 2018). Creswell (2009) argues that knowledge and meaning arise through the act of interpretation, rejecting the notion of objective knowledge as existing independently of human thought and reasoning. Wahyuni (2012) emphasises that the interpretative paradigm is grounded on the values/ principles of subjectivity, plurality, changeability, and social constructivism while recognising the researcher' s active and reflective role. Therefore, as a social work researcher, one was interested in understanding

the experiences of participants providing care and support during end-of-life. By adopting this paradigm, as a social work researcher, one was able to create meaning from individual experiences. The researcher supports the point outlined by Pulla and Carter (2018), who assert that as a social work researcher, the researcher is interested in how people make sense of the world, how they understand the behaviours of other people, or how they understand interactions between different people. Similarly, Cohan and Manion (1994) argue that using this paradigm facilitates researchers' understanding of the phenomenon of interest and the ability to derive knowledge during qualitative research.

It is essential to recognise that the interpretive paradigm possesses certain intrinsic limitations. Alharahsheh and Pius (2020) argue that interpretive research is criticised for its assumption that reality is subjective and varies among individuals; this perspective may result in the conclusion that research participants are unlikely to offer universally applicable interpretations. The data gathered and analysed within the interpretive paradigm is less amenable to generalisation, as it is predominantly shaped by specific contexts, viewpoints, and values (Alharahsheh & Pius, 2020). To address these limitations, the researcher selected participants identified by correctional social workers for the first sample, as well as individuals from the same profession and organisation for the second sample. This approach enabled the researcher to identify variations in individual experiences related to the research topic while synthesising common perspectives regarding the factors influencing the reintegration of elderly parolees during end-of-life care.

Additionally, Pham (2018) highlights that interpretivist prioritise achieving a nuanced understanding of phenomena within their contextual complexities rather than generalising findings to broader populations or settings; this focus can create challenges in establishing the validity and applicability of research outcomes through scientific methodologies. To mitigate this issue, the researcher elaborates how the study's trustworthiness can be upheld and how its trustworthiness and relevance can be substantiated through appropriate scientific practices. The table below reflect on the characteristics of interpretivism.

Table 5.1: Characteristics of interpretivism

Feature	Description
Purpose of research	To explore the experiences of caregivers and correctional service providers during the reintegration process of elderly offenders released on medical parole and the role that end-of-life care programmes play after incarceration.
Ontology	• There are multiple realities. • Human interactions and meaningful actions can be used to explore and construct reality. • Learn how people make sense of their social worlds in natural settings through daily routines, conversations, and writings while interacting with others. • Many social realities exist as a result of varying human experience, such as people's knowledge, perspectives, interpretations, and experiences.
Epistemology	• Research participants socially construct knowledge by engaging in real-life or natural settings. • In an interactive process of talking and listening, reading and writing, the inquirer and the inquired-into are intertwined. • Data collection is more personal and interactive.
Methodology	• Data collection processes entail using literature, interviews, and focus groups. • The values of the researcher influence research.

5.4. Research questions

A research question serves as the focal point that the study aims to address (Bailey, 2016). These questions are vital for establishing the parameters and direction of the research (Blaikie

& Priest, 2019). Denscombe (2012) emphasises that formulating a research question is a fundamental initial step that offers a framework for the investigation, facilitating the connection between the literature review and the types of data to be gathered. Essentially, the research question articulates what the researcher seeks to discover, emerging from a specific challenge encountered in the field. For this study, the research questions were articulated as follows:

1. What factors influence the reintegration process of elderly offenders released on medical parole during their end-of-life care phase from the perspective of family caregivers?
2. What are the experiences of caregivers taking care of elderly offenders released on medical parole during their end-of-life-stage care stage?
3. How does the available reintegration of social work services promote and improve the quality of care of terminally ill elderly parolee and their caregivers during end-of-life care?
4. What are the challenges and realities that community corrections social workers face when providing reintegration services to elderly offenders released on medical parole?

5.5. Research methodology

Selecting an appropriate research methodology was considered a complex task, given a range of available approaches for addressing the research questions. This study adopted a qualitative research approach which was well-suited to answer the research questions that informed the study. Qualitative research methods were deemed essential for understanding the narratives and actions of caregivers and correctional social workers. This approach was particularly well-suited for exploring participants' real-life experiences and perspectives on sensitive issues related to end-of-life care. This section outlines in detail the qualitative methodology employed in this study and its relevance to the research aims.

The focus of this study, medical parole and elderly parolees in South Africa, remain largely misunderstood. According to Shaw (2003, p.62), “qualitative research draws attention to features of a situation that others may have missed but which once seen have major implications for practice. It counteracts a tendency to treat the powerless as creatures with something less than normal human feelings”. This form of inquiry allowed the researcher to

gain in-depth insight into the subjective world of participants by exploring the "why" questions of the research (Maree, 2007). Denzin and Lincoln (2004, p.2) capture the idea perfectly as follows:

> "Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena, in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials... that describe routine and problematic moments and meanings in individuals' lives."

In this study, the qualitative approach enabled correctional officials and family caregivers to provide insight into their feelings, attitudes, and experiences during reintegration.

5.6. Research design

Utilising a paradigmatic framework to fulfil the objectives of the study was crucial for maintaining philosophical coherence throughout the research. This approach ensures alignment with the selected methodological strategies and the underlying epistemological and ontological assumptions, thereby offering a comprehensive structure for comprehending the intricate realities faced by individuals involved in end-of-life care during the reintegration process. This research employed a phenomenological design to explore the lived experiences of family caregivers and correctional social workers who provide end-of-life care to elderly offenders transitioning back into society following their release on medical parole. Phenomenology, as a qualitative research design, emphasises the understanding and articulation of individuals lived experiences and the meanings they derive from those experiences (Van Manen, 1990). The study aimed to elucidate the main challenges, support mechanisms, and emotional complexities endured by family caregivers and correctional social workers in providing end-of-life care, while also analysing their contributions to the reintegration process.

The choice of phenomenology is particularly appropriate for the current study, as it aims to achieve a profound comprehension of the subjective experiences of the participants. Moustakas (1994) posits that phenomenology centres on how individuals perceive and engage with a specific phenomenon, offering valuable insights into meaning-making processes that influence their actions and beliefs. In this context, the phenomenon under

scrutiny is the delivery of end-of-life care to terminally ill elderly offenders within a reintegration framework, with a focus on how family caregivers and correctional social workers navigate their roles in this often intricate and emotionally charged environment. The strength of the phenomenological design in this research lies in its capacity to reveal the complicated and usually obscured elements of caregiving experiences. Giorgi (2009) notes that phenomenology is particularly effective in elucidating lived experiences in contexts characterised by multiple complexities, such as caring for elderly offenders on medical parole. This methodological framework allows the study to investigate the actions of caregivers and social workers, their interpretations of their roles, and the emotional and logistical challenges they encounter in the caregiving process.

Furthermore, phenomenology enhances the understanding of the reintegration process by emphasising the emotional, psychological, and social aspects of care. This approach facilitates an exploration of how caregivers and correctional social workers navigate their responsibilities, manage their emotional responses, and seek or offer support to elderly parolees. Consequently, it yields important insights into the dynamics that may either promote or obstruct the successful reintegration of elderly offenders, a significant issue in the context of end-of-life care and reintegration (Katz et al., 2010). This was shown by the use of narrative communication to "hear" people's first-hand experiences of providing care and assistance to elderly parolees diagnosed with a life-limiting illness, released on medical grounds. Narrative communication involves recounting events, tales, and human experiences to listeners, audiences, or researchers. It is informed by the ontological idea that human communication is intrinsically narrative (Hinyard & Kreuter, 2007; Kellas, 2008), and that all human communications are tales that are created into narratives.

Moreover, narratives play a vital role in communication, and it has been widely used in research to address and facilitate social change. It is particularly impactful in the field of health, social, interpersonal communication for social and behavioural change and tackling various social concerns (Hinyard & Kreuter, 2007; Kellas, 2008). The narrative style allowed study participants to recount personal experiences of providing care and support to terminally elderly parolees during their end-of-life care. Personal experience in the current study were a powerful tool of narrative communication. What makes “the personal” powerful is its

propensity towards the communal, that in sharing our personal stories, we connect to others within a broader community.

The narrative interview process presented several challenges for the social work researcher, who had to adeptly navigate the dynamics of the conversations, interpret participant responses, and synthesise the gathered data. For the narrative interview to produce valuable insights, the researcher placed significant emphasis on establishing trust. Consequently, it was essential for the researcher to cultivate rapport with participants, thereby encouraging openness and facilitating the extraction of meaningful and genuine data. Throughout this study, the researcher encountered a degree of scepticism from participants, who expressed concerns that their disclosures might be used against them or lead to adverse personal repercussions. This apprehension affected the participants' trust in the researcher and shaped their responses to the questions posed.

Furthermore, discussions surrounding end-of-life issues often elicited intense emotional reactions from participants. Consequently, the researcher bore the responsibility of remaining attuned to these emotional responses and reminding participants of their right to withdraw from the study at any point. Correctional social worker participants in this study, owing to their professional training and responsibilities, frequently upheld emotional boundaries and restricted the depth of personal feelings or opinions shared during interviews. This limitation posed challenges in accessing the authentic, personal narratives essential for comprehensive qualitative analysis. To address this issue, the researcher emphasised the significance of the social workers' perspectives in enhancing practice, assured confidentiality, and exhibited empathy and understanding. Furthermore, the researcher positioned the interview as a platform for reflective practice and professional development, thereby encouraging more profound engagement. It is essential to recognise that this approach was crucial in acknowledging their expertise while providing a safe space for vulnerability, ultimately promoting more candid and reflective responses.

The adoption of a phenomenological design allowed this study to deeply engage with the lived experiences of family caregivers and correctional social workers, uncovering the complexities of providing end-of-life care during the reintegration of elderly offenders. By

focusing on subjective experience and meaning-making, phenomenology enriched the understanding of the emotional, social, and practical dynamics at play in this complex caregiving context and provided a foundation for future interventions and policies aimed at supporting caregivers and offenders during this critical phase of reintegration.

5.7. An Overview of the Data collection process

The interviews for this research were conducted at Durban Community Corrections, a non-custodial centre that operates under South Africa's Department of Correctional Services. This centre is responsible for managing non-institutional correctional measures, addressing individuals who have received various forms of sentencing, such as probation, medical parole, and other community-based penalties. Its primary objective is to facilitate the rehabilitation and reintegration of offenders into society. The study utilised qualitative research methods to investigate the experiences related to end-of-life care among elderly offenders who were transitioning back into the community after being granted medical parole, as perceived by their family caregivers and correctional social workers. The data collection process commenced with the identification and selection of participants, followed by recruitment, interviews, and ultimately the analysis of data, as elaborated in the subsequent sections.

5.7.1. Identification and selection of study participants

The study adopted non-probability sampling, meaning the sample was not selected using a random sampling method. Schreiber and Asner-Self (2011) argue that the nature of the information sought by the researcher, along with the specific demographic groups and documents or contexts deemed most appropriate for gathering that information, significantly influences the sampling methods used in qualitative research. In this research, purposive sampling was used to select study participants. Purposive sampling is "associated with research designs that are based on the gathering of qualitative data and focuses on the interpretation of experiences and perceptions", hence it is relevance for this study (Matthews & Ross, 2010:167). The participants were therefore selected based on well-defined criteria, with the primary focus on ensuring that the sample was representative of the study community (Bryman & Bell, 2009).

The study sample comprised 15 caregivers and six (n = 6) correctional social workers from the Durban Community Corrections Centre. Although the initial plan was to recruit 10 correctional social workers, only six were employed at the selected Community Corrections facility in eThekwini, which directly constrained the attainable sample size. Social workers who handle medical parole cases are very few, and only those directly involved with elderly parolees on medical parole met the eligibility criteria. Despite the small number, saturation was reached because their roles are highly specialised and their experiences relatively homogenous. Access to additional facilities required Department of Correctional Services approval, and several centres either declined participation or experienced delayed authorisation processes that extended beyond the study timelines. The rationale for interviewing 15 caregivers was informed by the concept of data saturation, which suggests that data collection continues until no new themes or information emerge that would alter or enhance the study's conclusions. Reaching saturation ensures that the researcher has comprehensively understood the phenomenon being studied (Fusch & Ness, 2015). In this study, saturation was reached at the 10th interview when no new information was provided, but it proceeded to the 15 interviews to ensure that no new data was excluded. Guest, Bunce, and Johnson (2006) argue that saturation in homogeneous groups is obtained during the 12th interview. The following criteria were to select participants.

5.7.1.1. Eligibility criteria for family caregivers were based on the following:

1. The participant is a primary caregiver caring for an elderly offender released on medical parole
2. The participants have taken care of medical parolees for a period exceeding 6 months
3. The participant is of any gender, race, culture or religion
4. The participant is willing to participate voluntarily and provide informed consent.

5.7.1.2. Eligibility criteria for Department of Correctional Services Employees were based on the following:

1. The participant is an employee working under the Department of Correctional Services
2. The participant is a registered correctional social worker
3. The participant is responsible for rendering post incarceration reintegration programmes to parolees in the Department of Correctional Services.
4. The participant is willing to participate voluntarily and provide informed consent
5. The participant has experience in delivering reintegration programmes to medical parolees.

5.7.2.1. Selection and Recruitment of Correctional Social Workers

Participants were recruited through the Department of Correctional Services (DCS). Upon ethical approval from the Department of Correctional Service, an internal memo was issued by the DCS to the respective correctional centre involved on behalf of the researcher. The memo alerted the head of prison of the intended research and requested for arrangements to be made between the researcher and the Centre. As soon as the correctional centre considered the memo, the researcher then made preliminary visits to the study site, Durban Community Corrections. The objective of these visits was to inform the management of the correctional facility regarding the purpose of the proposed research, to seek their permission, and to address any inquiries from potential participants related to the study. After being granted permission, the researcher issued recruitment letters which included a detailed outline of the study, and the risks involved should they choose to participate. These recruitment letters were returned to the researcher with the date and time the participants expected to arrive for their interviews. Although the employer granted permission for participants to partake in the study, these participants still reserved the right to refuse to participate since participation in this research was voluntary.

5.7.2.2. Selection and Recruitment of Family Caregivers

Following acquiring the area manager’s consent, the recruitment process was conducted in collaboration with correctional social workers. These professionals played a crucial role in identifying and inviting potential participants to a presentation led by the researcher, which outlined the research's aim, objectives, and methodology. The social work researcher

distributed 20 recruitment letters to individuals who expressed interest to attend the presentation, during which the procedures for in participating in the study were thoroughly discussed. While their support was instrumental in identifying potential participants, careful attention was paid to the ethical complexities involved particularly the potential for perceived coercion given the power correctional social workers may hold over individuals within the correctional and parole system. To mitigate this risk, correctional social workers were briefed on the importance of voluntary participation and were instructed not to directly approach individuals on the researcher's behalf or apply pressure to participate. Instead, they informed potential participants about the study and directed those interested to contact the researcher independently. This strategy helped preserve autonomy and reduce the influence of institutional authority, aligning with ethical standards in qualitative research involving vulnerable populations (Orb, Eisenhauer & Wynaden, 2001; Hennink, Hutter & Bailey, 2020). Additionally, during the informed consent process, participants were reminded that their decision to participate or not would have no bearing on their access to services or their relationship with correctional social workers.

To ensure ethical recruitment, the social work researcher made it clear to all prospective participants that their involvement in the study was entirely voluntary. Participants were given the autonomy to decide whether to take part and were explicitly informed that choosing not to participate would have no impact on any services they currently receive or may receive in the future. During the recruitment presentation, the researcher encouraged questions and provided detailed explanations to address any concerns, thereby promoting transparency and informed decision-making. Importantly, to prevent any undue influence, the recruitment process was carried out solely by the researcher, not by the correctional social workers. This precaution was taken to minimise the risk of perceived coercion, given the authority correctional social workers hold in relation to parolees and their families. It was recognised that if correctional social workers had approached participants directly, there could be a risk that individuals might feel pressured to participate believing it could affect their access to support or services from the Department of Correctional Services. By maintaining a clear boundary between institutional authority and research participation, the study upheld ethical standards for voluntary, informed consent in research involving potentially vulnerable populations (Orb, Eisenhauer, & Wynaden, 2001).

In some cases, there were more than one caregiver actively involved in caring for an ill person, meaning that the caregiving responsibilities were shared in such families. For this study, a primary family caregiver is someone who is faced with the responsibility of taking care of the terminally ill parolee and makes decisions on the type and nature of care the person is supposed to receive.

5.8. Data collection method

Individual interviews with family caregivers and correctional service providers were conducted using a semi-structured interview guide. Semi-structured interviews are characterised by a flexible structure (Edwards & Holland, 2013; Dudley, 2011). While the interview schedule is established in advance, it allows for modifying questions and including supplementary inquiries to either explore topics in greater depth or to seek clarification. The semi-structured interviews were initially conducted in English and translated to isiZulu to align with the participants' preferences. Both sample one and two interviews were carried out with the two selected samples, reflecting the specific objectives of this research study, investigating the experiences of family caregivers and correctional social workers in delivering end-of-life care support to elderly parolees on medical parole. Semi-structured interviews are defined as in-depth interviews where the participants must answer preset open-ended questions (Carey, 2009). Semi-structured, in-depth interviews are utilised extensively as interviewing format, possibly with individuals or groups. Once-off interviews were conducted and their duration ranged from 50-60 minutes. The interviews were conducted over a period of several weeks to accommodate participant availability and ensure ethical, respectful engagement.

5.8.1. Process and procedure for conducting in-depth interviews

- In all the interviews, I as the researcher first introduced themselves formally and then explained the study focus. In doing so, the researcher also stressed the parameters of confidentiality and emphasised that participants reserved the right to withdraw from the study at any time, not to answer, to withhold anything they did not want to disclose, and that their participation was entirely voluntary in every interview.

- Informed consent forms (Appendices A) were completed. Additionally, the participants were informed that they may pause the interview at any time or ask questions. All the participants in the study granted the researcher permission to use an audio recorder during the interview.
- Before audio recording each interview, the audio recording device was tested. The family caregivers and correctional social workers selected a pseudonym to ensure their anonymity in data reporting.
- The researcher filled out a demographic sheet to get accurate details on all the participants.
- The researcher ensured that the participants were comfortable before, during, and after the interviews.
- The researcher went ahead and ensured that the four participants (family caregivers) who indicated that they required psychosocial support, were attended to by a trained therapist and the researcher also ensured that all the participants including family caregivers and correctional social workers were offered debriefing services.

5.9. Data analysis

Data analysis is a process of "investigating data to make sense of it" (Aneshensel, 2013, p195). Although this definition may seem clear-cut, it fails to capture the complexities involved in qualitative data analysis, which encompasses the act of "making sense" and the active construction of meaning. In qualitative research, data analysis is fundamentally subjective and iterative. It necessitates the researcher to traverse various layers of interpretation, consider the socio-cultural contexts of participants, and engage in reflexive practices that interrogate their own biases and preconceptions (Karcher et al., 2024). This viewpoint underscores the intricate nature of qualitative inquiry, wherein the meaning-making process is neither linear nor neutral; somewhat, it is influenced by the researcher's positionality, the context of the research, and the power dynamics present during the interview process.

Thyer (2016, p100) posits that data analysis should be viewed as an "interactive unfolding of insight," wherein the researcher "repeatedly engages with the individual participants' stories

and ultimately weaves these together to tell their collective story." While this conceptualisation underscores the significance of participant narratives and the researcher's involvement with them, it also presupposes that the researcher can seamlessly integrate these stories into a coherent and unified narrative. This assumption raises concerns regarding the potential oversimplification of diverse and occasionally conflicting experiences. The metaphor of "weaving together" individual stories may risk homogenising distinct voices, thereby obscuring critical nuances or tensions present within the data. Furthermore, this process prompts inquiries about which voices are prioritised in the collective narrative: those who articulate their experiences more effectively or those whose narratives align with the researcher’s preconceived notions.

Moreover, within the context of this research , data analysis informally began with the process of transcribing. Audio recordings were converted into transcripts. This research study adopted qualitative thematic content analysis as a form of data analysis. In qualitative research, data analysis includes gathering and organising information, reducing the data into themes by coding and condensing the codes, and presenting the data in figures, tables, graphs or discussion (Creswell, 2013). Similarly, Braun and Clarke (2006), recognised as significant figures in this methodology, characterise it as a process for discerning themes or patterns within qualitative data by interpreting the meanings inherent in that data. This may be a list of themes, indicators, and qualifications causally related or between two forms. A theme is a pattern found in the information that, at a minimum, describes and organises the possible observation and, at maximum, interprets aspects of the phenomenon of interest. Braun and Clarke's (2006) thematic analysis have gained significant traction in qualitative research across various fields, such as psychology, social work, education, and health. The method is particularly recognised for its adaptability and ease of use, rendering it appropriate for diverse studies.

Joffe (2012) emphasises the effectiveness of thematic analysis in examining individuals' experiences and viewpoints. In investigating how individuals interpret and derive meaning from personal experiences, Joffe (2012) identified thematic analysis as a powerful tool for uncovering significant themes and reflecting the intricacies of participants' perspectives. This

research illustrated that thematic analysis applies to a wide range of populations, thereby highlighting its relevance in numerous research settings.

For the purposes of this research, qualitative data comprised the subjective experience of caregivers and correctional social workers, which, through content thematic analysis, was coded into themes. The main goal of content thematic data analysis is to "identify themes, i.e., patterns in the data that are important or interesting and use these themes to address the research or say something about an issue. This is much more than simply summarising the data; a good thematic analysis interprets and makes sense of it" (Maguire & Delahunt, 2017, p.3353); for this study coding of data was generated using both inductive and deductive approaches in that it used literature to create themes which constitute deductive approach since it is done prior and audio recording transcribed into transcripts as an inductive approach to coding. The table below discusses the different steps of thematic content analysis.

Table 5.1: Braun and Clarke's (2006) six-phase framework for doing a thematic content analysis

Step 1: Familiarisation with the data Following the interviews, the researcher transcribed and translated the recordings. Transcripts were consistently formatted and labelled with reference codes to support iterative analysis (Anderson, 2009). The researcher read and re-read the transcripts, listening again to the audio recordings to become deeply immersed in the data. This process enabled vivid recall of participants' voices, expressions, and emotions, which enriched the contextual understanding of their accounts.
Step 2: Generating initial codes Once familiar with the data, the researcher began identifying meaningful units of information relevant to the research questions. Coding was performed on both hard-copy and electronic transcripts, with no pre-set codes used. Instead, codes emerged inductively from the data (Maguire & Delahunt, 2017), allowing for the natural development of categories that reflected recurring patterns.

Step 3: Searching for themes Codes were then organised into broader thematic categories. Both interview-guide themes and newly emerging themes were considered, ensuring that the analysis remained grounded in participants' narratives while also responding to unexpected insights (Terre Blanche et al., 2006). Comparable coded segments were clustered to form preliminary themes.
Step 4: Reviewing themes The researcher examined the coherence and relevance of emerging themes, checking whether they accurately reflected the dataset and addressed the research questions. Themes that lacked sufficient evidence were refined or combined, while others were reorganised to improve clarity and conceptual alignment.
Step 5: Defining themes At this stage, the researcher developed clear, descriptive names for each theme and elaborated on their meaning and significance. Themes were refined to ensure that each captured a distinct aspect of the participants' experiences and contributed to the overall analytic narrative of the study.
Step 6: Working on the write-up The final phase involved interpreting themes in relation to the literature review, theoretical framework, research objectives, and contextual considerations. This also included reviewing the final thematic structure to ensure analytical rigour and internal coherence (Maguire & Delahunt, 2017). The write-up integrated illustrative data extracts with theoretical and empirical literature to support and contextualise the identified themes.

5.10. Establishing the trustworthiness of the study

The trustworthiness focuses on the researcher convincing the audience that the study's findings are important (Babbie & Mouton, 2001). The researcher ensured the study's trustworthiness by ensuring a degree of credibility, transferability, dependability, and confirmability. Trustworthiness in qualitative research is often criticised by positivists who

prefer to utilise the concepts of validity and reliability (Stahl & King, 2020). This is because most qualitative researchers believe that reality is constructed. As a result, quantitative validity is simply not an objective of qualitative research.

5.10.1. Credibility

Lincoln and Guba (1985) argue that credibility is one of the most crucial factors to determining trustworthiness in a qualitative study. Credibility in qualitative data is attained when the research provides an appropriate explanation or interpretation of human experiences that people who have had similar experiences would recognise. For this study, credibility was achieved through prolonged engagements with participants, semi-structured interviews and the utilisation of various materials to document study findings, such as digital audio recordings and the recording of nonverbal communication (Babbie & Mouton 2001). This allowed the present research to accurately document and report the experiences of the participants.

5.10.2. Transferability

Transferability in qualitative research refers to the extent to which the research finding can be generalised to other contexts and situations. Qualitative researchers maintain that the experiences of one setting may not necessarily be meaningful for another (Creswell, 2007). Therefore, the researcher employed purposive sampling and used detailed descriptions to ensure the transferability of the study findings.

5.10.3. Dependability

Dependability refers to the ability to judge if the findings of an investigation might be replicated if the investigation were recreated with the same/or similar participants in the same/or similar context (Babbie & Mouton, 2001). The researcher ensured dependability of the study by keeping an audit trail which is viewed as a "detailed description of sources and techniques of data collection and analysis (interview/observation), interpretations made, decisions taken, and influences on the researcher with the aim of demonstrating truthfulness within the findings" (Hadi & Closs, 2016, p.4). Therefore, the methodology chapter provided the reader a detailed description of the methods used to collect and analyse data.

5.10.4. Confirmability

Conformability is the extent to which the outcomes of an investigation can be confirmed by others rather than the enquirer's biases, motives, interests, or views (Babbie & Mouton, 2001; Trochim & Donnely, 2007). The researcher employed a reflective journal to meticulously document personal thoughts and feelings throughout the data collection process (Terreblanche, Durrheim, & Painter, 2006). All the materials utilised in the study, including transcripts and audio recordings, were subjected to a rigorous review and interpretation process conducted in collaboration with the research supervisor to enhance confirmability. Additionally, the analysis chapter incorporates selected excerpts from the interview transcripts that effectively illustrate participants' contributions, thereby enriching the interpretative framework of the research.

5.11. Ethical considerations

When engaging in research involving vulnerable populations, such as elderly offenders receiving end-of-life care or the family caregivers and correctional social workers who support them, it is essential for researchers to maintain a heightened awareness of the ethical dilemmas and considerations that arise throughout the research process. Vulnerable populations are characterised by increased susceptibility to harm or exploitation, which may stem from various factors including age, socio-economic status, mental health conditions, disabilities, or their interactions with the criminal justice system (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). This inherent vulnerability necessitates that social work researchers approach these individuals with both ethical rigour and empathy, carefully navigating issues related to power dynamics, agency, and oppression, while ensuring that the research does not inflict harm.

As a social work, researcher demonstrated a keen awareness of the risks associated with perpetuating oppression and marginalisation while investigating vulnerable populations. Consequently, the researcher implemented ethical practices aimed at mitigating these issues such as informed consent, confidentiality, participant vulnerability, and potential researcher bias. This was accomplished by securing informed consent, safeguarding confidentiality, offering emotional support, enhancing participant voice and agency, and employing

inclusive, culturally sensitive methodologies. Through the continuous practice of informed consent, the researcher prioritised the participants' voices, thereby honouring their autonomy and decision-making authority throughout the research process (Budgeon, 2022).

5.11.1. Ethical clearance process pertaining to obtaining gatekeepers' permission

To obtain a gatekeeper's letter from the Department of Correctional Services, ethical approval from the university was required as proof of the institution's approval to be submitted together with Research Application Form-G179-1 to the REC secretariat within the Research Directorate. The application was submitted in a scanned format with relevant signatures. The application included the following information:

- A summary of why this research has social value and why it must be done with a vulnerable group, with a thorough description of ethical considerations (i.e., analysis of the ethics of the project and measures to manage it)
- All the data collection instruments (interview guides)
- A clear description of how research participants will be recruited, who will recruit them, and how informed consent will be attained and by whom
- Attached informed consent documentation, recruiting advertisements and posters.

5.11.2. Obtaining informed consent

In line with respecting the individual autonomy of participants, it was important for the researcher to obtain consent. This meant that before the researcher could interview the participants, they had to obtain informed consent from family caregivers and correctional social workers, which entailed providing information to participants in order for them to take an informed decision. According to Neuman (2014, p.151), "it is not enough to obtain permission, people need to know what they are being asked to participate in". Therefore, in ensuring that the participants were well informed, the researcher had to orient participants on the study objectives and aims of the research, which also included the potential harm that this could have on them. Furthermore, before the commencement of the interviews, all the individuals involved in this research were informed about their rights as study participants,

ensuring that their decision to engage in the study was both informed and rational. A form, also called informed consent, was signed by the study participants as confirmation that they agreed and understood the parameters of their choice to participate in the study.

5.11.3. Confidentiality and anonymity

In keeping with the principles of non-maleficence and respect for the autonomy of participants, the researcher was responsible in ensuring anonymity of participants. This meant that they had to safeguard information obtained during and after the field work (Jahn, 2011). Neuman (2014, p.155) contends that confidentiality is the "ethical protection for those who are suited by holding research data by keeping study data private or confidential, without disclosing information in a way that allows or connects particular people to certain replies; researchers do this by providing data in aggregate form". In protecting the identity of study participants, several measures were taken to safeguard the privacy of participants, which included, but was not limited to anonymised participant personal information, the use of headphones during transcribing to guarantee that the interview audio was not overheard, and the storage of data in password-protected computer files. Any data that would have allowed for participant identity was eliminated from the field notes and interview transcripts, and pseudonyms were used when presenting the findings, as they will be in any subsequent publications.

5.11.4. Risk/harm associated with the study

Research involving individuals who care for vulnerable groups, such as elderly parolees at the end-of-life, demands a high level of ethical sensitivity, justification, and a commitment to minimising harm. Recognising the emotional and psychological burden associated with caregiving in such contexts, the researcher acknowledged the potential vulnerability of participants. As such, participation in the study was entirely voluntary, and no coercive methods were used to influence involvement. To mitigate potential emotional distress especially when participants reflected on the challenges of end-of-life care the researcher remained attentive to both verbal and non-verbal cues during interviews.

Participants were reminded throughout the process that they had the right to withdraw from the study at any time without any negative consequences. This approach was grounded in the ethical principle of non-maleficence, which requires researchers to avoid causing harm. As Egan (2015, p. 35) emphasises, it is essential to maintain "a non-manipulative and non-exploitative approach to clients," particularly in emotionally charged research contexts. In alignment with this, arrangements were made with a counselling organisation that provides free teletherapy services to ensure accessible mental health support. Given the intensive caregiving responsibilities of participants, traveling to access in-person counselling services could have posed a significant barrier. Teletherapy was thus considered a practical and ethically appropriate intervention to support participants' well-being during and after their involvement in the study.

5.11.5. Data storage

The research data was secured using an encrypted Universal Serial Bus (USB) that was kept together with a digital audio recorder in a digital safe that is also encrypted in a space where it is not identifiable and will be destroyed after five years in line with the University of KwaZulu-Natal's Humanities and Social Sciences Research Ethics Committee data management policy. The office in which the data is kept is lockable and only accessible by the researcher and study supervisor. There are visible camera and security guards who are part of the Risk Management Services tasked with watching over university property.

5.11.6. Plan for the dissemination of study findings

The researcher shall invite all the stakeholders including research participants to a two-hour interactive seminar as part of the series of knowledge sharing seminars that the researcher will organise. Moreover, the researcher will also document findings in a summary before the workshop, which will be given to the study participants as a form of written feedback on the research. As part of data dissemination, the researcher will also collaborate with social workers, caregivers and academics to develop a specialised programme and care plan to enhance the end-of-life care experiences for caregivers and elderly offenders released on medical parole.

5.12. Challenges encountered during the data collection process

Accessing participants, especially family caregivers and correctional social workers, posed significant logistical and ethical hurdles. For family caregivers, securing approval from community corrections was essential, and the bureaucratic processes involved were frequently protracted. Additionally, ethical issues related to consent, confidentiality, and the risk of coercion were particularly pronounced in the current research. It was imperative to ensure that participants were fully aware of their rights and that their participation was entirely voluntary, necessitating meticulous planning and effective communication with correctional authorities and family members (Finlay, 2020). Considering the sensitive nature of such a research topic as end-of-life care, the experiences of terminally ill elderly parolees, and the role of family caregivers presented several ethical dilemmas.

The researcher as a social work researcher also noticed that correctional social workers were cautious about disclosing institutional shortcomings. The researchers had to be sensitive to these concerns and ensure that participants felt supported in sharing their honest thoughts and feelings. Additionally, it was essential to address the emotional toll on the researcher when dealing with such sensitive topics, making sure that self-care and appropriate debriefing practices were in place, and this was critical for the social work researcher (Liamputtong, 2020).

5.13. Reflectivity of the study

Reflexivity in qualitative research involves the critical examination of the researcher's role, beliefs, values, and biases, as well as their influence on the research process (Finlay, 2020). This practice is particularly important in studies addressing sensitive and emotionally charged topics such as end-of-life care, where the researcher's personal experiences and perspectives can shape interactions with participants, data collection methods, and interpretation of findings. Reflexivity is an ongoing, self-reflective endeavour that enhances transparency and ethical rigor, ensuring that findings are valid, ethically sound, and grounded in participants' perspectives.

Given the sensitive nature of end-of-life care, the researcher-maintained awareness of both personal and participants' emotions throughout the study. At the time of data collection, the

researcher had recently experienced the tragic loss of a twin brother, necessitating careful monitoring and management of personal emotions to prevent countertransference. A reflective journal was maintained to record thoughts and feelings during data collection, enabling the researcher to audit their subjectivity and remain mindful of personal influence on the research process. Familiarity with the study site, stemming from prior experience as a student correctional social worker and conducting a master's-level study at the same centre, further highlighted the importance of reflexivity in navigating the research context.

In addition, some participants exhibited reluctance in disclosing certain aspects of their experiences, often stemming from concerns about confidentiality or potential judgment. For example, during one interview, a caregiver expressed discomfort discussing feelings of resentment and burnout. The researcher observed that the participant frequently glanced at the audio recorder, which signalled unease. In response, the researcher turned off the recorder to create a safer and more supportive environment, thereby enabling the participant to articulate their thoughts more freely.

Such context-sensitive decisions reflect the exercise of phronesis, or practical wisdom, in qualitative research. According to Conroy et al. (2018), phronesis integrates experience, ethical reflection, and situational awareness to guide researchers through complex interpersonal dynamics. Within this study, phronesis informed reflexive practice by prompting careful consideration of participants' emotional states, cultural norms, and the ethical implications of research actions. Reflexivity, in this sense, was an ongoing, deliberate process, requiring the researcher to critically examine how personal background, values, and professional experiences influenced interactions, data collection, and interpretation.

Reflexivity in the current study served as a methodological tool to account for the researcher's background, values, knowledge, beliefs, actions, perceptions, position, behaviour, feelings, thoughts, and emotions, and their influence on organising, conducting, and analysing qualitative data (D'Cruz et al., 2007). Critical self-evaluation of these subjective attributes and internal processes, combined with the application of phronesis, was essential for enhancing the accuracy of the research process and the trustworthiness of the findings.

5.14. Conclusion

In this chapter, the researcher discussed the rationale behind the chosen methodological approach and methods used to undertake the current study. The study adopted a qualitative approach as it focused on extracting detailed descriptions of participants' experiences and beliefs regarding elderly parolees on medical parole. Therefore, it was fitting for a study with unquantifiable data. Considering the paucity of local studies on the research problem of releasing terminally ill elderly parolees on medical parole, the objectives outlined in the study prescribed the use of a phenomenological design, which was shown using narrative communication. Personal interviews were conducted with six (n=6) correctional social workers and 15 caregivers, utilising a semi-structured interview schedule. This chapter covered the different aspects of the research process that was implemented in this study. Their progression and achievement were examined, along with the methodologies used. The chapter is concluded by providing detailed information on the ethical considerations and an in-depth reflection based on the researcher's experience during data collection. The next chapter presents a comprehensive discussion of the study findings.

CHAPTER 6

DISCUSSION OF FINDINGS PART 1

Navigating unchartered waters of providing end-of-life care during reintegration

"Caregiving at the end of life is not about saying goodbye, but about making each moment count, offering comfort, and ensuring that love remains the most powerful force until the very last breath."

Megan O'Brien

6.1. Introduction

This chapter presents a detailed account of the research findings derived from the study conducted in eThekwini region. The research aimed to explore the experiences and perspectives of two key groups, namely family caregivers and correctional social workers. To gather rich and nuanced data, in-depth interviews were conducted with participants from both groups. In total, the study included 15 and six (n=six) correctional social workers providing a diverse range of insights into the subject matter. In-depth interviews were transcribed for thorough analysis, allowing for careful examination of the participants' responses, capturing the complexities of their experiences and the context in which they operate. To analyse the data, thematic content analysis was employed. This approach facilitated the identification of recurring themes and patterns within the data, enabling a deeper understanding of the issues at hand.

The initial sections of this chapter focus on providing demographic information about the participants, specifically the correctional social workers (Sample 1) and family caregivers (Sample 2). This demographic overview serves a critical function of situating the study findings within the social and educational contexts of the participants that shapes the lived experiences of the participants. Understanding demographics helps to frame the subsequent analysis and discussion, offering insights into how various factors may influence the experiences of both family caregivers and social workers. Following the demographic overview, the chapter proceeds to a systematic presentation of themes and subthemes derived from the data. that emerged from the analysis. Each thematic category is presented in-depth, accompanied by a comprehensive critical discussion that underscores its relevance to the study's overarching objectives. This discussion goes beyond highlighting the relevance of the themes to the broader context of caregiving and correctional social work, offering critical

implications for social work practice, policy, and future research. By examining these themes, the chapter aims to contribute to a deeper understanding of the challenges and dynamics faced by family caregivers and correctional social workers in eThekwini region. In so doing, it foregrounds the often-overlooked intersection of these two roles within the wider social support system.

6.2. Demographic profile of correctional social workers (Sample 1)

Table 6.1: Details of correctional social workers that constituted Sample 1

Participant	Gender	Age	Race	Language	Highest educational level	Length of service	Division and rank
CSW1	Female	51	African	IsiZulu	BSW	24 Years	Senior social worker
CSW2	Female	47	African	IsiZulu	BSW	21 Years	Senior social worker
CSW3	Male	47	African	IsiZulu	MSS (Social Work)	20 Years	Senior social worker
CSW4	Male	45	African	IsiZulu	Development Studies (Hon)	11 Years	Social work supervisor
CSW5	Female	58	African	IsiZulu	BSW	33 Years	Senior social worker
CSW6	Female	60	African	IsiZulu	BSW	20 Years	Senior social worker

6.2.1. Demographic representation of correctional social workers (Sample 1)

The interviews for this study were conducted at the participants' offices within the Durban Community Correctional Centre, a non-custodial facility. All the participants were employed in the Department of Correctional Services, collaborating specifically with parolees and correctional officials. The sample included two male and four female correctional service

providers working the non-custodial centre, representing a range of occupational ranks within the Department. The highest-ranking participant was a social work supervisor, while the lowest was a senior social worker. All the interviewees granted permission for the interviews to be audio-recorded.

The participants responded to a series of questions (Appendix C) regarding the implementation of social work services and the extent to which these services supported elderly parolees released on medical parole, as well as their caregivers, during the end-of-life stage.

6.3. Demographic profile of family caregivers (Sample 2 participants)

Table 6.2: Details of family caregivers that constituted Sample 2

Pseudonym	Gender	Population group	Age	Educational qualification	Caring experience	Relationship to the elderly parolees	Employment status
Abigali	Female	African	51	Grade 09	2 years	Wife	Unemployed
Balingene	Female	African	37	Grade 12	4 years	Daughter	Unemployed
Tholakele	Female	African	49	Grade 11	3years	Daughter	Unemployed
Delisiwe	Female	African	53	Grade 10 & caregiving certificate	5 years	Girlfriend	Unemployed
Mabusi	Female	African	63	Grade 04	2 years	Sister	Unemployed
Kanyamba	Female	African	84	Grade 06	3 years	Mother	Unemployed
Veronica	Female	African	65	Grade 04	2 Years	Sister	Unemployed
Hloniphile	Female	African	66	Grade 11	1 Year	Sister-in-law	Unemployed
Maria	Female	African	53	Grade 06	3 years	Sister in-law	Unemployed
Mondli	Male	African	29	Grade 12	3 years	Grandchild	Unemployed
Ongezwa	Female	African	35	Grade 10	3 Years	Daughter	Unemployed
Zinhle	Female	African	40	Diploma in Hospitality	2 years	Daughter	Unemployed
Noxolo	Female	African	45	Grade 12	2 years	Daughter	Unemployed

Zodwa	Female	African	66	Grade 11	1 years	Widow	Unemployed
Marriam	Female	African	62	Bachelor of Education	1 year	Widow	Unemployed

6.3.1. Demographic representation of family caregivers (Sample 2)

Family caregivers from the various areas of Durban region participated in individual and confidential interviews conducted at the various centres of the Department of Correctional Services. In Sample 2, the gender composition consisted of 14 females and one male, who were tasked with caring for elderly parolees during the end-of-life care phase. This demographic composition underscores the predominantly gendered nature of caregiving, wherein women are more likely to assume the role of caregiving (e.g., Henz, 2011; Stotts, 2014). This pattern reflects deeply ingrained societal and cultural norms about gender roles in caregiving contexts.

The ages of the participants ranged from 29 to 84 years, with six participants (n=6) were elderly individuals themselves while simultaneously providing care to an elderly parolee. As indicated in *Table 6.3* only two-family caregivers reported that the elderly parolee in their care had passed away within one year of release under medical parole. Data were gathered from 15 African family caregivers, as outlined in Table 6.3. The duration of caregiving responsibilities ranged from a minimum of one year to a maximum of five years. Notably, all the participants in this study were unemployed at the time of the study, highlighting the potential economic strain associated with full-time caregiving

The participants were chosen based on their involvement in providing care and support to elderly family members who had been granted medical parole. The participants were asked to respond to a series of questions (Appendix D) regarding the factors affecting the reintegration process of elderly parolees released on medical parole. They were encouraged to share their experiences related to caregiving during the end-of-life care stage, the availability of social work services aimed at facilitating reintegration and enhancing the quality of life for both the ailing elderly parolee and their family caregiver, as well as their access to resources and support throughout the reintegration process.

6.4. Themes

Table 6.3: The themes that emerged from the data collected from both correctional social workers and family caregivers

Theme	Sub-theme
Theme 1: Barriers and enablers to the reintegration of elderly parolees in end-of-life care	• Physical confinement and loneliness during end-of-life • State-induced isolation • Access to social protection for parolees during end-of-life care. • Leveraging spiritual practices to support the reintegration of elderly parolees in the end-of-life stage
Theme 2: Caregiver's experience of assuming the caregiving role of elderly parolees	• Regrets and resentment towards the caregiving role during end-of-life care • Medication management
Theme 3: Navigating caregiving during the end-of-life care of elderly paroles	• Social and physical conditions of elderly paroles in end-of-life stage • Here in body and gone in spirit: Managing ambiguous Loss • The rise and fall of compassion among the Caregivers of elderly paroles • Loss of faith among caregivers and the evolving roles and responsibilities during end-of-life care • Self-care in informal caregiving
Theme 4: Caregiving competence and preparedness in providing quality care to elderly parolees.	• Caregiving knowledge and skills • The need for end-of-life care training and support during reintegration

6.4.1. Theme 1: Barriers and enablers to the reintegration of elderly parolees in end-of-life care

This theme highlights the complex challenges that elderly parolees face during end-of-life care, which profoundly affects their post-incarceration reintegration. Key barriers identified include limited healthcare access, pervasive societal stigma, and insufficient family or community support. Conversely, facilitators such as specialised re-entry programmes and community healthcare services were found to contribute positively to the quality of life for this population. Detrimental conditions such as confinement, loneliness, and lack of social protections significantly impact the reintegration process for elderly offenders on medical parole. Drawing from the Ecosystems Theory, the findings suggests that a parolee's adjustment is intricately linked to the alignment with their environment, a lack of congruence often results in psychological stress and isolation. Additionally, participants consistently emphasised the role of spiritual practices in enhancing the quality of life for terminally ill elderly parolees, thereby highlighting their importance in promoting a smoother and dignified transitions.

6.4.1.1. Physical confinement and loneliness during end-of-life

End-of-life experiences are often marked by physical confinement and profound loneliness, particularly for individuals with terminal illnesses. Loneliness, as conceptualised by Gray and Worlledge (2018), arises when an individual's social circle is insufficient to meet their needs. Within the context of this study, loneliness was strongly associated with declining physical health, which in turn compromised parolees' mobility and independence. Caregivers reported that ill elderly parolees experienced emotional isolation due to their inability to engage in routine social activities such as visiting friends or family or participating in community life. This is illustrated in the following participant narratives:

> *"Since my father's release, he has been struggling with profound loneliness at home. Unfortunately, our family seems reluctant to visit him, often offering excuses instead. His health condition keeps him confined to bed, and it's heart-breaking to witness his isolation; he desperately needs companionship and someone to share his thoughts with. He rarely engages with the children or even watches television, often spending weeks alone in his room, consumed by tears that flow even when he isn't in physical*

pain. This emotional turmoil is evident, as he finds it difficult to articulate the experiences he endured while incarcerated. Once a vibrant and sociable individual, my father has been stripped of his friendships and joy, leaving a shadow of the person he used to be". (Noxolo)

The father is marked by stigma as a former prisoner. The family's disengagement and his loss of friendships reveal how societal attitudes about criminality and ageing intersect, compounding his marginalisation and exclusion. This narrative also indicates the societal failure to recognise the humanity of formerly incarcerated individuals, especially in vulnerable life stages. Noxolo's narrative that "he rarely engages with children or even watches television...consumed by tears" reflects a cumulative chronic trauma and neglect over time, illustrating how transitions from prison to parole, from health to illness may not have been supported at every level. From the perspective of Ecosystems Theory, parolees' loneliness and isolation experienced by elderly parolees can be understood as emanating from complex, multi-level ecological interactions (Gottfried & Mather, 2018). Another participant elaborated that:

"The primary issue I see is that he experiences significant emotional fatigue due to his inability to walk independently. This limitation does not only isolate him from social interactions but also deepens his sense of loneliness. He yearns for the ability to engage in activities and connect with others, just like his peers do. For example, he often expresses a longing to walk again, like our neighbour who, despite having suffered a stroke, manages to get around. This comparison only amplifies his feelings of isolation and sadness". (Ongezwa)

Another participant also observed that:

""There were times when my husband would find himself alone, and it was heartbreaking to witness. He would sometimes collapse onto the floor, unnoticed by anyone until my return from work, only to discover him sleeping there. It seemed he had grown accustomed to this solitude, and in those moments, the physical pain he felt was often overshadowed by the profound loneliness that enveloped him". (Marriam)

The above excerpts reinforce the view that persistent loneliness when left unaddressed, can evolve into a vicious cycle of negative beliefs, emotions, and actions, warranting serious attention (Cacioppo & Patrick, 2008; Gray & Worlledge, 2018). Abedini et al. (2020) contend that older adults experiencing loneliness may face more significant challenges in end-of-life care compared to their socially connected peers, often exhibiting a greater burden of symptoms. In this study, the findings indicated that physical confinement and loneliness among elderly parolees with health issues surfaced as a notable outcome during their reintegration process. This aligns with the principles of the Ecosystem Theory, which asserts that the direct engagement between elderly parolees and their family members is essential for fostering their emotional health (Gottfried & Mather, 2018); thus, the transition from the highly structured environment of prison to the complexities of community life often complicates the adjustment process for parolees. This challenge is exacerbated for elderly individuals, particularly those with terminal illnesses, who face not only the typical hurdles of reintegration but also significant health-related issues.

Moreover, for terminally ill elderly parolees, re-entry into society is fraught with significant obstacles. They often grapple with profound emotional and psychological difficulties, such as anxiety, depression, and the fear of dying alone, which can be compounded by the stigma associated with their criminal history (Higgins & Severson, 2009). The lack of a robust support network, including family, friends, and community resources, can further isolate these individuals, making it even more challenging for them to navigate their new reality.

6.4.1.2. State-induced isolation

Ill-health was identified as one of the primary factors limiting the mobility of elderly offenders. However, the caregivers also emphasised that parolee related conditions significantly contributed to both restricted physical mobility and psychological withdrawal from social interactions.

> *"He no longer spends time with his family as he used to; he has his own diet and can no longer be social due to his parole restrictions. Even it comes to his kids; he does not want to interact with them too because he says his parole restricts him".* (Noxolo)

The fear of breaching parole conditions and the associated risk of re-incarceration can substantially reinforce feelings of state mediated isolation among parolees (Haney, 2018).

Although interactions with immediate family members may serve as a protective factor and contribute positively to the wellbeing of the offender, participants shared that the pervasive anxiety surrounding potential parole violation remained a dominant concern, as some participants explained below:

> *"He's not the same joyful person he used to be now he often finds himself alone fearing that they will take him back to prison. Although many people care for him deeply, he seems to have lost that spark of happiness".* (Balingene)

> *"She does not want to socialise with other people. She likes to be indoors because she is always on the lookout for when the department might come to make her sign. She does not want them to find her in the presence of others. There is nothing I can do because the law is the law*". (Mabusi)

The narration that "she is on the lookout for when the department might come to make her sign" shows that although the offender may be released on medical parole, the conditions associated with the release lead to state-induced isolation. These policies can significantly restrict parolees' independence, social connections, and access to quality treatment, even while their goal is to maintain public safety and compliance (Smith, 2020). The sensation of isolation experienced by many people released on medical parole is exacerbated by movement limitations, stringent supervision, and restricted access to family support (Jones & Brown, 2019). Their reintegration into society and access to essential healthcare services may be hampered by this forced separation, which may have a detrimental effect on their mental and emotional health. narration that "he seems to have lost that spark of happiness" indicates the deteriorating psychological well-being. Addressing these challenges requires a careful balance between ensuring public safety and upholding humane, dignified conditions for individuals on medical parole.

Research shows that transitioning to community living during end-of-life care represents a major shift that necessitates family support to facilitate effective adaptation (Cooney, 2012; Lee et al., 2013; Sussman & Dupuis, 2014). This transition encompasses not only a change in physical location but also significant emotional and psychological adjustments that can impact the well-being of elderly parolees. Key to successful reintegration is the level of agency individuals have in the process. When elderly parolees feel they have control over

decisions such as what to bring, how to set up their new space, and when to move, they tend to feel more empowered, reducing anxiety and helplessness during this phase.

While the shift from incarceration to the community can be daunting, having control over the relocation process and maintaining important relationships can immensely enhance adaptation. The following section explores the nuanced challenges associated with accessing state pensions during end-of-life care for elderly parolees.

6.4.1.3. Access to social protection for parolees during end-of-life care

In South Africa, social protection measures are implemented to assist elderly parolees and their caregivers, specifically targeting the distinct challenges encountered during the processes of reintegration and caregiving. As mentioned in the restructuring of social security grant committee, the government of the Republic of South Africa committed itself to ensuring that this critical source of income continues to play a pivotal role in the eradication of poverty and deprivation for the disadvantaged elderly parolees (CRSS Report, 2001). Elderly parolees requiring end-of-life care are eligible for various social protection initiatives. Notably, these individuals can access the Old Age Pension (Old Age Grant), which is designed for those aged 60 and older, offering financial support to individuals lacking sufficient retirement funds (Smith, 2023). Additionally, caregivers who attend to elderly parolees may qualify for a caregiver dependency grant (Smith, 2023). This grant, while modest, is not intended as a salary for caregivers; rather, it serves to encourage them in their caregiving roles while also promoting their own wellbeing. Upon their release from a correctional centre, caregivers reported significant challenges in accessing and applying for social assistant grants. In this research, the caregivers indicated that some of the elderly parolees released on medical parole were not recipients of the elderly grant due to long waiting periods and delays, as reported in the utterance below:

> *"It has been quite a while since we submitted the request for his pension approval. Frankly, it's difficult to understand how someone over 60, who is unwell, can be released without any support, especially when we are struggling financially. He does not receive any government aid, like a social grant, which makes our situation even more challenging. The burden is heavy, as he requires proper nutrition to take his*

medication, and without assistance, meeting these basic needs becomes a significant strain on him". (Hloniphile)

Reiterating the flawed administration process of obtaining the elderly grant, another participant said:

"Since his release, I have been trying to register for a social grant at SASSA, but unfortunately, there has been no progress. I visited the offices, and they informed me that they were awaiting a response from the District Office. When I followed up at the district, they assured me that they had sent the necessary communication and advised me to wait for 24 hours. However, it has been quite some time now, and there has been no action taken, nor any follow-up on their part". (Mondli)

A significant number of elderly parolees and their families relied solely on the old age pension grant to meet the physical and health care needs of elderly parolees. Despite receiving government welfare assistance, many continued to face financial instability. The caregivers consistently pointed out that the pension grant was insufficient to meet the healthcare expenses of the elderly parolees. One caregiver specifically noted that the physical limitations of the elderly parolee prevented them from using taxis, forcing them to depend on more expensive Uber services, which exacerbated their financial difficulties and negatively impacted the quality of care, as illustrated in the following statement.

"Managing his needs while he is on medical parole has proven to be quite challenging. I find myself needing to arrange transportation for his doctor visits, which comes at a steep price of around R700 (US$35), a significant burden considering my daily earnings of only R100 ($5,36). During our recent appointment, I explained to the doctor that he struggles to take his prescribed medication due to our lack of food, a situation exacerbated by my limited income as a domestic worker. Thankfully, the doctor assisted us in applying for a social grant, which, while helpful, only partially alleviates our financial strain. With the R2000 (US$107) we receive, I still must allocate R400 (US$21,44) for funeral insurance, leaving little room for essentials, especially with the rising costs of food". (Tholakele)

Despite receiving the grant, the participant (Tholakele) narrated that the transport and food costs were exorbitant, making it difficult to survive. The below participant also echoes similar sentiments regarding grant insufficiency to cover the caregiving needs of an elderly parolee:

> *"He receives a SASSA social grant, but the amount is too small and doesn't stretch far. Additionally, I provide him with financial support since he needs to go for regular check-ups, which means we often have to arrange for private transportation."* (Delisiwe)

As discussed in Chapter Two (Literature Review), the findings align closely with those presented by Mngoma (2023), indicating that this scenario presents considerable difficulties for elderly parolees and their families who have been granted medical parole. Most elderly parolees come from economically disadvantaged backgrounds, consequently, their families lack the financial capital necessary to provide essential end of life care and support for those on parole. At times, the lack of the relevant documentation hinders access to this important source of support as noted by one of the correctional social workers:

> *"In my unit, difficulties related to a lack of relevant documentation such as IDs are rife. Therefore, they are often unable to access social protection upon release. Additionally, there may be no one actively ensuring that the person is receiving social grants. So, their living situations are often not conducive to their medical needs".* (CSW1)

Many people in South Africa, including elderly parolees and caregivers struggle to access social protection benefits because they do not have valid identification documents (McKenzie et al., 2014). Without an identification document (ID), individuals are excluded from essential services such as social grants, healthcare, and even employment opportunities. This situation underscores the multifaceted difficulties encountered by elderly parolees in securing social protection during the end-of-life phase.

6.4.1.4. The social and physical conditions of elderly parolees in end-of-life stage

Access to housing greatly impacts both physical and mental well-being, a relationship that is particularly evident among medically released elderly individuals who often spend prolonged periods indoors (Centre for Ageing Research and Development in Ireland, 2013). In this

research, caregivers described the social and physical difficulties encountered while providing care for parolees within low-income households. The geographical positioning of the residence plays a vital role in determining the availability and access to transport, particularly because during end-of-life care, medical care visits often become regular. In low-income households, sometimes the geographic location is not accessible to ambulances and cars as one of the caregivers reported:

> *"Our small house sits at the edge of a narrow dirt road, making it difficult for ambulances or taxis to reach us. Because of this, often are often compelled to carry my father in a makeshift stretcher or push him in a cart whenever we need to take him for appointments".* (Noxolo)

Another caregiver participant also shared significant insights into the social and physical challenges faced by elderly parolees, particularly in their end-of-life stage. One narrative that stands out relates to the difficulty of mobility and the impact of such challenges on dignity as detailed below.

> *"Our home is perched on a hill, making it difficult for vehicles to reach us, so we often rely on a wheelbarrow to transport him. The bathroom is situated outside the house and each time we take him there, he feels quite embarrassed, as he's used to handling this on his own".* (Kanyamba)

This finding underscores the broader issues of accessibility and independence faced by elderly parolees, particularly those nearing the end-of-life. The location of the house often affects access to transport and therefore access to timely resources. The use of the words "embarrassed' reflects the perceived loss of dignity by the parolees. The participant (Noxolo) further elaborated on the indignity that they face for example 'During rainy days, we sometimes use a bucket, which leads to unpleasant odours pervading the house'. In low-income households, there may be insufficient space to accommodate all family members comfortably.

Caring for someone who is unwell in challenging conditions presents an extra layer of difficulty and underscores the undignified circumstances that many face. Another participant shared her sad story, "We frequently had to strategise where he would sleep because the roof leaked during rainstorms, which meant we had to move his mattress around the house."

(Zodwa). This statement encapsulates the daily struggles that caregivers endure, as they navigate not only the physical needs of their loved ones but also the environmental challenges that affect caregiving.

The act of moving a mattress from one location to another is not merely a logistical task; it reflects a deeper reality of instability and the constant need for adaptation. It highlights the lack of adequate housing and the impact of poor living conditions on the health and wellbeing of both the elderly individuals receiving care and their caregivers. Zodwa's experience illustrates the resourcefulness required to manage such situations, as she and others like her must devise creative solutions to ensure comfort and safety in the face of adversity. Zodwa's acknowledgment of the need to develop a "*plan on rainy days"* speaks to the ongoing effort and emotional labour involved in the execution of caregiving duties. It is a testament to their commitment and love, as they strive to maintain dignity and an acceptable quality of life despite the obstacles they encounter.

In this research, caregivers emphasized the absence of accessible restrooms and insufficient bathroom amenities, which significantly hinder the capacity of elderly individuals to maintain their independence. Frequently, elderly parolees found themselves reliant on family caregivers for assistance with fundamental activities, resulting in a diminished sense of autonomy, self-worth and dignity. The word shame in the following narratives also reflects the perceived loss of dignity by an elderly parolee. The participant elaborates the indignity faced the elderly parolee endured.

> *"The only toilet we have is an old outhouse in the backyard, and every time we help him get there, he lowers his head in shame he was always a strong, independent man, and relying on us for something so personal is difficult for him."* (Marriam)

In the discussions with correctional social worker participants, they also shared similar narratives. For, example,

> *"Their homes are often not in good condition to care for terminally ill patients. You may find that the patient does not have a proper bed, blankets, or even food, which is essential since they need to take their medications".* (CSW1)

Another participant reflected that the lack of appropriate social and physical conditions among elderly parolees in end-of-life stage made it difficult to provide quality care as mentioned below:

> *"Using the outdoor toilet was a real challenge, particularly because he was heavy, and our living situation was far from ideal for someone in his condition".* (Zodwa)

The oversight of inadequate living conditions during end-of-life care for elderly parolees' post-incarceration has significant implications, as it neglects essential needs for those approaching the end of life. This research corroborates the findings by Keene et al. (2018), who assert that housing plays a crucial role in shaping the experiences of elderly parolees after their release, with many facing challenges when it comes to meeting their basic needs. Consequently, it is essential for the Department of Correctional Services to evaluate the living arrangements of ill elderly parolees prior to their release to ensure their needs are adequately addressed. By examining these issues, the research sheds light on the urgent need for targeted interventions and support mechanisms that can facilitate a more successful reintegration process for this vulnerable population.

6.4.1.5. Leveraging spiritual practices to support the reintegration of elderly parolees in the end-of-life stage

In most African families, spirituality is central to restoring harmony and promoting healing in families (Agyekum & Newbold, 2016; Bhikha & Glynn, 2013). As evidenced in the current study, cleansing rituals during end-of-life care and the release of elderly parolees after incarceration constituted a significant aspect of traditional healing practices within African spirituality, as they are thought to restore harmony and equilibrium within individuals (Agyekum & Newbold 2016; Bhikha & Glynn, 2013). According to Mbiti (1990), ancestors inhabit the spiritual realm and serve as intermediaries between their descendants and divinity. They are regarded as sources of protection and are invoked during periods of crisis (Marumo & Chakale, 2018). Additionally, their support and blessings are typically granted when appropriate rituals are performed and sacrifices are offered (Thabede, 2008). While they provide guidance, protection, and blessings, they may also impose penalties if familial rituals are neglected (Ross, 2018). The caregivers in this study believed that a lack of proper

reverence towards spiritual practices can lead to misfortunes, indicating that veneration is essential for securing blessings and protection as detailed in the narrative below:

> *"We conducted a cleansing ceremony for him upon his release, seeking protection from our ancestors and asking for their forgiveness for his past wrongdoings. This was done so that he could heal and, if he were to pass, be welcomed on the other side. I believe this ceremony has had a positive impact, as we have noticed significant changes in his behaviour such as having clearer dreams compared to when he was recently released"*. (Kanyamba)

Consulting both the traditional and Western medical professionals was perceived as necessary to navigate the spiritual and physical care of the offender as one participant narrated below:

> *"We conducted a cleansing ceremony organised by his family. Additionally, I sought advice from both traditional healers and Western medical professionals to understand the factors that contributed to his condition. This process helped me come to terms with the situation, and following the cleansing, noticeable changes began to emerge such as frequent supernatural visitations from other family members who passed on"*. (Delisiswe)

Delisiwe and Kanyamba's narrations about 'supernatural visitation from other family members' and 'clearer dreams' suggests the value of the ceremonies in facilitating transformation from a state of trauma to one of improved wellbeing (Vinesett et al. 2015). Through these ceremonies, the offender can confront personal pain and, through a spiritual connection with unseen forces, transcend the challenges and progress (Stark, 2006). Families may perform a cleansing ceremony to manage ill-health as the participant below indicated:

> *"After my uncle returned from prison, we only performed one cleansing ceremony when his situation deteriorated. It was only when his health took a turn for the worse that I sought traditional help, and I was advised that a cleansing ritual was necessary to help restore balance in his life".* (Wandile)

The narration shared by Wandile relates to the repercussions of neglecting these rituals, which can manifest through poor health and illness (Awolalu, 1976). Many communities believe that illness can be a manifestation of spiritual imbalance or the result of negative energies,

and cleansing rituals are seen as a means to restore health and well-being (Bosire, Cele, Potelwa, Cho, & Mendenhall, 2022).

> *"We intend to hold a cleansing ceremony for him, but currently, we are unable to proceed due to his parole restrictions, which require him to stay close to home in case the department needs him to sign. Nevertheless, I believe that the ceremony will have a positive impact".* (Abigal)

Cleansing rituals are of considerable importance in various cultures and societies, as they serve multiple significant purposes that extend beyond mere tradition. One of the primary functions of these rituals is the elimination of diseases, both physical and spiritual (Audet et al., 2017). By engaging in these practices, individuals and families seek to rid themselves of harmful influences and promote healing and harmony.

6.4.2. Theme 2: Caregivers' experiences of assuming the caregiving role for elderly parolees

The process of reintegrating elderly parolees into society is complex and often encompasses more than just the legal and administrative dimensions of parole. It incorporates emotional, psychological, and practical elements, particularly for the caregivers who take on the responsibility of their care. Caring for elderly parolees who have spent considerable time in incarceration presents a wide array of challenges that are influenced by personal, societal, and institutional factors. Caregivers often find themselves not only fulfilling the role of healthcare providers but also navigating the intricacies of reintegration, as parolees return to a society that may have evolved beyond their recognition. The release of elderly offenders on medical parole represents a critical juncture in the reintegration process, particularly when it involves caregivers who assume responsibility for their care. This process is not merely a transition from incarceration to community life but a profound shift that includes complex emotional, logistical, and ethical challenges for those assuming the caregiving role. For caregivers, this experience is uniquely shaped by the nature of the parolee's release, the medical and psychological needs of the elderly offender, and the broader societal and familial context of reintegration.

Key findings in this research highlight the ways in which caregivers' experiences are influenced by the nature of the parolee's release. These experiences are often shaped by the

degree of readiness that characterises the caregiver as they assume such a significant role, the challenges associated with managing caregiving tasks, and the caregiver's ability to cope with the emotional demands of caring for an elderly offender with a complicated past. Caregivers frequently encounter a complex mix of emotions, from empathy to resentment, as they navigate the balance between offering care and managing the tension of a parolee's reintegration into society. This theme critically explores how caregivers' perceptions and emotional responses to assuming caregiving roles upon the release of elderly offenders on medical parole can affect the reintegration process. It emphasizes that the success of reintegration is not solely dependent on parolees' ability to adapt but also on the caregivers' capacity to manage their own experiences and expectations.

6.4.2.1. Regret and resentment towards the caregiving role during /end-of-life care

Upon the return of the elderly parolee, family caregivers must adjust their lifestyles and routines significantly. This adjustment often complicates their ability to maintain employment, leading to the postponement of future aspirations (Graneheim et al., 2014). The findings in this study indicated that caregivers were thrust into situations where they were supposed to manage both the immediate needs of their loved ones and their own emotional responses, often without any preparation or support, as narrated bellow:

> *"It all started on a Tuesday afternoon, just as I was finishing a long day of work. My phone rang, and it was someone from the Department of Correctional Services calling to tell me that dad, who had been in prison for the last few years, was being released. But there was something else. He wasn't coming back as we expected. He was being released directly to my home. My heart sank. The idea of caring for dad had always been a distant thought, something we might discuss in a few years. But now, I had no time to prepare. I wasn't ready. I didn't even know how to begin. I hung up, staring at the walls, feeling a weight I hadn't anticipated. By the time dad arrived with the correctional officers holding him, I could tell he wasn't just sick. He was fragile, almost broken. His body had wasted away from illness, his face a shadow of the man I remembered. He wasn't the same strong, proud father I once knew. His movements were slow, and he seemed confused, and disoriented. It felt like an alien was in my home, someone I had to care for but didn't truly know anymore. I tried to find my feet,*

but there was no manual for this. No instructions on how to balance the demands of caregiving with the emotional toll of reconnecting with a father who had been absent for so long". (Ongezwa)

Tholakele, in the study, recounted an experience akin to that of Ongezwa above, wherein she was unexpectedly burdened with caregiving responsibilities. She further elaborated on her situation as follows:

"It was a quiet Thursday morning when the call came regarding my father, who I hadn't seen in years, was being released from prison and would be sent to live with me. There was no time to prepare. The Department of Correctional Services informed me that he was in poor health and needed immediate care, but I wasn't sure how to handle it. I had my own family, my job, and my routine. The thought of adding elderly, ill family member into the mix felt overwhelming. When he arrived, I was shocked. His frailty was evident, and he was confused, unsure of where he was or why he had been sent to my home. He needed help with everything from eating to moving around. I found myself scrambling to manage his physical needs while also trying to process my own emotions. I hadn't been close to him in years, and the weight of responsibility felt heavy". (Tholakele)

The lack of involvement and preparation surrounding the release of ill elderly parolees significantly contributes to caregivers experiencing a profound sense of regret and resentment towards their caregiving roles. Without prior notice or adequate support, caregivers are thrust into situations where they must manage not only the immediate physical needs of their loved ones but also the emotional complexities that accompany caring for someone with a complicated history. This abrupt transition creates a feeling of powerlessness, as caregivers often feel ill-equipped to handle the overwhelming responsibilities.

The findings of the current research also indicate that family caregivers often encounter emotions of regret and resentment when assuming the caregiving responsibilities for elderly parolees, especially in situations involving end-of-life care. These feelings arise from the weight of caregiving responsibility, the emotional strain associated with observing a loved one's deterioration, and the impact of caregiving on their personal lives and future plans, as illustrated below.

> "*If I had realised that agreeing to his medical parole would lead to complications for me, I wouldn't have made that choice. I truly regret believing I could handle it. Honestly, if I could, I would want him back in prison because this situation is overwhelming for me; I can barely take care of myself".* (Balingene)

Another participant also indicated that:

> *"It's possible that if the Department had informed me about his serious illness and that he was bedridden, I wouldn't have put my own health at risk. I regret agreeing to it, and I really dislike myself for that decision. In prison, he seemed to be receiving better care. I even wrote a letter to the Department, stating that I was withdrawing from providing care."* (Zodwa)

The evident lack of emotional readiness among family caregivers has profoundly influenced their capacity to provide care, resulting in feelings of despair, hopelessness, frustration, and anger. This emotional distress, as articulated by the caregivers, has impacted the quality of care for elderly parolees. Another participant in the study said,

> *"I wish they had assisted me in mentally preparing before entrusting him to my care; this experience has been traumatic. When he arrived here, I felt completely adrift. I understand that one cannot simply abandon someone, but I sincerely regret assuming this responsibility. The odour each morning is intolerable, and I am compelled to clean without comprehending the root of his illness. My anger has consumed me to the point where I neglected even the most fundamental tasks. Frankly, if it were possible, I would return him to prison; at least there, they are equipped to manage his condition and have nurses to attend to him".* (Kanyamba)

It is evident that caregivers who experience persistent depletion of energy and emotional reserves may start to question their choice to assume the caregiving role. In line with the Caregiver Dynamic Theory, which posits that the state of exhaustion frequently coexists with feelings of guilt and frustration, as caregivers struggle to meet their own needs or those of their dependents (Schulz & Sherwood, 2008). Consequently, caregivers frequently experience depression and anxiety, which can intensify their feelings of regret (Pinquart & Sörensen, 2003). Over time, the cumulative effects of caregiving can lead to a significant

sense of loss not only concerning the individual receiving care but also regarding the caregiver's own wellbeing and independence.

Additionally, correctional social workers identified that caregivers frequently experienced feelings of regret and resentment toward their caregiving role, as illustrated in the excerpt below.

> *"A caregiver can agree to take in an elderly parolee, but the true test comes when they have to live with that individual. Initially, caregivers may be thrilled at the prospect of welcoming someone back from prison, but the harsh reality of the parolee's health condition can lead them to reconsider their commitment. This withdrawal can make it difficult to find a replacement caregiver, especially since many offenders have histories of committing crimes against family members. Even in cases where that's not true, the knowledge that they are harbouring a former criminal can create significant discomfort for the caregiver."* (CSW1)

Another social work participant reported that due to the resentment, some of the elderly parolees requiring end of life care are neglected and abandoned:

> *"As a correctional social worker at a different community corrections facility, I faced considerable obstacles while visiting an elderly man who was terminally ill and living in a rondavel after being released on medical parole. The monitoring official couldn't enter the home due to its deplorable conditions, which forced me to muster the courage to go inside. It quickly became clear that the offender was not receiving adequate care; his family had abandoned him after his conviction for a crime against a relative. This experience shed light on a troubling truth: he was left to endure suffering without access to basic hygiene or support, revealing the harsh neglect that some terminally ill offenders experience after their release."* (CSW6)

The findings indicate that the caregiving responsibilities associated with end-of-life care had a detrimental impact on the wellbeing of the participants. As noted in the previous chapters, family caregivers typically carry a significant emotional burden emanating from their caregiving role (Rabow et al., 2004). While some family caregivers may feel privileged and satisfied in their roles, this research found that family caregivers experienced despair, remorse, wrath, resentment, and feelings of inadequacy towards their role during end-of-life.

The following segment explores how caregivers applied skills gained from prior roles in providing care for elderly parolees, critically assessing the effectiveness of these skills and identifying challenges encountered in this caregiving context.

6.4.2.2. The lack of knowledge on medication management and polypharmacy

Most caregivers with the responsibility of providing care to elderly parolees reported a lack of basic knowledge about medication management including the best way to administer the medication. This situation poses a significant challenge to their reintegration, as caregivers frequently lack the necessary preparation to manage and administer medications effectively as noted in the following narrative:

> *"I don't really understand much about his medication as there wasn't anyone to explain the side effects and how to manage them, I only know that he takes medication for high blood pressure. When it comes to medication, I was really scared to administer, because of the state of illness, you are not sure if you are killing them or helping them. I am not even sure if the dose is correct or not. Convincing someone to take medication that you have no knowledge about it challenging and I face resistance from them because they think I am killing them."* (Abigal)

During end-of life care, most elderly paroles were prescribed multiple medications which was administered by the caregivers. Abigail's narrative indicates the difficulties associated limited understanding of administering these medications. Additionally, they mentioned that some of the capsules were quite large, making it challenging for the elderly parolees to swallow them, as illustrated below.

> "*I have limited knowledge about the medication. All I know is that he takes pills provided by the clinic. There are so many tablets that I sometimes get confused. When they are in pain, the biggest challenge for them is swallowing the pills, as some are quite large and look very similar to each other."* (Marriam)

One of the caregivers in the study brought attention to the challenges posed by polypharmacy. She expressed that her limited understanding of medication management made it difficult for her to handle the intricate medication schedules, keep track of side effects, and avoid dangerous drug interactions:

> *"Honestly, my dear child, there are moments when I don't give him his medications as prescribed because I feel unprepared, and I worry about their impact on his mental health. He's meant to take seven tablets each day, three at a time, but if you asked me which ones are for his stroke, diabetes, or high blood pressure, I wouldn't have a clue. Sometimes, I even let him skip some doses because it just feels like too much for someone his age."* (Hloniphile)

The above excerpt corroborates the conclusions drawn by Pazan and Wehling (2021), who contend that polypharmacy significantly heightens the risk of adverse drug interactions. In this context, polypharmacy is defined as the concurrent use of multiple medications. Chock et al. (2021) emphasise the crucial role of caregivers in supporting and encouraging medication adherence to enhance the quality of life. However, the findings indicate lack of sufficient knowledge regarding the medications may adversely affect adherence during the reintegration process. In many instances, caregivers in this study struggled to comprehend the purpose of their medications, which hindered their ability to persuade the elderly parolee effectively.

6.4.3. Theme 3: The impact of caregiving during end-of-life care stage

The researcher sought to explore the experiences of family caregivers who attend to elderly parolees during their final stages of life. As stated in Chapter Two of thesis, family caregivers providing prolonged end-of-life care for family relatives with life-limiting illnesses experience physical, social, and emotional disruptions to their health as consequences of witnessing a decline in their relative's health (Mystakidou et al., 2013). There is a growing recognition of the unique requirements of families who provide end-of-life care for individuals with terminal illnesses, in particular, parolees. Nevertheless, a thorough examination of the experiences of family caregivers, in all their intricacies, underscores the need for a deeper comprehension of their challenges and experiences, particularly in the context of caring for elderly individuals released on medical parole. The analysis of the emotional and psychological effects of caregiving in end-of-life situations reveals four prominent themes derived from the data, the relationship between compassion fatigue among carers of parolees, caregivers' sense of ambiguous loss, the challenge of balancing self-care with caregiving demands, and lastly, the link between loss of faith among caregivers and the

evolving roles and responsibilities during end-of-life care, which are discussed in detail below.

6.4.3.1. The rise and fall of compassion among the caregivers of elderly paroles

The caregiver must demonstrate a genuine sense of concern and empathy, feeling compelled to act when they recognise that the individual receiving care is in distress (Figley, 2002). When caregivers display this empathetic reaction, along with an unwillingness or inability to detach themselves from the caregiving context and a deficiency in personal fulfilment, they may experience compassion stress (Figley, 2002). If this compassion stress persists over an extended period, it can ultimately result in compassion fatigue due to sustained exposure to the suffering of the care recipient. Most of the caregivers in the study reported a 'change' in the quality of their caregiving and their feelings. The change was characterised by a decline in empathy and connection with the parolee, crucial for effective care. One of the caregivers used the term 'anger' to articulate her sentiments of disconnection and exasperation, in the excerpt below:

> *"Things have changed, this caregiving role has turned me to something else, when it's time to change him,* a *profound wave of anger washes over me. I used to be very caring but not anymore. I am so aggressive towards him. I don't even feel anything when it's time to prick him to check his diabetes, I am no longer gentle, I must stay at home and look after him while others are at work there is no form of appreciation from anyone you just doing it because it's a family member; it's really frustrating. Sometime if he falls on the floor, I just look at him and my guilt hits and then I respond."* (Zodwa)

The '*I don't even feel anything*' segment above is an expression of losing empathy, which provides a glimpse of complexities surrounding compassion fatigue. Another participant also shared how their experience of caregiving has made them unempathetic to the ill elderly parolee:

> *There are moments when I find myself wishing I could wake up to find he has passed away; I believe that would bring me a sense of freedom. This caregiving role is a round-the-clock commitment. Even during the night, when I hear him stirring in pain, I used to get up to check on him and wouldn't rest until he was settled. Now, I simply*

roll over and go back to sleep, knowing that come morning, I'll be the one preparing porridge." (Delisiwe)

The *'that would bring me a sense of freedom'* segment indicate a need to reclaim the lost freedom and sense of self that is consumed by caregiving responsibilities. The desire for the elderly parolee's death was not an unusual sentiment among family caregivers; rather, it underscored the compassion fatigue experienced as a consequence of caregiving during the end-of-life phase.

The participant below further narrated about the complexities of caring for a parolee without support:

"Any caregiver in our shoes would be lying if they say there is a reward for caring for these people. At first, I used to be scared and understanding, sometimes he fights with me especially when I must bath him. This one time I found him on the floor, and I just left him there, and that's when I knew that the energy and dedication I had was gone. This person will swear at me and call me names and there after I must be one to feed, bath and take care of him. I am not getting paid for all this and no one bothers to even check up on how we are coping." (Hloniphile)

Hloniphile' s narration that '*this time I found him on the floor, and I left him there*' reveals a profound bitterness and a struggle to show compassion. In addition, the lack of emotional support evidenced by the narration *'no one bothers to even check up on how we are coping'* signifies a sense of social disconnect.

The link between caregiver fatigue and the unpaid responsibilities of caregiving, which include daily tasks like cleaning, meal preparation, dressing children, and caring for sick family members is well documented (Lombardo & Eyre, 2011). These cumulative obligations can overwhelm caregivers, leading to emotional exhaustion and negatively impacting their physical health and wellbeing. The findings also indicate that the 'change' was a gradual process. Another participant's narrative cited below supports the notion that caregivers, particularly those taking care of elderly parolees, often experience compassion fatigue due to the emotional and physical toll of continuous caregiving.

> *"At times, I attempt to empathise with his situation, but it becomes exhausting. Taking care of an elderly person through tasks such as cooking, cleaning, washing, and feeding them feels like a trivial task."* (Balingene)

It is evident that caregivers, especially those caring for elderly individuals on medical parole, report significant emotional exhaustion due to the demands of caregiving. Unpaid caregiving, particularly with heavy responsibilities, negatively impacts caregivers' mental and physical health, with a more pronounced effect on women (Bom et al., 2019b; Hiel et al., 2015; Uccheddu et al., 2019). The next section will explore the concept of ambiguous loss experienced by caregivers during end-of-life care.

6.4.3.2. 'Here in body and gone in spirit': Caregivers' sense of ambiguous loss

Caregivers of elderly parolees battling with terminal illnesses encounter a distinct form of grief that arises from the numerous and unforeseen losses experienced prior to death. This grief, also referred to as ambiguous loss, pertains to the diminishing personality traits, cognitive functions, and physical capabilities of the individuals they care for, who are the very recipients of their support (Blandin & Pepin, 2017; Large & Slinger, 2015, Lindauer & Harvath, 2014). The caregivers in this study experienced ambiguous loss because of progressive illness of the elderly parolee. Ambiguous loss is defined as "a situation of unclear loss that remains unverified and thus without resolution" (Boss, 2016, p. 270). During the provision of end-of-life care, some of the caregivers highlighted that they were caring for loved ones who were physically present but psychologically, spiritually and emotionally absent:

> *"He is unable to manage tasks on his own and has become quite dependent, resembling a baby in many ways. He requires help with every little thing. Each day brings a new challenge and witnessing his suffering feels like coexisting with someone who is alive yet not truly present."* (Mondli)

Another participant also reported the following:

> *"You know that feeling when someone is physically present but emotionally absent? It's a haunting experience, where the body remains, but the spirit has long departed. I dread the thought of being a burden to my family, trapped in this state. After his*

release from prison, I was overwhelmed with depression and anger, even telling my family to wait for my call, as if he were still here. We've navigated the full spectrum of grief, and now we're even planning a ceremony to ask our ancestors to help him find peace. It's incredibly painful to have someone in the house who is here in body but gone in spirit." (Tholakele)

Tholakele's narrations indicate a complex process of death-in waiting, the experience of caring for someone who is 'trapped' in an ill body, waiting to eventually die. Another participant reflected on this ambiguity and constantly being in a state of chronic mourning:

"I sometime find myself planning the funeral and sometimes I feel like I'm going crazy, but my sister is alive, but it feels like they are gone but not sure. I sometime cry to a point that my eyes even swell up. This experience has taught to live with grief while they are still alive." (Veronica)

Veronica's narrative about living with grief while *'they are still alive'* reflects this stage of being "frozen or stuck in a state of chronic mourning" (Zhang et al., 2006, p. 1192). Most of the participants' narratives indicated that they were in a prolonged state of unresolved grief (Doka, 1989). In contrast to conventional bereavement, which typically involves a clear loss and allows for a pathway toward closure, caregivers facing ambiguous losses often struggle to engage in a complete or socially recognised grieving process. They experienced uncertainty regarding how to mourn an individual who remains physically present yet has undergone significant emotional or cognitive changes.

Self-care while managing caregiving responsibilities was a significant factor in the process of caring for the elderly parolees, a theme that is discussed below.

6.4.3.3. Self-care in informal caregiving

Self-care in the context of informal caregiving is typically linked to the equilibrium between the pressures faced by informal caregivers and their ability to cope with these pressures, a factor that is crucial for their overall health and wellbeing (Semere et al., 2021). In this study, most caregivers had the sole responsibility of caring for their relatives. Time for self-care was limited as reflected below:

> *"As a caregiver for my elderly mother, I soon realised how simple it was to prioritise her needs over my own. Each day turned into a frantic dash—cooking meals, organising her medications, and ensuring her comfort. With her health declining, the burden felt increasingly heavy on my shoulders. Finding a moment to relax was a luxury I rarely had, and the thought of focusing on my own self-care felt almost impossible. I convinced myself that as long as she was alright, I would manage just fine."* (Zinhle)

The added responsibility can push its way into the caregiver's family life, leisure time, work, finances, and, in some cases, physical and mental health. This situation can ultimately result in a diminished quality of life for those caregivers (Araújo et al., 2018). The findings from the current research indicated that the caregivers were in survival mode, and in their perception their reality was fundamentally altered as detailed in the following participant's account.

> *"When she was released from prison, I was overwhelmed with shock. Nights became sleepless as fear consumed me. Her condition troubles me deeply, and I constantly fret about the possibility of it being passed down through our family. I often neglect my own wellbeing, prioritising her needs above my own, fully aware of the kindness she has shown me. I know she would do the same for me if our roles were reversed. Each day feels like a struggle for survival, and all I can do is push through".* (Marriam)

One participant articulated how the health conditions of elderly parolees transformed their lived experiences, compelling them to adopt a survival mindset, as elaborated in the following discussion.

> *"After his release, his mother struggled deeply with trauma and found it difficult to come to terms with the situation. She was hesitant to change or bathe him, unable to accept the drastic changes in his condition. I focused all my attention on managing his care, without considering my own wellbeing. I would spend hours assisting both of them, trying to find ways to make the situation more manageable, and neglecting my own physical and emotional needs. Despite this progress, I was emotionally drained and physically exhausted. I had been so focused on their needs that I*

neglected to take breaks, which left me feeling overwhelmed. I pushed through the fatigue, telling myself that there was no time to rest. The constant stress and lack of self-care made me irritable and disconnected. I realised too late that without taking care of myself, I was less able to provide the support they both needed, and that neglecting self-care was taking a toll on my own health and wellbeing." (Maria)

The narratives provided by the caregivers highlighted the challenging aspects of informal caregiving. However, certain individuals exhibited a capacity to embrace their circumstances and discover methods to transcend their challenges. This resilience was evident in their development of self-efficacy and their reliance on social networks, as illustrated in the subsequent narrative.

"Initially, it can feel like you're trapped and emotionally detached. However, as time passes, you come to understand that challenging circumstances compel you to adjust and find a way to cope with whatever life throws your way. For instance, when I plan to visit my other family or need to go out, I wait for the children to return from school before I leave, often asking the neighbours to keep an eye on things. In the end, you realize that survival is up to you; no one else is going to rescue you". (Mondli)

Mondli's accounts, including narratives such as *'finding a way to cope' and 'survival is up to you,'* illustrate a resolute commitment to acknowledging and navigating the challenges associated with caring for his relative. Similarly, another caregiver recounted her experience of seeking respite, as elaborated in the narrative that follows:

"The responsibilities of caregiving were piling up, and I felt like I was constantly on the go—there was always something that needed my attention. Between helping with meals, making sure medications were taken, and managing everything else, I barely had time to breathe. But I knew something had to change when I realized I hadn't had a moment to myself in weeks. One day, after another long stretch of caring for him, I decided I needed a break. I told myself that even though I felt guilty, I couldn't continue like this without burning out. I took a few hours to go for a walk alone. It was only a short walk around the block, but the quiet, the fresh air, and the space to think without distractions gave me the much-needed moment of clarity. That time-out helped me reset and gave me the strength to return with a clearer mind and a little

more patience. It was a reminder that I couldn't give my best care if I wasn't taking care of myself first". (Delisiwe)

Caregivers, as discussed in earlier chapters, are required to navigate their own emotions of grief and anger while simultaneously providing care for individuals at the end-of-life, who may be experiencing severe pain and fear. This role entails considerable sacrifice and has a profound impact on the overall quality of life for caregivers. The finding in this study suggests that the caregiving role during end-of-life care prevented caregivers from engaging in self-care activities. This finding is consistent with Winslow (1997). Further, the Caregiver Dynamic Theory elucidates the intricate nature of the caregiving experience in the context of end-of-life care, positing that the survival mode identified in this study serves dual functions: it acts as both a protective mechanism and a detrimental response. On the one hand, this survival mode equips family caregivers with the necessary tools to manage the pressing demands associated with caregiving. Conversely, it poses risks to caregivers' physical and emotional wellbeing, ultimately contributing to the phenomenon of burnout. Burnout is a state marked by fatigue, diminished enthusiasm, a lack of motivation, feelings of helplessness, hopelessness, and frustration (Primo, 2007). All these characteristics of burnout were discernible in the participants' responses below.

> *"This entire situation is so overwhelming that it triggers migraines, forcing me to seek medical help. Additionally, because he is older, I constantly need to check in on him. The only way I manage to care for myself is by visiting the doctor for my headaches"*. (Abigal)

Another participant also shared:

> *"It's challenging to navigate everything because effective communication with him is lacking, and at times, he resists any help offered. This makes it incredibly tough to provide the care he needs. Emotionally, it has taken a toll on me, feeling unable to engage in meaningful conversations or spend quality time together. Despite how overwhelming it has become; I continue to focus solely on his needs and neglect my own. I don't make time for myself, and as a result, I feel more drained every day. My exhaustion grows, yet I push through, telling myself that caring for him is more important than anything else, even at the cost of my own wellbeing."* (Balingene)

Similarly, one of the participants, expressed the emotional toll that daily caregiving takes on her. She shared,

> *"Right now, everything feels like too much, and I'm exhausted from this responsibility. The most challenging aspect is handling the tube feeding, and there are times when I find myself watching him breathe, questioning if he's still here with us."* (Noxolo)

The findings of this study clearly highlight the significant stress experienced by caregivers providing end-of-life care. This added pressure can lead family caregivers to face an increased risk of depression. The study indicates that this stress often stems from inadequate preparation and training regarding the specific needs of elderly individuals in their final stages of life, as well as how to navigate the challenges that arise during this critical time. It is pertinent to highlight that these results align with earlier studies, wherein family caregivers reported challenges in allocating time for personal activities (Huis in het Veld, 2015; Satink et al., 2018). The existing literature indicates that an imbalance in activities can have detrimental effects on health (Edwards, 2015). Therefore, it is essential to provide adequate support for family caregivers to recognise the importance of achieving a balance in their activities and effectively managing their roles. The next part of this chapter focuses on the link between loss of faith among caregivers and the evolving roles and responsibilities during end-of-life care.

6.4.3.4. The link between loss of faith among caregivers and the evolving roles and responsibilities during end-of-life care

Some of the caregivers reported skepticism and disappointment/disillusionment towards religion and spirituality. The findings indicated that for many participants, religious and spiritual practices were inadequate in helping them navigate the daily difficulties of end-of-life care. The results of this study suggest that the caregivers did not possess strong positive religious convictions and experienced minimal support in managing the demands associated with caregiving. This outcome stands in contrast to Tolliver's (2001) assertion that religion serves as a significant source of support and solace for caregivers. The following utterances reflect the loss of faith among caregivers.

> *"I've poured out my heart in prayer, shed countless tears, and even tried fasting, but nothing seems to change. My faith in God has dwindled to almost nothing. I find*

myself reluctant to pray anymore, questioning what kind of God would let me endure such relentless pain day after day". (Delisiwe)

Similarly, another participant shared her feelings about her efforts to connect with God while facing the constant challenges of providing end-of-life care. She revealed that these experiences left her increasingly despondent, as illustrated in her narrative:

"Many people tell me to cling to God, assuring me that everything will turn out fine. I often respond that I'm not interested in hearing about God. If He truly existed, I wouldn't be enduring this suffering. I've stopped praying; instead, I confront my challenges head-on". (Zinhle)

Balingene, another participant in the study, expressed that they experienced a similar loss of faith during end-of-life care and elaborated on their feelings in saying:

"Waking up next to someone who is slowly fading away each day can shatter your faith and make it feel like God is nowhere to be found. I've grown disillusioned with religion; it often seems to offer nothing but empty promises. The pastors we encounter appear insincere, merely paying others to boost their congregation and line their pockets". (Balingene)

This finding was unexpected, as it contradicted the prevailing belief that caregivers frequently rely on religion to navigate their daily challenges (Acheampong, 2024; Koonce & Hyrkas, 2023). Caregivers commonly find solace in religious practices as a primary coping mechanism (Maoae et al., 2008). While it is widely acknowledged that religion plays a significant role in the experiences of caregivers, the findings indicate that some caregivers were discouraged when their prayers were not answered. The study revealed that the exhaustion experienced by caregivers in their roles fostered a sense of hopelessness, which hindered their ability to connect with God or perceive any divine support during the end-of-life process (Vitaliano et al., 2003). The subsequent topic addressed in this chapter explores the preparedness and confidence of caregivers in delivering high-quality care to elderly parolees during their end-of-life stages.

6.4.4. Theme 4: Caregiving competence and preparedness in providing quality care to elderly parolees

One of the significant themes from this study was caregiver competence and preparedness to care for elderly parolees. These responsibilities include not only providing physical assistance but also offering emotional support and managing the inherent stress associated with caregiving (Luth et al., 2021). Sufficient understanding of medication management and polypharmacy, the emotions of regret and resentment that often arise in the context of caregiving during end-of-life phase, the significance of transferable skills acquired from previous caregiving roles, and the essential need for training and support tailored to end-of-life care as a component of the reintegration process, below are the sub-themes that are emerged.

6.4.4.1. Caregiving knowledge and skills

Some of the family caregivers encountered minimal difficulties in adapting to new caregiving responsibilities. The ease in transition was mainly attributed to prior experience as caregivers within the family context. The findings of the study indicate that most participants had previously served as primary caregivers for other deceased relatives. Consequently, this prior caregiving experience enabled them to effectively use their skills in providing end-of-life care for the elderly, as elaborated in the subsequent statements.

> *"My sister and mother fell seriously ill, and I took on the responsibility of looking after them, taking them to various doctors and clinics. This experience made me accustomed to caring for someone in a critical condition. Shortly after my mother and sister passed away, my husband was also released into my care. Despite the immense challenges during that period, the skills and knowledge I gained from caring for my mother and sister proved invaluable, helping me navigate my new role*." (Tholakele)

Another participant observed that her experiences in caring for her grandmother and mother significantly enhanced her caregiving skills, particularly in the area of medication management. This background has equipped her to fulfil her caregiving responsibilities more effectively. She expressed,

> *"I make it a point to ensure she takes her medication consistently, and she is quite knowledgeable about the timing and method of taking it. Our experiences with our mother and grandmother's illnesses have really prepared us to care for those facing similar health challenges."* (Mabusi)

It is discernible that individuals assigned the caregiving responsibilities following incarceration possessed previous experience in familial care, which contributed to their comfort in delivering support during the end-of-life stage. For example,

> *"I have been the one taking care of everyone who gets sick at home; they all have died under my care. So, when he was released, I knew from the beginning that I had to be one taking care of him, it has become the norm that when they get sick, I am the one who is called. My experience of taking care of other has prepared me to offer the safe care to him, even when it comes to bathing and feeding them, understanding how to communicate with a dying person, also seeing the signs when they about die."* (Zodwa)

According to the Caregiver Dynamic Theory, the above statements illustrate how family caregivers leverage the competencies they have developed through their caregiving experiences. These competencies encompass both technical caregiving skills, such as medical administration and physical support, as well as interpersonal skills, including empathy and effective communication. The results indicate that, over time, caregivers cultivate resilience, adaptability, and a more profound comprehension of the needs of their loved ones. Consequently, these skills not only enhance the quality of care delivered but also contribute to the caregivers' personal growth and their capacity to navigate various life challenges (Clark & Lee, 2024). The next part of this section focuses on the need for end-of-life care training and support during reintegration.

6.4.4.2. The need for end-of-life care training and support during reintegration

Caregivers require specialised skills development and support to provide quality end-of-life care. As highlighted in the previous chapter, correctional social workers in South Africa face significant challenges in providing adequate end-of-life care, largely due to the high costs associated with caring for terminally ill elderly parolees. The lack of knowledge on end-of-life can also lead to frustrations and stress-related challenges. Caregivers also require information on the behavioural manifestations associated with every special need. Considering this information this study also revealed a glaring need for end-of-life care training and support during reintegration. The participants indicated that comprehensive training on various types of special care needs would significantly enhance their ability to

deliver quality end-of-life care. Such training would entail a thorough understanding of the nature of these special needs. It is crucial to provide education to family caregivers to ensure that they are informed about the specific requirements of each elderly parolee under their supervision. All the participants unanimously recognised the need for specialised training to adequately address the needs of elderly parolees. They concurred that elderly parolees possess distinct needs, require guidance, skills, and pertinent information to effectively cater to these unique requirements as highlighted in the following utterances.

> *"I wasn't given any guidance on how to look after him, and I'm not well-acquainted with his condition or requirements. I believe it's far more beneficial for someone to fall ill while you're present, so you can hear directly from the doctors, rather than being in the dark about it after being away."* (Hloniphile)

Similarly, another participant expressed the following:

> *"I wasn't provided with any training on how to care for him as a paralysed individual. The parole officer at the prison only informed me about his medication schedule and the types of pills he was taking. I really needed guidance on basic caregiving, as even simple tasks like helping him use the restroom or knowing how to assist him left me feeling completely lost."* (Maria)

Apparently, family caregivers providing care during the end-of-life phase seek information concerning the patient's illness, its progression and prognosis, available treatment alternatives, as well as possible symptoms and side effects.

> "*It would be beneficial for me to receive training that could enhance my knowledge and skills in this area. As I previously indicated, my experience began with my mother, and it has now extended to my grandfather. Therefore, I am eager to acquire more knowledge regarding the care of individuals with medical conditions."* (Mondli)

The insufficient training and comprehension regarding the illnesses of elderly parolees led some participants responsible for the care of elderly parolees with mental health issues, to advocate for the individual's admission to a psychiatric hospital. She stated,

> *"The individual in question should be admitted to a mental health facility and given the appropriate medication."*

It is evident that caregiving is a multifaceted and evolving process, wherein the interplay between the caregiver and the care recipient significantly influences the overall caregiving experience. Therefore, caregiving is not a fixed role; rather, it is shaped by various factors, including the caregiver's competencies, emotional reactions, and the broader social environment in which caregiving takes place (Pearlin et al., 1990). A fundamental tenet of this theory is the recognition that caregiving is inherently dynamic and subject to change over time, necessitating that the caregiver confronts a range of challenges that demand adaptability, especially when caring for individuals with chronic illnesses or disabilities.

Considering these evolving challenges and the highlighted need for training, it is imperative for family caregivers to receive adequate training to effectively manage the caregiving process. Such training is crucial as it equips caregivers with the essential knowledge and skills required to handle medical responsibilities, address emotional stress, and safeguard their own wellbeing. This need for training is particularly pressing given the increasing demands placed on family caregivers during the end-of-life care phase, many of whom may lack formal caregiving experience, and susceptible to feelings of isolation, stress, and burnout (Bauer et al., 2015).

6.5. Conclusion

In this chapter, I have presented the experiences of caregivers providing informal caregiving of elderly parolees who are released on medical parole in low-income families. The reintegration of parolees who require end-of life care has received very little attention in research. Firstly, the health, mental and physical condition of elderly parolees posed a challenged to the reintegration process. The elderly parolees encounter a complex set of barriers and enablers during their transition from incarceration to community living, which impact reintegration during the end-of-life care phase. Limited healthcare access, feelings of loneliness, social isolation, and inadequate support systems often hinder the successful reintegration of elderly parolees into society.

Additionally, the research revealed that financial support for caregivers is frequently inadequate, imposing further strain on families already grappling with the emotional and logistical difficulties associated with caring for a terminally ill relative. This lack of sufficient financial assistance can exacerbate stress and exert pressure on caregivers, potentially

diminishing the quality of care provided to elderly parolees. These financial difficulties further complicate the adjustment process, making the transition from prison to community a multifaceted and challenging experience for both elderly parolees and their family caregivers. Cleansing rituals emerged as a significant enabling factor, facilitating meaning, support, and a sense of protection among the elderly parolees. The study's findings indicate that these rituals empowered elderly parolees and their family caregivers to confront their suffering and navigate the challenges associated with the end-of-life phase.

The study unpacked the perceptions about assuming the caregiving role of elderly parolees during their final stages of life. The results revealed that caregivers often experienced regrets and resentment related to their responsibilities during end-of-life care. Family caregivers also expressed concerns about their insufficient knowledge regarding medication management, which they identified as a significant barrier to the adherence of elderly parolees to their prescribed treatments. Additionally, the research highlighted the prevalence of polypharmacy among seriously ill elderly parolees nearing their end-of-life, complicating their reintegration process.

The study highlights the realities of caregiving during the end-of-life phase. Family caregivers experienced significant emotional fatigue due to the demands of continuous caregiving when caring for an elderly individual released on medical parole. The study also unveiled that family caregivers of elderly parolees facing terminal illnesses encounter a distinct form of grief that arises from the numerous and unforeseen losses experienced prior to death.

The research indicated that family caregivers often operated in a state of survival, perceiving a significant transformation in their reality that hindered their capacity to balance self-care with the demands of caregiving. Additionally, t the responsibilities associated with end-of-life care inhibits caregivers from participating in self-care activities. As highlighted in this chapter, family caregivers articulated that their roles were unanticipated and frequently accompanied by stress, which adversely affected their ability to engage in self-care during this critical period. Interestingly, most participants noted that their religious and spiritual practices fell short of providing the essential support needed to cope with the daily challenges of end-of-life care. Despite their diverse religious backgrounds, caregivers experienced a

profound sense of disconnection following the passing of the elderly individuals they cared for.

The study also investigated the preparedness of caregivers and their confidence in providing high-quality care to elderly individuals on medical parole. The study revealed that family caregivers encountered minimal challenges in adapting to new caregiving responsibilities, a phenomenon attributed to their prior experiences in family caregiving, which enabled them to effectively apply skills homed in earlier roles. As a result, the importance of transferable skills gained from past caregiving experiences emerged as a vital element facilitating the reintegration process. Furthermore, the findings emphasized the critical need for training and support in end-of-life care as fundamental components for improving caregivers' preparedness and competence. In this regard, the training requirements for caregivers include essential knowledge and skills for managing medical tasks, coping with emotional stress, and safeguarding their own wellbeing. The next chapter is a presentation of the second section of the findings and discussion.

CHAPTER 7

DISCUSSION OF FINDINGS PART TWO

Navigating the Final Journey: The Role of Correctional Social Work in End-of-Life Care Challenges and Realities

"*Social workers at the end of life provide more than just support; they offer a compassionate presence that helps families navigate the emotional, ethical, and practical challenges, ensuring dignity and peace in life's final chapter*"

Ira Byock

7.1. Introduction

his chapter introduces the main theme, which centres on the overarching role of correctional social workers in supporting elderly parolees during end-of-life care. It also presents the related themes and sub-themes that structure the discussion that follows. The chapter highlights the unique challenges encountered by both social workers and family caregivers during the reintegration process, drawing attention to systemic gaps, ethical dilemmas, and the practical realities of providing care to a highly vulnerable population.

End-of-life care provided during the reintegration of elderly parolees released on medical parole poses distinct and intricate challenges for correctional social workers serving in non-custodial settings. Elderly offenders released on medical parole often encounter distinct obstacles in accessing comprehensive healthcare services, specifically end-of-life and palliative care. Correctional social workers operating within these institutions must navigate significant constraints including limited resources, rigid institutional regulations, inadequate training and insufficient infrastructure, all of which hinder their capacity to effectively address the complex and evolving needs of individuals nearing the end of their lives.

This chapter examines the complexities involved in delivering end-of-life care programmes in the post-incarceration period, emphasising the role of correctional social workers, the unique challenges they encounter, and the shortcomings of current programmes in addressing the needs of this vulnerable population of terminally ill elderly parolees.

7.2. Themes

Table 7.1.: The themes that emerged from the data collected from both correctional social workers and family caregivers

Theme	Sub-theme
Theme 1: The role of correctional social work in promoting and improving the quality of end-of-life care for elderly parolees	• Gaps in correctional social work programmes for elderly parolees and their families during end-of-life care • The suitability of after-care social work programmes for elderly parolees during the end-of-life care stage. • The lack of collaboration between correctional social workers in custodial and non-custodial centers
Theme 2: Challenges and realities faced by correctional social workers during the reintegration process	• Lack of training and preparedness on end-of- life care amongst social work • The necessity of advocacy aimed at policy reform and resource allocation • The impact of Medical Parole Policies on Caregivers and Elderly Parolees

7.3.1. Theme 1: The role of correctional social work in promoting and improving the quality of end-of-life care for elderly parolees

Correctional social workers provide a number of services to parolees during their reintegration into society after incarceration through casework, group work, and community work programmes (Murhula, Singh &Nunlall, 2019). The primary role of the correctional social worker is to facilitate the transition of elderly parolees from prison into society. This is in tandem with the Ecosystems Theory, which argues that the provision of end-of-life care social work services during reintegration is based on the social worker's ability to advocate for or access quality end-of-life care services for their clients (Ferrell, 2013). The most salient theme that emerged from the data hinged on the role of social work services in promoting and improving the quality of care for terminally ill elderly parolees and their caregivers during the provision of end-of-life care. In this section, I will discuss the following sub-

themes: the lack of support from correctional social workers during reintegration; the suitability of after-care social work programmes during elderly parolees' end-of-life care stage; and the lack of collaboration between correctional social workers in custodial and non-custodial centres during the reintegration of terminally ill elderly parolees into society.

7.3.1.1. Gaps in correctional social work programmes for elderly parolees and their families during end-of-life care

Correctional social workers play a crucial role in terms of overseeing and facilitating aspects related to the placement of the reintegration of elderly parolees into society during the end-of-life care process, providing essential guidance and monitoring services for their well-being and that of their caregivers. However, in this study, family caregivers reported never having received a visit from a correctional social worker at their homes since the release of the elderly parolee in their care. The absence of post-release support contributed to the participants' pronounced sense of disconnection from the reintegration process. Some participants expressed feelings of regret about their decision to assume care-giving responsibilities. One of the participants articulated her frustration by stating:

> "*I haven't received any support from correctional social workers; they seem quite disoriented, and I am uncertain about the type of help they offer. Had I known that they would not assist me, I would have declined taking on the care-giving role"* (Tholakele).

Another participant below articulated their dissatisfaction with the inability of correctional social workers to offer adequate support, characterising them as "missing in action." Furthermore, the participant conveyed the view that despite the invisibility of social workers, there was an expectation that they had a responsibility to provide support to the parolees and families members as mentioned below:

> *"I was surprised to learn that the Department of Correctional Services employs social workers. I haven't had the chance to meet any of them yet, and I'm not familiar with the services they offer. This unfamiliarity has left me with a narrow perspective on the important contributions they are making to our communities. Their role is meant to assist us as caregivers by providing essential support and resources, guiding us*

*through complex care-giving systems, and helping parolees access the services they need to enhance their lives, but they are **missing in action**"* (Mabusi).

The participants expressed their concerns regarding the challenges encountered by caregivers upon the reintegration of elderly parolees into society. They reported feeling neglected and not appreciated by correctional social workers, which resulted in diminished trust and confidence in the support services being provided. One participant articulated this sentiment as follows:

*"The correctional officials dropped him off, left him with me and walked away. They left me to handle everything on my own. I haven't encountered a single social worker since then. Even the officers who come by to have him sign documents show little concern for his well-being. One officer even suggested I pray for his death, calling him a vegetable. This clearly illustrates how little the correctional workers care about those of us who are responsible for the parolees; the officials don't even make an effort to conduct a home visit to see how the parolees are being cared for***"** (Noxolo).

Admittedly, correctional social work participants identified gaps in the planning and release of elderly parolees who are released on medical paroled They attributed this gap to the inadequacy of the reintegration processes. One participant remarked:

"The services available for terminally ill individuals lack a clear and effective framework, which poses significant challenges regarding meeting their needs. Unlike the standard release process for healthy individuals, the approach for those who are terminally ill is quite different; they are typically admitted and then sent home without a structured plan. Often, we are not even informed by the Department of Correctional Services when an elderly parolee is released on medical parole, leaving us unprepared to support this vulnerable group. Regrettably, most of our services are designed with healthier, younger parolees in mind, resulting in a noticeable absence of tailored programmes for the terminally ill" (CSW3)

Another correctional social worker, a participant in this study, expressed concerns regarding the absence of a well-defined scope of practice within non-custodial centres and specialised programmes aimed at end-of-life care. According to the participant below, this deficiency

was contributing to the inadequacies and gaps in delivering effective social work support during the reintegration process:

> *"At present, community corrections do not provide any dedicated programs aimed at illness and end-of-life care. The complexities involved in meeting the needs of those who are gravely ill pose significant challenges in delivering specialised services. Implementing support in a person's home without a well-organized program is simply not practical. Consequently, the absence of established support systems greatly hampers our capacity to effectively meet the needs of these individuals"* (CSW6).

Most participants pointed out that, in general, there are no services for ill elderly parolees during the end-of-life period. A participant elaborated this finding, stating that:

> *"When it comes to aftercare services for those who are terminally ill, I can't recall witnessing any services being offered. This gap in services has been creating difficulties in the past"* (CSW2).

The participant indicated that the inability to adequately screen caregivers during the reintegration process often leads to complaints from caregivers, which in turn compels the Department of Correctional Services to revoke medical parole. For instance, one participant recounted a specific incident in which a caregiver was merely a girlfriend rather than a family member. The participant had the following to say in this regard:

> *"There was a situation where a caregiver was simply a girlfriend, not a family member, and when she chose to end the arrangement, neighbours informed us of the issue. Regrettably, the parolee had to return to prison. If there had been a well-organised service in place to ensure that the parolee was matched with a reliable and suitable caregiver, such scenarios might have been prevented. Unfortunately, I don't remember any community correctional services that specifically address illness and end-of-life care"* (CSW2).

The findings are consistent with observations made during the recruitment phase, as the researcher discovered that correctional social workers were largely unaware of the existence of terminally ill parolees released on medical parole within their system. As a result, they depended on monitoring officials deployed to oversee elderly offenders who had been granted

medical parole during the recruitment process. This observation underscores the lack of support services provided by correctional social workers to terminally ill elderly parolees and their families. Furthermore, this finding corroborates the findings of a study conducted by Nduli and Mthembu (2022), who concluded that the efforts of correctional social workers tend to focus largely on younger parolees and their families, primarily due to the higher recidivism rates associated with this group. Consequently, elderly parolees and their caregivers often receive inadequate support and attention in their post-release phase.

7.3.1.2. The suitability of after-care social work programmes for elderly parolees during the end-of-life care stage.

Correctional social workers at the chosen centre did not allocate medical parolees to any aftercare programmes, and in certain cases, correctional officials opted not to engage correctional social workers due to the elderly parolees' vulnerable health conditions. Despite the Department of Correctional Services providing a range of social work programmes designed for reintegration, these initiatives notably excluded ill elderly individuals released on medical parole (Singh et al., 2016). This observation aligns with existing literature that underscores the inadequacy of social workers in delivering end-of-life care programmes for elderly parolees in their post-release stage. One of the correctional social workers also supported the view that post-release social work services did not serve the needs of ill elderly parolees as depicted by the following utterances:

> *"Presently, there are no social work programmes tailored and dedicated to offer adequate support to terminally ill elderly parolees. As a social worker, you bear the responsibility of figuring out how to assist each patient with unique needs. There are no formal programmes in place to equip you for the diverse challenges that may come up during visits to terminally ill patients. This situation underscores a critical deficiency in service delivery. Establishing training initiatives centred on palliative care could significantly improve social workers' capacity to address these individuals' end-of-life care requirements"* (CSW3).

The lack of suitable post-release support exacerbates the challenges faced by terminally ill elderly parolees and their caregivers during the reintegration process. Furthermore, caregivers reported the unavailability of social work programmes designed to assist them in providing

quality end-of-life care for terminally ill elderly parolees a gap they observed as a significant shortcoming of the existing programmes. Resultantly, the absence of effective end-of-life care strategies for the individuals' re-entering society has left correctional social workers ill-equipped to address the end-of-life care needs of elderly parolees and their families, thereby putting considerable strain on family relationships. One participant reported:

> *"The existing aftercare programmes fall short in terms of effectively supporting seriously ill elderly parolees and their families. Notably, there is a lack of assistance, especially regarding collaboration with healthcare providers. Improving communication and coordination with doctors would greatly enhance the situation for both parolees and their families. By facilitating timely visits and consultations, social workers could assist families to better prepare for the parolee's needs, ensuring they receive the essential care and support they need during this crucial period"* (CSW 2).

Evidently, the Department of Correctional Services did not offer any end-of-life care programmes for offenders released on medical parole. This finding also suggests that terminally ill elderly parolees and their caregivers were deliberately excluded from participating in programmes offered by social workers. The excerpt captured below confirms that the current aftercare social work programmes hardly accommodate ill elderly parolees, thus:

> *"Our current approach as social workers tends to prioritise general services over specialised programmes that cater to the distinct needs of terminally ill elderly parolees. Presently, there are no dedicated initiatives aimed specifically at alleviating the plight of this demographic, which hampers our effectiveness in tackling their unique challenges. As a result, I frequently find myself depending on outside organisations to bridge this gap. Rehabilitation should be a collaborative effort involving correctional services, institutions, communities, and families. However, the absence of targeted services for terminally ill elderly parolees prevents us from delivering thorough support. This dependence on external resources can result in delays and inconsistencies in the provision of care, making the situation even more difficult for these vulnerable individuals"* (CSW5).

These findings corroborate those of Albertus' (2010) study, which established that the first six months of release from prison constituted the most vulnerable period for the ill elderly parolees, as most of them reportedly faced the harsh realities of re-entry into society. Therefore, post-release end-of-life social work programmes are extremely crucial when it comes to the enhancement of the quality of life for offenders that have been granted medical parole. Albertus' (2010) found that due to the structure and content of social work programmes rendered by the Department of Correctional Services, the ill elderly parolees scarcely benefited from these programmes, as they felt that their unique needs were not addressed.

7.3.1.3. The lack of collaboration between correctional social workers in custodial and non-custodial centres

The outcome of this research study indicates that there was no connection between correctional social workers operating in custodial facilities and those in non-custodial settings. Under this theme, the participants highlighted a significant lack of collaboration between custodial and non-custodial correctional social workers and, consequently, this compromised the quality of services provided during the end-of-life care for elderly parolees as indicated below:

> *"Collaboration among various sections of the Department of Correctional Services is crucial. For instance, custodial social workers often fail to connect with their counterparts in community-based corrections. Social workers operating in non-custodial environments are unaware of the needs of ill elderly parolees during their release, along with the social work assessment conducted. This information is intended to help us prepare and offer the necessary support as these individuals reintegrate into the community. However, custodial social workers do not communicate this information, which renders it difficult to communicate with family caregivers. To enhance this process, it is vital to bridge these communication gaps and ensure comprehensive involvement from all the relevant stakeholders"* (CSW5).

The participants reiterated that many of their deficiencies in helping during the reintegration of terminally ill elderly parolees stemmed from the fact that custodial social work within the

Department of Correctional Services are excluded from the preparatory phase of the reintegration process. The participant below further elaborated on this disconnect:

> *"Custodial social workers often do not collaborate effectively with their non-custodial counterparts in community corrections. This lack of cooperation during the early phases of the release process can hinder the development of a unified support system, which is crucial for ensuring the provision of quality care for terminally ill elderly parolees. By involving non-custodial social workers from the beginning, we can create a more holistic strategy for resettlement and reintegration of the elderly offenders, ultimately enhancing the experience for both the parolees and their caregivers"* (CSW3).

At the microsystem level, the lack of collaboration between custodial and non-custodial social workers affects the health and emotional stability of the offenders. During the reintegration process, an individual may experience feelings of neglect or lack of support, especially in the absence of a coordinated approach that ensures seamless care between prison healthcare providers and community-based social workers. Research indicates that terminally ill individuals in correctional facilities are frequently short-changed by a disjointed care system, consequently rendering them inevitably vulnerable (Ferrell, 2013). In the absence of effective collaboration, there is a heightened risk that offenders may not receive the necessary end-of-life care or mental health services as they transition from incarceration to community living. The participants had the following concerns to share with regard to this dilemma:

> *"The lack of a structured service delivery system among correctional social workers in both custodial and non-custodial settings have significant repercussions for the elderly parolees and their families. In one particular case where I had limited information, I found myself facing a challenging situation, having to advocate for the well-being of the elderly offender to obtain a comprehensive history of the parolee. This case arose from a complaint regarding an elderly parolee nearing the end of life and experiencing psychosis. Had the custodial social worker worked collaboratively with us, the parolee could have received timely institutional care. Instead, the parolee was released and ultimately passed away, as the caregivers were inadequately trained to manage the complexities of a brain tumour"* (CSW1).

The findings in this section strongly suggest that the inability of both custodial and non-custodial social workers to collaborate effectively in the reintegration of ill offenders nearing the end of their lives can have serious consequences on the reintegration process. When these professionals have not joined forces, the support systems impacting elderly offenders at the different levels of the reintegration process fall short in terms of delivering the essential continuity and quality of care. This disconnection can result in adverse health outcomes, extended suffering, and frequent interruptions in the reintegration journey, highlighting the urgent necessity of developing cohesive strategies in the care of offenders experiencing terminal illnesses.

7.3.2. Theme 2: Challenges and realities faced by correctional social workers during reintegration

Findings from this study reveal a significant gap in the visibility and involvement of social workers in end-of-life care for elderly parolees. Both participants and social workers confirmed the lack of structured services and dedicated programmes to support terminally ill parolees during reintegration. This absence highlights a critical service delivery vacuum, particularly given the complex needs of this population and their families. Despite these limitations in the local context, literature from other settings illustrates what a more integrated and responsive model could look like. In some contexts, community correctional social workers are recognised as key members of the palliative care team, providing a range of psychosocial services throughout the end-of-life phase (Meghani & Hinds, 2015). These services include case management, behavioural health counselling, advance care planning, support for families, participation in ethics committees, and bereavement counselling (Altilio & Otis-Green, 2011; Meier & Beresford, 2008; NASW, 2018). However, these examples remain largely aspirational in the South African context, where such roles and services are either underdeveloped or entirely absent. This tension between global best practices and local realities underscores the urgent need to reimagine the role of correctional social workers not hypothetically, but through grounded, context-specific strategies that reflect both the capacity and constraints of our current system.

7.3.2.1. Lack of training and preparedness on end-of- life care amongst social work

The findings of the study attest to the fact that a significant number of correctional social workers involved in the study lacked awareness regarding the specific requirements of elderly parolees suffering from terminal medical conditions. This observation reveals that the domain of correctional social work is inadequately equipped to establish effective reintegration programmes for terminally ill elderly offenders transitioning from incarceration to their communities, particularly concerning end-of-life care, as illustrated in the subsequent excerpts:

> *"At present, there is no structured training available for correctional social workers in the field of correctional services. The Department of Correctional Services recognises the existence of parolees who are on medical parole and confined to their beds. Unfortunately, many social workers lack crucial training which, I think, is vital for meeting the needs of terminally ill patients on parole. Establishing a training programme centred on end-of-life care could greatly improve our knowledge and capacity to assist these at-risk individuals"* (CSW3).

The inadequacy of training and preparedness in end-of-life care emerged as a critical issue, exposing a significant gap in the professional skills necessary in providing suitable correctional social work services to terminally ill elderly parolees on medical parole. Another participant reiterated that:

> *"At this time, there isn't a dedicated training programme for correctional social workers focused on terminally ill parolees. Although there is a policy in place that addresses the needs of the elderly, it falls short of addressing the distinct challenges that terminally ill parolee's encounter. This gap in specialised training does not guarantee the well-being of those we serve"* (CSW4).

Against the backdrop of the challenges confronting elderly parolees, which are exacerbated by terminal illnesses, the participating correctional social workers emphasised the value of specialised palliative care training. The participants reported feeling unprepared to address the diverse and intricate needs of elderly individuals released on medical parole. This conclusion is supported by Mnguni and Mohapi (2015), who noted that some of the difficulties faced by correctional social workers stemmed from the generic nature of social

work education, which lacks a specialised focus on correctional social work. In the following excerpt, a participant disclosed that:

> *"There is a complete lack of training. Without proper training, we struggle to deliver our mandate because we haven't learned the necessary skills needed to manage medically ill parolees. Additionally, we aren't even made aware of the basics of this area of specialty; many of these individuals need specialised end-of-life care that offers support and assistance during their reintegration into communities"* (CSW6).

The participants argued that the lack of training on palliative and end-of-life care made it challenging for them, as correctional social workers, to foster meaningful relationships with ill elderly parolees during their transitioning from prison to society. Some of the aspects of these findings resonate with those of Plessis and Lombard (2018), who highlighted that correctional service providers often lack the necessary training needed to meet the reintegration needs of offenders after their release from correctional custody. Similarly, a study conducted in Namibia reported that the majority of correctional service providers employed in the Department of Correctional Services often lacks the necessary work-related skills they need to meet the needs of parolees during the reintegration process (Chipango, 2016).

One of the participants also highlighted some of the training needs, as reported in the following utterance:

> *"Understanding end-of-life care is essential for social workers assisting medically ill parolees. Simply granting these individuals medical parole can create the impression that they are being sent home to face death. Consequently, training in palliative care is vital in terms of helping both the parolees and their families navigate this difficult change. Furthermore, introducing life skills programmes aimed at building resilience can greatly support these individuals. These programmes can provide valuable coping mechanisms, enabling them to accept their situations, leading to an enhancement of the overall quality of their lives"* (CSW3).

Drawing from the Ecosystem Theory, this research posits that the quality of end-of-life care may be adversely affected by a lack of structured and specialised social work services. Most

correctional social workers consistently expressed feelings of inadequacy in addressing the complexities associated with post-incarceration services offered to elderly parolees. Similarly, Nduli and Mthembu (2022) noted that the lack of preparedness among correctional social workers led to the exclusion of elderly parolees from necessary services, failing to address the specific needs of this demographic group. Consequently, the participating caregivers were compelled to navigate this challenging journey without adequate support. The sub-theme discussed in this section emphasises the necessity of developing advocacy aimed at policy reformation and resource distribution.

7.3.2.2. The necessity of advocacy aimed at policy reform and resource allocation

Advocacy, as it relates to the realm of correctional social work, involves the initiatives undertaken by social workers to assist, represent, and defend parolees, together with their families, or groups that may be disenfranchised, and lacking the necessary power, resources, or capacity to advocate for their needs (Reichert, 2011). This practice is essential to the field of correctional social work, as it aims to promote social justice and enhance the well-being of parolees. In this study, the participants emphasised the vitality of their role in advocating for policy changes that would enable elderly parolees and their caregivers to access improved healthcare and end-of-life services during their reintegration process. For example, one correctional social worker recounted the efforts they made in engaging with the local councillor in constructing a functional toilet for the family, thereby facilitating access for the ailing elderly parolee. The participant shared:

> *"In one instance, I engaged the local councillor and the Human Settlement Department to secure a proper toilet for a wheelchair-bound elderly parolee who was unable to use a bucket as a toilet" (CSW4).*

The findings under this theme underscore the necessity of correctional social workers having to advocate for resource mobilisation and allocation during the release of ill elderly parolees to ensure that their reintegration-related needs are addressed during the end-of-life period. In that regard, a participant had the following to share:

> "*The existing White Paper on Corrections (2005) that identifies elderly offenders as a distinct group, but it's crucial for us as correctional social workers to push for the*

inclusion of end-of-life services in this classification. This addition would enhance our ability to advocate for the cause of these parolees and ensure that nursing support is integrated into our aftercare services. I recall a particular home visit where I encountered an elderly parolee living in poor an unsuitable and unhealthy environment. This experience underscored the necessity of advocating for the release of ill elderly parolees into well-equipped settings that are capable of meeting their needs" (CSW5).

Evidently, one of the participants emphasised the fundamental role advocacy plays in maintaining the connection between social work and social justice. The findings indicate that by advocating for the welfare of elderly parolees facing end-of-life issues and striving for systemic reform, social workers can contribute to the establishment of more equitable and inclusive settings. Furthermore, advocacy is consistent with the ethical standards set forth in the National Association of Social Workers (NASW) Code of Ethics, which urges social workers to "challenge social injustice" and "promote social, economic, and environmental justice" (NASW, 2017). Some participants highlighted the need to revise Section 79 of the Republic of South Africa Correctional Services Act Number 111 of 1998 to include the pre-screening and education of caregivers before the ill elderly parolees are released on medical parole as illustrated below:

"It is essential to continue advocating for the acknowledgment of family caregivers under Section 79 of the Correctional Services Act Number 111 of 1998 to enhance their rights and well-being. The current focus tends to be too narrow, as it primarily addresses the release of ill parolees without considering the critical role of quality caregiving. By implementing this policy, correctional social workers would be better equipped to evaluate caregivers, thus ascertaining whether they possess the necessary skills to support elderly parolees. This initiative would also pave way for advocating for vital resources aimed at educating caregivers on the best practices with regard to caring for these individuals. Ultimately, the Department of Correctional Services stands to benefit significantly from empowering family-based caregivers, enabling them to provide effective support to ill parolees and make them prepared to handle challenging situations" (CSW3).

Another significant finding emerging from this study bordered on the urgent need for various groups to advocate for the rights of terminally ill elderly parolees' post-incarceration condition. This concern emerged prominently among correctional social workers who recognised the inadequate attention being paid to terminally ill elderly parolees. One participant shared the following view:

> *"As a correctional social worker, I've identified a significant gap in our practice. There is urgent need for developing a dedicated end-of-life care policy tailored for ill elderly parolees and their caregivers. Instead of distancing ourselves from this vulnerable group, we should actively advocate for their needs. This population is often overlooked, and even after their release, many of them return home where there is no support they require. Essential items like wheelchairs, food parcels, and asthma pumps are critically needed, highlighting the necessity of advocating for policies that promote a coordinated response involving various external stakeholders"* (CSW6).

Another participant highlighted the need for adopting a systemic advocacy initiative for appropriate reintegration programmes. After revealing that once terminally ill parolees are released, they are abandoned and left with a caregiver who has no knowledge of the elderly parolee's health status, as indicated in the excerpts below:

> *"As correctional social workers, it is crucial for us to advocate for the rights and well-being of family caregivers. It is disheartening to note that elderly parolees grappling with serious health issues are left in the hands of caregivers who lack information about the health conditions of the parolees, thus rendering them unprepared to traverse the challenges of caregiving. I've seen many caregivers, often middle-aged or elderly women struggling with their own health issues, reach a breaking point due to the overwhelming demands of their caregiving role. To make matters worse, our programmes often overlook the importance of including families in the end-of-life care process for these ill parolees. Many caregivers are already experiencing burnout and grief long before the actual passing occurs"* (CSW1).

The study findings highlight the need for correctional social workers to advocate for more extensive reintegration programmes that address the unique requirements of elderly offenders and their family caregivers, especially those approaching the end of their lives. These

reintegration services should be essentially designed to be human-centred and holistic. Advocacy for policy reform is vital in terms of ensuring that individuals receive high-quality, respectful, and compassionate care during their travesty of the end-of-life journey. Correctional social workers, particularly in community-based correctional environments, are in a distinctive position to recognise deficiencies in the care being provided and to champion improvements in both individual needs and systemic reform. The Ecosystems Theory posits that such changes must be implemented at various levels, from the individual to the societal, to cultivate an environment characterised by dignity, support, and an enhanced quality of life for those confronting end-of-life challenges (Madden, 2017). Consequently, this finding emphasises the importance of correctional social workers having to engage in policy advocacy to secure additional funding and resource mobilisation for caregivers and elderly parolees struggling with terminal health conditions. The next sub-section focuses on the impact of medical parole policies on caregivers and elderly parolees.

7.3.2.3. The impact of Medical Parole Policies on Caregivers and Elderly Parolees

The participants indicated that the current medical parole policies often fail to adequately address the distinct end-of-life care needs of elderly individuals who are released on medical parole, as they require comprehensive support systems that encompass not only medical care but also emotional and psychological assistance as they navigate the challenges accompanying terminal illness. Unfortunately, the existing policies tend to overlook these critical aspects, leaving elderly parolees without the necessary resources to manage their conditions effectively. A participant stated:

> *"We really don't know what the medical parole policies say because no one inducted us on the policy. They just dumped my father and left him in my care. Since we are always up and down visiting hospitals, the officials always think that my father is absconding. So, this adversely affects my caregiving role because these conditions don't seriously consider the health of my father and more often than not the policy doesn't consider the caregiver of the person they are releasing. Resultantly, my voice as a caregiver is neglected and I must now be the one who has to frequently go to hospitals because they don't even bother to link us with the healthcare system. It is really a nightmare to be given such responsibilities. Sometimes, I get so angry, and*

honestly, I cannot wait for him to just die because seeing him in this condition with no support in such compromised position is painful" (Noxolo).

The transition from prison to placement on medical parole represents a crucial step in facilitating the reintegration of elderly and terminally ill individuals into society. This process not only acknowledges the unique challenges faced by this vulnerable population but also highlights the need for adopting a more compassionate and supportive approach to their care. The findings of this study underscore the complexity characterising the relationship between medical parole policies, the specific end-of-life care needs of elderly parolees, and the vital role that caregivers play in this dynamic. One participant shared the following view:

"The release of elderly parolees on medical parole often places a heavier caregiving burden on their family members. Caregivers frequently express the emotional and physical toll this responsibility takes on them. For instance, in one case I encountered, a family member shared the view that they had to modify their work hours and reduce their shifts, resulting in a decrease in income, and all this was done to ensure the elderly parolee receives the necessary care" (CSW5).

Gottfried and Mather (2018) aver that elderly parolee released on medical parole may require daily medical care, including medications, and specialist appointments, but the family caregiver may not have access to the same resources available in a hospital or prison setting, as depicted in the excerpt below:

"Several of our parolees reside in rural areas, a scenario which poses challenges when they are granted medical parole due to the scarcity of resources that are needed to support them. In one particular instance, an elderly parolee who was unwell was released, and their family faced significant difficulties managing the caregiving responsibilities. Eventually, we received a call from a caregiver expressing their inability to secure transportation to help the parolee during critical moments. Tragically, this lack of support contributed to the parolee's untimely passing just a few weeks after their release from prison" (CSW1).

According to the Ecosystems Theory, the absence of sufficient emotional or practical support can jeopardise caregivers' role due to experiences such as burnout or compassion fatigue,

thus ultimately impairing their ability to provide high-quality care (Horsley, 2019). Consequently, this disconnection among systems frequently results in significant resource deficiencies. Family caregivers may find themselves uncertain about where to seek assistance, whether it involves addressing the parolee's medical requirements, locating community resources, or obtaining financial aid, thereby exacerbating the difficulties characterising their caregiving responsibilities (Toseland & Rivas, 2017). Another participant also reported that after the release of elderly offenders on medical parole, caregivers reported experiencing aggressive behaviours exhibited by the elderly parolees, as indicated below:

> *"Most family caregivers often reported experiencing aggressive behaviours displayed by ill parolees, which often include swearing or exhibiting confrontational attitudes towards them. These reports highlight the necessity of improved understanding and support for both the parolees and their caregivers as they collectively face these difficulties"* (CSW4).

The correctional social worker's report is supported by the remarks of a caregiver, who strongly reinforced this point, stating:

> *"He struggles with mobility. Each time he's in his wheelchair, he attempts to stand up, growing frustrated when he realises, he can't walk. I believe his main desire is to visit the tavern. Additionally, he becomes quite aggressive and swears at us when it's time for him to take his medication, insisting that he was never ill before his arrest and blaming the prison for his current state. Sometimes, when bathing him, he would claim that I wanted to kill him"* (Maria).

Ill elderly parolees who display aggressive behaviours that potentially stem from health complications, past traumatic experiences, or the challenges associated with their reintegration into society, can cause a profound emotional and psychological impact on their caregivers (Kramer & Farkas, 2018). The Caregiver Dynamics Theory posits that caregivers typically get into an emotional bond with those they care for; however, the presence of aggressive actions, such as verbal hostility, physical confrontations, or unpredictable mood changes, can undermine this bond, resulting in heightened stress and emotional distress for the caregiver (Schulz & Sherwood, 2008). Furthermore, the study highlights a significant gap in the involvement of family caregivers in the planning process involving the release of

elderly parolees. Caregivers are essential to the successful reintegration of these individuals into the community, yet they are frequently excluded from discussions and decisions regarding the care and support provided in the post-release period. This lack of involvement can lead to inadequate preparation for both the parolees and their caregivers, which ultimately compromises the quality of care that elderly individuals receive during this vulnerable time of their lives.

The finding embedded in this sub-theme implies that medical parole policies, which are designed to offer compassionate release to individuals grappling with illness or terminal conditions, have profound implications for caregivers. These policies may introduce various challenges, including heightened emotional stress, financial burdens, ambiguity in caregivers' roles, and insufficient support given to those providing care. To effectively tackle these issues, it may be essential to establish robust support systems that encompass improved access to healthcare services, legal assistance, and financial resources, thereby alleviating the pressures exerted on caregivers and ensuring that individuals granted medical parole receive the necessary care.

7.4. Conclusion

This chapter has examined the key themes and sub-themes that align with the research objectives and the study's overarching aim. The chapter examined the contributions of correctional social work services towards enhancing the quality of care provided to terminally ill elderly parolees and their caregivers during the end-of-life phase of their reintegration into society. The study's findings highlighted a significant deficiency in the support offered by correctional social workers throughout the reintegration process, resulting in feelings of disconnection among the involved individuals. Additionally, the findings indicate that existing aftercare social work programmes implemented at the end-of-life stage in the parolees' lives often overlook the specific needs of the ill elderly parolees, thereby failing to address their unique circumstances. Furthermore, the findings underscore the detrimental effects posed by ineffective collaboration between custodial and non-custodial social workers in the reintegration of terminally ill offenders into society, which can lead to serious repercussions across multiple dimensions including psychosocial, ethical, legal, and practical challenges, aftercare social work programmes.

The findings of the current study suggest that community correctional social workers face a variety of challenges that significantly impact their roles and the individuals they serve. One of the findings concerns correctional social workers' lack of training and preparedness to discharge their support roles within the context of end-of life care. Lack of ongoing training specifically in palliative care contribute to lack of preparedness to address the diverse and intricate needs of elderly individuals released from incarceration on medical parole. Furthermore, the challenges identified by the correctional social workers highlighted a considerable deficiency in training and resources available for both caregivers and elderly parolees. The findings highlight c the necessity of embarking on advocacy aimed at policy reform and resource allocation. Correctional social work professionals emphasised their vital role in advocating for policy changes that would enable elderly parolees and their caregivers to access improved healthcare and end-of-life services during their reintegration into community life. Lastly, the findings of the study also indicated the impact of medical parole policy on ill elderly parolees and their caregivers, highlighting the policy-induced challenges, which include heightened emotional stress, financial burdens, ambiguity in roles, and insufficient support offered to those providing care. The next chapter presents the conclusions and recommendations deriving from the study.

CHAPTER 8

CONCLUSIONS AND RECOMMENDATIONS

8.1. Introduction

The preceding chapter thoroughly examined the findings and themes arising from the data analysis, which fostered a comprehensive understanding of the complexities characterising the reintegration of terminally ill elderly offenders on medical parole. This chapter synthesises the insights drawn from the data analysis into coherent conclusions and actionable recommendations that align with the study's objectives, and research aims, and questions. The reintegration of elderly offenders granted medical parole during end-of-life care is a multifaceted process influenced by social, psychological, and systemic factors. This research study specifically investigated the nuances of end-of-life care provided during the reintegration process, drawing on the perspectives of correctional social workers and caregivers who were directly involved in the delivery of after-care services to elderly parolees on medical parole.

This qualitative study employed interviews and observations to highlight the unique challenges confronting the Department of Correctional Services, including the need for specialised medical attention, the importance of social support networks, and the role of community resources in facilitating the elderly parolee's smooth transition from incarceration into society. The data analysis included a detailed evaluation of the role of Community Correctional Services within the eThekwini Metropolitan area located in KwaZulu-Natal, shedding light on the operational frameworks and policies governing the reintegration process. In this chapter, the researcher distils the key findings from the previous analysis into clear conclusions reflecting the realities of elderly offenders on medical parole.

Moreover, the chapter also presents proposed recommendations aimed at improving the reintegration process, enhancing the quality of end-of-life care, and addressing the specific needs of this vulnerable population. By doing so, it is hoped that the study will contribute to the ongoing discourse on criminal justice reform and the humane treatment of elderly offenders released from correctional confinement on medical parole, which is part of the correctional system. Ultimately, the insights gained from this research study not only underscore the importance of a compassionate approach to the reintegration process but also

highlight the need for systemic changes that can better support elderly parolees as they navigate the complexities of returning to their communities during the end-of-life phase of their lives.

8.2. Summary and conclusions

8.2.1. Revisiting research aims and objectives

The overall aim of this study was to explore the experiences of end-of-life care among elderly offenders reintegrating into society after being released from incarceration on medical parole, as perceived by family-based caregivers and correctional social workers. Specifically, the study sought to understand the challenges, support systems, and emotional dynamics involved in the provision of care to elderly parolees during this phase of their reintegration into society, and to identify the roles and perspectives of family caregivers and correctional social workers in facilitating or hindering this process. The study sought to achieve the following objectives:

1. To describe factors that influence or affect the reintegration of elderly offenders released on medical parole during end-of-life care stage, from the perspective of family caregivers
2. To develop an in-depth understanding of family caregivers' experiences in relation to caring for elderly parolees during the end-of-life care stage
3. To explore how the available reintegration of social work services promote and improves the quality of care of ill elderly parolees and their caregivers during end-of-life care stage
4. To identify the challenges and realities that Community Corrections social workers encounter when reintegrating elderly offenders released on medical parole.

This study primarily explored the experiences of family caregivers and correctional social workers in the context of end-of-life care provided to ill elderly parolees. It aimed to identify the factors influencing the reintegration of elderly offenders who are released on medical parole during the end-of-life phase and to investigate how existing social work services designed for reintegration enhance the quality of care for ill elderly parolees and their caregivers. The researcher posited that both family caregivers and correctional social workers

face challenges facilitating the reintegration of elderly parolees granted medical parole. Furthermore, the lack of understanding and integration of end-of-life care within correctional social work education negatively impacts the reintegration process and the overall quality of care delivered to the ill elderly parolees.

8.2.2. Discussion of the key findings

8.2.2.1. Barriers and Enablers to the Reintegration of Elderly Parolees in End-of-Life Care

The primary aim of this research was to elucidate the factors influencing the reintegration of elderly offenders who are released on medical parole during their end-of-life care, as perceived by family caregivers and correctional social workers. The results indicated that elderly individuals on medical parole are embedded within a constricted micro and meso-systems characterised in this study by physical confinement and pervasive social disconnection. These environmental constraints are closely associated with deteriorating health, are marked by progressive losses in mobility and autonomy as they approach the end-of-life stages. The structural limitations imposed by parole conditions, although legal, appear to disrupt vital relational systems, including family ties, thereby exacerbating the experiences of loneliness and social isolation.

The policy framework at a macro-level, which is necessary to govern medical parole, creates institutional barriers that often dislocate elderly parolees from essential care networks. Rather than facilitating community integration, particularly for elderly parolees who are in the end-of-life stage, these policies undermined the parolees' capacity to access meaningful social support, access to quality healthcare and resources (Smith, 2020). This disjuncture between policy intents and lived experiences illustrates how systematic factors can exacerbate vulnerability among the already marginalized communities. In South Africa, the application process for social protection services particularly social grants is widely recognised as complex and fraught with systemic barriers. These issues are compounded by vulnerable populations, especially those residing in rural or under-resourced areas. Specifically, the process of applying for grants through the South African Social Security Agency (SASSA) is marred by administrative delays, insufficient support services, and challenges related to documentation requirements. These structural obstacles disproportionately affect

marginalised groups, including elderly parolees, a population frequently overlooked in policy frameworks.

Elderly parolees should be viewed as a distinct and vulnerable group within the broader context of social protection. Their unique circumstances including prior incarceration, deteriorating health, and limited familial or social support compound the already challenging process of reintegration into society. Additionally, the study underscored the need to address the multifaceted challenges elderly parolees face in obtaining social protection when receiving end-of-life care. Most caregivers reported that securing social assistance required repeated travel over extended periods, often spanning several months, to SASSA offices an effort made more burdensome by financial constraints and lack of access to transport. As a result, many caregivers were forced to leave their jobs to provide full-time care, relying solely on the elderly parolee's grant for household income. These findings highlight how deeply social protection is tied to family survival and caregiving dynamics, especially in economically vulnerable communities.

Further compounding the issue is the lack of valid identification documents among elderly parolees and their caregivers, as noted by McKenzie, McConkey, and Adnams (2014). Without proper documentation, access to critical services such as healthcare, employment, and social grants becomes virtually impossible. This administrative exclusion not only undermines the parolee's reintegration but also strips families of essential support mechanisms during end-of-life care. Therefore, the case of elderly parolees illustrates a pressing need to re-evaluate the inclusivity and accessibility of South Africa's social protection system. Tailored policy interventions are essential to ensure that this group is not further marginalised by institutional processes that fail to account for their complex needs.

These findings have significant implications for how social reintegration policies and end-of-life care are conceptualized for elderly parolees in South Africa. Unlike much of the existing literature that focuses primarily on institutional or post-release supervision (Cullen et al., 2007), this study brings attention to the lived experiences of elderly parolees within the home and community context, emphasising the critical role of housing and environmental infrastructure in either facilitating or undermining reintegration and dignity. A key contribution of this study is its nuanced exploration of how inadequate housing is not just a

logistical issue but a moral and human rights concern that erodes autonomy, self-care, and emotional well-being during an already vulnerable phase of life.

Additionally, this study expands current knowledge by highlighting how spiritual practices, particularly culturally embedded rituals such as cleansing ceremonies, play a functional, not merely symbolic, role in the reintegration and healing process. While prior research has acknowledged the role of religion or spirituality in coping (Ndlovu-Gatsheni, 2018), this study shows that these practices are not auxiliary but central to the reintegration process, promoting spiritual continuity and social acceptance within families and communities. These findings suggest that reintegration frameworks must move beyond narrow legal or procedural approaches and instead adopt a holistic, person-centered model that includes adequate housing, cultural sensitivity, and emotional support systems. This perspective not only aligns with but also expands existing literature by drawing attention to how intersecting physical, social, and spiritual factors shape reintegration outcomes. In doing so, the study offers a unique contribution: it situates reintegration within the broader discourse of aging, care ethics, and decolonial understandings of personhood and community belonging elements that are often underexplored in correctional research.

8.2.2.2. Caregiver's experience of assuming the caregiving role of elderly parolees

The second objective of this research was to explore the experiences of family caregivers who assist elderly parolees in the end-of-life stages of their lives. The findings of this study expose a profound oversight in the design of reintegration and end-of-life care frameworks for elderly parolees in South Africa: the invisible and evolving burden carried by informal family caregivers. While caregiving literature has long acknowledged the stress experienced by those caring for the elderly (Schulz & Sherwood, 2008), this study introduces a unique perspective by situating that burden within the context of medical parole, where caregivers must navigate a complex mix of emotional commitment, systemic neglect, and correctional stigma. These caregivers are often untrained and unsupported to assume the dual responsibility of delivering complex medical care while managing their own emotional, financial, and social disruptions.

Framed through the lens of Caregiver Dynamic Theory, caregiving in this context is not a static task but a fluid, relational process shaped by shifting care demands, emotional bonds, and the caregiver's own adaptation over time. Caregivers in this study were often thrust into their roles without preparation, undergoing a process of role acquisition and burden accumulation marked by uncertainty, emotional fatigue, and identity disruption. The emotional responses expressed such as regret, helplessness, and resentment reflect this dynamic process and reveal systemic failures in acknowledging and supporting caregivers as central agents in the continuum of care, particularly during end-of-life stages.

The theory helps illuminate how the lack of caregiver training particularly in managing polypharmacy, identifying pain, and delivering palliative care creates a vicious cycle of suffering, where both the elderly parolee and caregiver experience diminishing well-being. Caregiver Dynamic Theory stresses that without adequate support, caregivers may experience emotional and physical burnout, which in turn compromises the quality of care provided to the parolee. These findings thus call for reintegration policies to move beyond the parolee as the sole subject of concern and to formally recognize and resource informal caregivers through counselling services, respite care, and structured clinical training. What is unique in this study is its intersectional and interprofessional lens, bringing together aging, incarceration, informal care, and health to show how reintegration happens not in isolation but within a fragile web of family and community relationships. By applying the Caregiver Dynamic Theory, this research highlights caregiving as a dynamic identity transformation rather than a singular event. In doing so, it advances a more holistic understanding of reintegration as one that is responsive to the caregiver's evolving role and central to sustaining dignity and continuity of care for elderly parolees.

8.2.2.3. The impact of caregiving during end-of-life care stage

The above-mentioned theme explored the impact caregiving had on elderly parolees during the end-of-life stage of their existence. This study makes an important contribution to the understanding of caregiving in high-stakes, underexplored contexts specifically, the provision of end-of-life care to elderly parolees. While the broader caregiving literature has long acknowledged the emotional and physical toll of unpaid care (e.g., Bom et al., 2019b; Pinquart & Sörensen, 2003), this research highlights how caregiving during end-of-life is

intensified by structural neglect, emotional ambiguity, and identity dislocation. Unlike traditional caregiving settings, the caregivers in this study were thrust into unfamiliar roles, often without preparation, guidance, or institutional support, revealing a systemic failure to treat caregivers as integral participants in the reintegration and healthcare continuum.

A particularly important and underexplored finding is the emergence of ambiguous loss and emotional disconnection. As Boss (2016) explains, ambiguous loss occurs when a loved one is physically present but psychologically or emotionally absent. This study found that caregivers not only grappled with the progressive decline of the parolee but also experienced a profound emotional grief before death, complicating their ability to process or cope. This type of anticipatory grief, combined with their evolving caregiver roles, resulted in cumulative emotional exhaustion, an area less emphasized in existing reintegration or palliative care literature. The application of Caregiver Dynamic Theory enriched this analysis by framing caregiving not as a one-time role but as a continually shifting identity process shaped by physical demands, emotional entanglement, and systemic pressures. Many caregivers functioned in a state of "survival mode", a temporary coping mechanism that, while adaptive in the short term, became harmful over time leading to psychosomatic strain, burnout, and deteriorating health. This supports the theory's assertion that without external intervention and support, prolonged caregiving under chronic stress becomes unsustainable.

This research also challenged dominant assumptions in the literature about the role of faith and spirituality in caregiving. While previous studies (e.g., Makoae et al., 2008) have identified religious practices as protective and supportive, this study found the opposite: caregivers frequently reported that their spiritual frameworks failed to deliver the comfort they needed. This unexpected finding reveals a disruption in faith tied to the emotional weight of caregiving and highlights the importance of culturally nuanced, individually tailored support structures. Religion, while significant in some caregiving narratives, may not be universally effective, and alternative or secular strategies must be considered in program design. Moreover, the study underscores that gendered caregiving dynamics remain entrenched, with women reporting more severe psychological and physical effects, mirroring findings in broader caregiving literature (Phillips et al., 2009; Hiel et al., 2015). However, the unique contribution here lies in situating these gendered impacts within the under-theorised

terrain of carceral family care, where expectations of loyalty, cultural obligations, and emotional ambivalence intersect.

In sum, the unique contribution of this study lies in its multidimensional, intersectional approach: it connects correctional health, aging, caregiving identity, ambiguous loss, and spirituality domains that are rarely studied together. By integrating Caregiver Dynamic Theory with grounded, qualitative data, the study reframes caregiving not just as an act of compassion, but as a site of structural vulnerability and identity transformation, requiring systemic response. These findings call for a paradigm shift in how post-carceral reintegration and palliative care policy are developed, centring caregiver needs as co-constitutive of the parolee's well-being.

8.2.2.4. Caregiver preparedness and confidence in providing quality care to elderly parolees

The study highlighted the importance of transferable skills gained from prior caregiving experiences, such as the ability to manage medication schedules, provide basic nursing care, navigate healthcare systems, and communicate effectively with medical professionals. The results revealed that many participants had previously acted as primary caregivers for their late relatives, and this experience equipped them with essential skills to provide effective end-of-life care to ill elderly parolees. These prior caregiving roles served as informal yet valuable training grounds, helping caregivers develop practical competencies such as medication management, personal care, and emotional support. Importantly, this finding highlights the experiential and cumulative nature of caregiving knowledge, which is often acquired through lived experience rather than formal education.

Moreover, the study higlights the importance of recognising and leveraging past caregiving experiences as a resource that can enhance caregivers' confidence and resilience in navigating the emotional and logistical complexities of end-of-life care. Within the broader context of family caregiving, this reflects a well-documented phenomenon: caregivers often transition between roles across the life course, carrying forward skills while also facing the risk of caregiver fatigue or burnout if support systems are not in place. This finding also reinforces the need for targeted interventions that both affirm caregivers' existing strengths and provide structured opportunities for additional training or support. Caregivers should be encouraged

to view their prior experiences not only as a foundation for effective care but also as a reminder of their capacity for adaptation and growth. However, recognising these strengths must be paired with access to psychosocial support, respite services, and health literacy resources to ensure that caregiving remains sustainable. In this way, the study contributes to a growing body of literature calling for a more formalised recognition of informal caregiving expertise, and for policies that support caregivers as skilled partners in the provision of end-of-life care particularly in contexts of medical parole where formal support systems are minimal.

Furthermore, the findings pointed to the need for targeted training and support mechanism as integral components for end-of-life care continuum within the broader framework of the reintegration process. Emphasis was placed on the vital role of comprehensive training in equipping caregivers to address the evolving specialised needs of elderly parolees' Participants stressed that a deep understanding of these needs is crucial for both healthcare professionals and family caregivers. Consequently, training programmes should be designed to provide caregivers with the requisite knowledge and skills needed to cater to the unique requirements of each elderly parolee. All the participants concurred on the necessity for specialised education for both professionals and family caregivers, acknowledging the notion that elderly parolees in end-of-life stage possess distinct needs that require targeted guidance, relevant skills, and accurate information.

This research underscores the pressing necessity of organising training initiatives aimed at improving the care of elderly parolees, emphasising the unique difficulties they encounter. The results indicate that the establishment of such training programmes could enhance the quality of caregiving results, guaranteeing that elderly parolees obtain the high standard of care they require. Furthermore, it is essential to provide education for family caregivers, as this will bolster their ability to address the specific needs of those they care for, ultimately promoting improved well-being and dignity for elderly parolees during the end-of-life stage of their lives.

8.2.2.5. The role of social work services in promoting and improving the quality of care of terminally ill elderly parolees and their caregivers during end-of-life care

The third objective of the research focused on exploring the extent to which existing reintegration social work services enhance the quality of care being provided to elderly parolees suffering from illness, as well as their caregivers, during the end-of-life phase of their existence. The findings indicated a significant deficiency in the support offered by correctional social workers throughout the reintegration process. The findings widely recognised the instrumental role that these professionals play in managing and facilitating the reintegration of individuals returning from incarceration, particularly in the context of end-of-life care, where they offer vital guidance and oversight to safeguard the welfare of elderly parolees and their caregivers. However, the study revealed that correctional social workers scarcely conducted home visits. This finding highlights a significant gap in post-release support, suggesting that the lack of routine home visits by correctional social workers may hinder effective monitoring, reintegration, and continuity of care for elderly parolees.

Moreover, this absence of support implied adverse experiences for the participants, fostering a sense of alienation from the reintegration process. Some caregivers even voiced regret regarding their decision to take on caregiving responsibilities, attributing their dissatisfaction to the lack of essential support. This situation underscores a significant shortcoming in the reintegration framework, highlighting the urgent need for more robust support systems tailored to empower caregivers of elderly parolees. To mitigate caregiver fatigue and enhance the reintegration experience, it is crucial to engage correctional social workers in delivering ongoing, practical assistance. Addressing this deficiency could facilitate more effective reintegration and promote caregiver well-being, thus ultimately yielding better outcomes for elderly parolees.

The findings of the study further indicated that correctional social workers at the selected correctional centre did not assign medical parolees to any aftercare programmes. In some cases, correctional officials shunned involving correctional social workers due to the elderly parolees' fragile health status. Although the Department of Correctional Services provides a range of social work programmes intended to enhance the reintegration of former offenders, these programmes conspicuously omit elderly parolees released on medical parole, thereby

creating a significant void in the care and support meant for this at-risk demographic. The absence of suitable post-release assistance initiatives during end-of-life care intensifies the difficulties encountered by ill elderly parolees and their caregivers during the former's reintegration into society. This deficiency in care programmes is further aggravated by the lack of correctional social work initiatives specifically aimed at aiding family caregivers in delivering quality end-of-life care, a concern that family caregivers themselves highlighted. The inability to implement effective end-of-life care strategies for elderly parolees re-entering society illustrates correctional social workers' lack of the requisite knowledge and skills needed to meet the distinct needs of this vulnerable group. Consequently, the absence of customised support not only imposes an excessive burden on caregivers but also strains familial relationships, thereby undermining the implementation of the overall reintegration process.

The current circumstances necessitate immediate reform in correctional social work programmes, thus ensuring that elderly parolees, particularly those released on medical parole, obtain essential post-release care and support. It is imperative to establish targeted social work initiatives that provide training for caregivers and empower social workers with the resources needed to meet end-of-life care requirements. Implementing these changes enables the Department of Correctional Services to improve reintegration outcomes, alleviate the burden shouldered by caregivers, and enhance the overall quality of life for elderly parolees. This promotes healthier family dynamics and facilitates more effective transitions into communities.

The study identified a significant disconnect between correctional social workers operating in custodial and non-custodial environments, with the latter specifically encountering difficulties stemming from insufficient understanding of the needs of elderly parolees on medical parole. This research highlighted a substantial deficiency in collaboration between custodial and non-custodial correctional social workers, which adversely affected the quality of end-of-life care services meant for elderly parolees. The results indicate an urgent need for devising enhanced coordination and training programmes designed to better serve this vulnerable population. Furthermore, the findings emphasised the reality that the lack of effective collaboration between custodial and non-custodial correctional social workers in facilitating the reintegration of seriously ill elderly parolees can lead to significant and

extensive repercussions. The absence of cohesive support systems has often resulted in the provision of fragmented care that fails to ensure the necessary continuity and quality during critical phases of the reintegration process, ultimately jeopardising the well-being of offenders and imposing additional challenges on the caregivers.

8.2.2.6. Challenges and realities faced by correctional social workers during the reintegration process

The last objective of the study sought to identify the challenges and realities facing social workers in Community Corrections when reintegrating elderly offenders released on medical parole. The research highlighted considerable shortcomings in the correctional social workers' training and preparedness. It emerged that these professionals often felt inadequately prepared to address the intricate and varied needs of elderly individuals granted medical parole. The investigation pinpointed notable obstacles, especially in training and resource availability, which adversely affected both the caregivers and the elderly offenders on medical parole. A particularly alarming discovery was the insufficient training in palliative and end-of-life care, which impeded the correctional social workers' ability to forge meaningful relationships with elderly parolees as they transitioned from incarceration to community living. Deficiencies in training and resource allocation underscored a more extensive issue also noted by Du Plessis and Lombard (2018), who also observed that correctional service providers frequently lack the essential skills and knowledge required to facilitate the reintegration of offenders into society following their release from prison.

A significant conclusion drawn from this research is encapsulated in the pressing necessity of championing the rights of terminally ill elderly parolees following their release from incarceration, a sentiment widely expressed by correctional social workers. These social work practitioners pointed out that this particularly vulnerable group frequently receives insufficient attention during the reintegration process. They emphasised the critical need for their involvement in advocating for legislative reforms that would guarantee access to improved healthcare and end-of-life services for elderly parolees and their caregivers as they transition from prison back into society. This situation necessitates the rolling out of comprehensive reforms aimed at prioritising the health and welfare of elderly parolees, ensuring that they obtain the necessary support during this pivotal stage of their lives.

Therefore, the call for advocacy in policy reform is vital as it guarantees that individuals, especially elderly parolees being confronted by terminal illnesses, are afforded care that is not only high-quality but that which is also delivered with dignity and compassion throughout their end-of-life experiences. Correctional social workers, particularly those engaged in community corrections, are in a distinctive position to recognise deficiencies in care and to advocate for both personalised support and broader systemic enhancements. These professionals are instrumental in promoting policies that can improve accessibility of healthcare and offer better assistance to elderly parolees as they navigate the final chapters of their lives.

Drawing from the Ecosystems Theory, this conclusion highlights the necessity of significant transformations across various levels, ranging from the individual to the larger societal context, in order to cultivate an environment that promotes dignity, support, and an enhanced quality of life for individuals facing end-of-life challenges (Madden, 2017). Consequently, it is imperative for social work practice within community corrections to prioritise advocacy for extensive policy reforms and to foster collaboration with healthcare systems, thereby effectively addressing the unique needs of elderly parolees. Additionally, social workers must receive adequate training in palliative and end-of-life care, which empowers them to manage these intricate issues and delivers the highest standard of care. The implementation of these reforms is essential for establishing a more compassionate and equitable system for vulnerable populations during the final stages of their lives.

Furthermore, the responses from both family caregivers and correctional social workers suggest that the existing medical parole policies inadequately meet the unique end-of-life care requirements of elderly individuals on medical parole. These individuals frequently necessitate extensive support systems that encompass not only medical treatment but also emotional and psychological support as they confront the difficulties associated with terminal illnesses. Unfortunately, the existing policies fail to address these critical dimensions, resulting in elderly parolees lacking the essential resources needed to effectively manage their critical health conditions, thereby increasing their vulnerability. This situation highlights the pressing need for policy reform aimed at tailoring medical parole frameworks that accommodate the complex needs of ill elderly parolees experiencing terminal health challenges. Correctional social workers, especially those operating within correctional and

community correctional environments, should champion the development of comprehensive care plans that integrate medical, emotional, and psychological support. Such reforms must be underpinned by systemic changes that enhance collaboration among correctional institutions, healthcare providers, and community resources, thereby facilitating the provision of holistic and compassionate care for elderly parolees.

8.3. Recommendations

The recommendations presented in this chapter were derived directly from the validated thematic findings of the study. Given the exploratory nature of the research, some descriptive detail was necessary to accurately reflect participants lived experiences before drawing analytical conclusions. Building on these thematic insights, each recommendation was formulated by tracing a clear and explicit link between what emerged from the data and the actions proposed. This approach ensures that the recommendations are firmly grounded in evidence, logically coherent, and reflective of the issues raised by participants, while avoiding any overextension beyond what the data supports. The findings from this study suggest the need to design policy and practice guidelines that seek to improve the support and resources accessible to elderly parolees during the last stages of their lives. The proposed measures aim to advance compassionate, person-centred care and enhance collaboration among correctional services, healthcare professionals, and family caregivers. Additionally, these recommendations are structured to promote a comprehensive and rehabilitative strategy that addresses the medical and emotional requirements of ill elderly parolees, thereby ensuring that they receive dignified treatment and essential care and support they need as they reintegrate into society.

8.3.1. Recommendations for the Department of Correctional Services

The study makes the following recommendations for adoption by the Department of Correctional Services for it to effectively respond to the end-of-life needs of elderly parolees and their caregivers.

- The research revealed that elderly individuals released on medical parole grapple with significant emotional challenges as they integrate into society during the last days of their lives. Considering these findings, it is suggested that the Department of Correctional Services establishes a robust support framework tailored specifically to

address the challenges facing elderly parolees upon their release on medical parole. This framework should encompass not only their physical health requirements but also prioritise the emotional well-being of both the parolees and their caregivers during this critical phase of their lives. Incorporating specialised counselling, emotional support services, and resources aimed at enhancing emotional and spiritual care into the parole process could greatly alleviate the emotional hardships faced by these elderly individuals.

- The research indicated that older individuals released on medical parole faced significant difficulties obtaining their pension grants while receiving end-of-life care. In light of these findings, it is recommended that the Department of Correctional Services should streamline and facilitate the processes involved in accessing the elderly parolees' pension grants to ease the parolees' challenges in this critical phase of their lives. This initiative should encompass the provision of specialised assistance to help them navigate bureaucratic challenges, secure prompt financial support, and tackle any systemic obstacles impeding access to these vital resources. Additionally, re-entry support vouchers may also provide valuable support to terminally ill elderly parolees, as well as their caregivers, currently awaiting approval of their pension grants from the South African Social Security Agency.
- The study findings also highlighted that inadequate housing had a significant adverse impact on the reintegration and dignity of elderly parolees released on medical parole. Taking this finding into account, it is recommended that the Department of Correctional Services should comprehensively evaluate housing conditions to ensure that they adequately address the elderly parolees' end-of-life requirements. Furthermore, it is advisable for the Department of Correctional Services to explore the establishment of transitional housing alternatives for ill elderly parolees released on medical parole, thereby facilitating their reintegration into society, simultaneously maintaining their dignity during this pivotal period of their lives.
- The findings revealed that caregivers faced significant emotional fatigue stemming from the relentless pressures exerted by their caregiving responsibilities, especially when attending to elderly individuals on medical parole. Therefore, the Department of Correctional Services is advised to offer specialised support and resources tailored to benefit those caring for elderly parolees. Such initiatives might encompass training

sessions, availability of counselling services, and respite care options, all aimed at reducing emotional strain and empowering caregivers to effectively handle the challenges compromising their roles.

- The current research underscored the necessity of tailoring training and support focused on end-of-life care as a crucial component of the elderly parolees' reintegration into society. The results highlighted the importance of a comprehensive training programme designed to meet the unique care requirements of terminally ill elderly parolees, thus enhancing the quality of end-of-life care. In response to these findings, it is highly imperative for the Department of Correctional Services to establish targeted training and support initiatives that specifically cater to the end-of-life care needs of elderly parolees during their reintegration into society. Equipping caregivers with specialised training will make them more adept at addressing the distinct physical, emotional, and spiritual challenges faced by elderly parolees. This proactive strategy not only aims to improve the quality of end-of-life care but also seeks to create a more dignified and supportive reintegration process. Ultimately, such initiatives will foster the development of a more compassionate and knowledgeable society, enabling both elderly parolees and their caregivers to navigate this difficult period with enhanced confidence and resilience.
- The findings of the study indicated significant deficiencies in the correctional social workers' training and readiness to play their roles. These professionals frequently perceived themselves as insufficiently equipped to square up to the complex and diverse needs of elderly individuals on medical parole. Consequently, it is advisable that the Department of Correctional Services implements comprehensive training programmes designed to furnish correctional social workers with specialised competencies necessary for assisting elderly parolees, particularly those nearing the end of their lives. Additionally, correctional social work professionals should be provided with resources that address not only the physical and emotional requirements of elderly parolees but also the psychological dimensions of palliative care. Enhancing the incorporation of end-of-life care training into the curricula of correctional social work and providing continuous professional development opportunities could markedly elevate the quality of care and the success of the

reintegration process for elderly individuals transitioning from the prison system to the society.

8.3.2. Recommendations for correctional social workers in the Department of Correctional Services

The study makes the following recommendations for correctional social workers providing services to offenders released on medical parole to adopt in effectively responding to the end-of-life needs of elderly parolees and their caregivers during reintegration.

- The research findings highlighted that most caregivers experienced a deep and complex feeling of ambiguous loss as they navigated the end-of-life care of elderly parolees suffering from progressive illnesses. In light of these findings, it is suggested that correctional social workers undergo specialised training to better understand and address the emotional difficulties caregivers encounter, especially concerning ambiguous loss the feel during this critical phase. Social workers should have access to resources that can assist caregivers in coping with their grief, including counselling services and effective strategies tailored to help them manage the intricate challenges of caring for elderly parolees facing serious health issues.
- The research indicated that correctional social workers hardly performed home visits for the elderly individuals released on medical parole. This lack of engagement had a significant negative impact on the participants' experiences, leading them to struggle with feelings of disconnection from the reintegration process. Some caregivers expressed remorse for having chosen to assume caregiving roles, linking their dissatisfaction to the absence of the necessary support. To remedy this issue, it is suggested that home visits be made a compulsory element of the reintegration strategy designed for elderly parolees. By offering consistent, face-to-face assistance, correctional social workers can ensure that both parolees and their caregivers experience a sense of connection and support, thereby mitigating feelings of isolation during this difficult transition. Such an initiative would not only reduce alienation but

also empower caregivers to manage their duties with increased confidence and fulfilment. Implementing this recommendation could influence a more successful reintegration process fostering a greater sense of community and diminishing caregiver regret, ultimately enhancing the well-being and dignity of elderly parolees as they approach the end of their lives.

8.3.3. Recommendations for social work programme developers, coordinators, and planners

Programme developers play a crucial role in the creation of interventions tailored to address the specific needs of elderly offenders, drawing upon extensive research to inform their designs. Additionally, they evaluate the effectiveness of the programmes implemented by social workers within the Department of Correctional Services, ensuring that these initiatives are responsive to the evolving requirements of the population they serve. Therefore, the study makes the following recommendations for adoption by programme developers, coordinators and planners for them to effectively respond to the end-of-life needs of elderly parolees and their caregivers during reintegration.

- The research findings indicated that the Department of Correctional Services, despite offering a variety of social work initiatives aimed at facilitating reintegration, significantly neglects elderly parolees released on medical parole. This oversight has resulted in a critical lack of care and support for this vulnerable population. The findings underscore a notable deficiency in the services rendered by the Department of Correctional Services, as elderly parolees on medical parole are explicitly excluded from existing programmes designed for the reintegration of elderly parolees. To remedy this situation, the Department of Correctional Services should create and implement specialised reintegration initiatives that cater specifically to the needs of ill elderly parolees. These initiatives should prioritise their distinct requirements, including access to healthcare, emotional support, and assistance from family members. By addressing this gap, the Department of Correctional Services can provide the necessary care and support for this at-risk group, thereby improving their quality of life and facilitating a more successful reintegration process. The anticipated effects of such changes would not only enhance the reintegration experience for elderly parolees but would also foster a more inclusive and empathetic criminal justice

system that adequately addresses the needs of all individuals, irrespective of their age or health status.

- The investigation uncovered a significant lack of collaboration between custodial and non-custodial correctional social workers, which negatively impacted the quality of end-of-life care services provided to elderly parolees. Consequently, it is advisable for coordinators and planners within the Department of Correctional Services to implement a more integrated and cooperative framework that bridges the disconnection between custodial and non-custodial social workers. Such a coordinated approach is crucial to ensuring that ill offenders receive consistent and comprehensive care during their reintegration process, particularly in the last stages of their lives. In the absence of this collaboration, existing systems are likely to remain inadequate, resulting in suboptimal outcomes for both offenders and their families. To rectify these deficiencies, it is imperative to reform policies to encourage enhanced teamwork and resource sharing among social work professionals, thereby improving the quality of care and facilitating better reintegration outcomes for the at-risk offenders.

8.3.4. Recommendations: A Framework for Supporting Caregivers and Elderly Parolees During the End-of-Life Stage

To make a distinct contribution to policy and practice, this study proposes a comprehensive framework aimed at supporting both caregivers and elderly parolees during the end-of-life phase. Drawing from the study's findings and grounded in Caregiver Dynamic Theory and the concept of ambiguous loss, the following recommendations are offered:

- Caregivers should be formally recognised as integral stakeholders in the reintegration and end-of-life care of elderly parolees.
- Reintegration planning should include a caregiver needs assessment, and caregivers should be included in medical parole case conferences and discharge planning.
- Introduce accessible mental health services for caregivers, including trauma counselling, grief support, and support for managing ambiguous loss.

- Develop peer-led support groups to foster emotional resilience and reduce isolation among caregivers.
- Streamline access to social grants and legal identification for elderly parolees and their families.
- Consider the introduction of financial support or stipends for caregivers providing full-time end-of-life care.
- Ensure that caregivers are not financially penalised for their role by facilitating employment flexibility or offering tax relief.
- Design caregiver support programmes that reflect the cultural values and coping strategies of diverse communities.

8.3.5. Recommendation for future research studies

Future research should aim to explore in greater depth the integration of palliative care within custodial facilities, particularly focusing on the unique challenges arising in end-of-life situations for incarcerated individuals. This exploration is crucial, as the provision of palliative care in such environments often encounters significant barriers, including institutional policy constraints, resource limitations, and the emotional and psychological complexities faced by both inmates and correctional staff. Understanding these challenges can lead to the development of more effective care models that prioritise the dignity and comfort of individuals during the final days of their lives.

In addition to examining the broader context of end-of-life care in correctional settings, it is equally important to investigate the experiences of correctional social workers who are integral members of the multidisciplinary teams within the Department of Correctional Services. These professionals play a vital role in advocating for the needs of incarcerated individuals, particularly during end-of-life care. By gathering the insights of correctional social workers, researchers can better understand the emotional toll of their work, the support systems available to them, and the strategies they employ to navigate the complexities of providing compassionate care in a challenging environment.

Moreover, to gain a more comprehensive understanding of the end-of-life care experiences of both family caregivers and correctional social workers, it is imperative to replicate this study across various regions of the KwaZulu-Natal province and South Africa. Such

replication would enable a comparative analysis of different practices, policies, and cultural attitudes towards end-of-life care in non-custodial settings. By capturing a diverse range of experiences and perspectives, researchers can identify best practices and areas that need improvement, ultimately enhancing end-of-life care services for incarcerated individuals and their caregiving families. This broader approach will not only enrich the existing body of knowledge on end-of-life and reintegration but also inform policy changes that can lead to the provision of more humane and effective care to those facing end-of-life challenges within the correctional system.

8.6. Conclusion

The chapter presented the overall conclusions drawn from the experiences of end-of-life care encountered by elderly offenders who are reintegrating into society following their release on medical parole from the perspectives of family caregivers and correctional social workers. The research revealed several negative factors and one positive factor influencing the reintegration of ill elderly parolees during end-of-life care; and the experiences of family caregivers taking care of ill elderly parolees during the end-of-life stage of their lives.

This qualitative study examined the experiences of family caregivers residing in eThekwini and providing care to elderly parolees during their end-of-life stages, as well as the perspectives of correctional social workers involved in the correctional release process involving elderly offenders on medical parole. It is anticipated that the findings from this study will enhance caregivers' understanding of elderly parolees' end-of-life care requirements within the Department of Correctional Services, thereby bolstering advocacy initiatives aimed at promoting best practices that are more attuned to the complexities of end-of-life care.

This thesis concludes with the wise words from an unknown author:

> "*In the final moments, it's not about the medical procedures or the fight to prolong life, but about holding their hand, whispering memories, and creating a space of peace; where the love we shared echoes louder than any pain, reminding them that they are cherished, and that their life mattered deeply, even as it gently slips away*."
>
> **Anonymous**

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APPENDICES

A. Informed Consent for participants
B. Semi-structure interview guide (sample 1-Correctional Social Workers)
C. Semi-structured interview guide (sample 2- Caregivers)
D. University of KwaZulu-Natal Provisional Approval letter
E. Ethics approval Department of Correctional Services letter
F. Internal Memo Department of Correctional Services
G. University of KwaZulu-Natal Full Ethics Approval Letter
H. Recruitment letter for Correctional Social Workers
I. Recruitment letter for Caregivers

A. Information Sheet and Consent to Participate in Research

Dear Prospective Participant,

My name is Sethenjwa Bonny Nduli (student number: *215007294*). I am a PhD candidate studying at the University of KwaZulu-Natal, Howard College Campus. The title of my research is: Exploring the end-of-life care, re-integration and resettlement of elderly offenders released on medical parole in eThekwini Municipality, South Africa. The aim of the study is to explore the end-of-life care experiences during reintegration process of elderly offenders released on medical parole after incarceration. I am interested in interviewing you so as to share your experiences and observations on the subject matter.

Please note that:

- The information that you provide will be used for scholarly research only.
- Your participation is entirely voluntary. You have a choice to participate, not to participate or stop participating in the research. You will not be penalized for taking such an action.
- Your views in this interview will be presented anonymously. Neither your name nor identity will be disclosed in any form in the study.
- The interview will take about 45min-60min.
- The record as well as other items associated with the interview will be held in a password-protected file accessible only to myself and my supervisors. After a period of 5 years, in line with the rules of the university, it will be disposed by shredding and burning.
- If you agree to participate, please sign the declaration attached to this statement (a separate sheet will be provided for signatures)

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number: **HSSREC/00006622/2024**).

In the event of any problems or concerns/questions you may contact the researcher at: School of Social Sciences, University of KwaZulu-Natal, Howard College Campus, Durban. Email: 215007294@stu.ukzn.ac.za; Cell: +[redacted] or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Thank you for your contribution to this research.

CONSENT

I _____ have been informed about the study entitled Exploring the end-of-life care, re-integration and resettlement of elderly offenders released on medical parole in eThekwini Municipality, South Africa by Mr Sethenjwa Bonny Nduli.

I understand the purpose and procedures of the study (add these again if appropriate).

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at the School of Applied Human Sciences, University of KwaZulu-Natal, Howard College Campus, Durban. Email: 215007294@stu.ukzn.ac.za; Cell: +[redacted]).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

I hereby provide consent to:

Audio-record my interview / focus group discussion YES / NO

_____ _____

Signature of Participant **Date**

B. Semi-structure interview guide (sample 1-Correctional social workers)

SCHOOL OF APPLIED HUMAN SCIENCES

DISCIPLINE OF SOCIAL WORK

CORRETIONAL SERVICE PROVIDERS

Exploring the end-of-life care, re-integration and resettlement of elderly offenders released on medical parole in eThekwini Municipality, South Africa.

Interview Guide

- **Age**
- **Gender:**
- **Marital Status**
- **Level of education**
- **Length of service**

To explore how the available reintegration social work services promote and improve the quality of life of ill elderly parolees and their caregivers during end-of-life care.

1. What are some of the social work services offered by community correction that focus on terminally illness and end-of-life care?
2. Tell me how it is for you to provide social work services for terminally ill elderly parolees during their end-of-life care?
3. As a social worker how do you promote the rights and welfare of terminally ill elderly parolees?
4. What are the unmet needs of terminally ill elderly parolees?
5. What challenges are faced by the social workers in responding to the needs terminally ill parolees?
6. How are the services adapted to suit the end-of-life care needs of terminally ill elderly parolees?

7. How does social work service offered to terminally ill elderly parolee involve their family caregivers during resettlement and reintegration? If so, how does the exclusion or inclusion of caregiver promote the quality of care?
8. Do think that these services assist terminally ill elderly parolees and their families? If yes, how so.
9. Do you think there are problems in implementing social work sevices to terminally ill elderly parolee? If yes what are those problems
10. What are some of the factors that might strengthen your abilities to deliver effective social work services to medically ill parolees?
11. What support services do you think family caregivers need in order to take care of terminally ill parolees?

To identify the challenges and realities that community correctional service providers face when reintegrating elderly offenders released on medical parole

1. What are the emerging problems that happen when rendering social work programs or when monitoring ill elderly offenders released on medical parole?
2. Do you often receive complains from family caregivers about terminally ill elderly parolees, if so, what are the common concern?
3. How do you address concerns coming from family caregivers?
4. What key challenges do think the department must look to in terms of offenders released on medical parole?
5. Is there any training that correctional social workers receive in order to be efficient in providing services to elderly people?
6. What further recommendations would you suggest as part of making sure that social work correctional programs and monitoring programmes meet the needs of elderly parolees?
7. What additional skills are needed for a social worker to render effective services to the medically ill parolees?
8. Are there are any projects within the department addressing the issues of ill elderly offenders released on medical parole?
9. What do recommendations would like to add regarding the release of medically ill elderly parolees?

Thank you very much!

C. Semi-structured interview guide (sample2- Family caregivers)

SCHOOL OF APPLIED HUMAN SCIENCES

DISCIPLINE OF SOCIAL WORK

Interview Guide

SOCIO-DEMOGRAPHIC INFORMATION

- Age
- Marital Status
- Gender
- Population group
- Level of education
- Relationship to the offender
- Religious beliefs

To describe factors that affect the reintegration and resettlement process of elderly offenders released on medical parole during end-of-life care from the perspective of family caregivers.

1. Do you think, things would have turned out differently if the offender was released without a medical condition? If yes, why?
2. What are some of the challenges that the offender has experienced due to their medical ill after being released or during release?
3. What do you consider to be the main problems faced by the terminally ill parolee on their return?

4. What kinds of resources (social, economic, cultural) are available in the community for the elderly offenders released on medical parole to draw from?
5. Do you think that the parolees medical condition makes it more difficult for them to live effectively in society? If so, why?
6. Which of the following people have been most supportive to the elderly parolee released on medical parole and why? How has the relationship changed in anyway? How did the terminally ill elderly parolee if so, how?
    a. Immediate family members
    b. Extended family and relatives
    c. other community people
    d. Community resource persons
7. What role has culture played in the reintegration of the elderly parolee?
8. Of what use has been the support provided by NGOs and Other Development agencies to the elderly parolees? Is the support empowering or disempowering to the formerly abducted child mothers?
9. Generally, what is the attitude of the community towards the terminally ill elderly parolee?
10. What community structures are in place to support the reintegration process of the elderly parolee?
11. How effective are these structures in providing support to the elderly parolee?
    a. Specifically, how have the Community Care Givers (CCGs) and Community Volunteer Counsellors (CVCs) supported the terminally ill elderly parolee?
    b. What about the local leadership structures, sub county local governments? What about FBOs and CBOs?
    c. How prepared is the community to receive the returnees? (Probe: has the community been effectively prepared for the elderly parolees released on medical parole?)
    d. What other community structures exist and are these structures prepared to deal with elderly parolees who are terminally ill?
12. What are the main obstacles affecting the reintegration of terminally ill elderly parolees? How can these issues be addressed?

16. What conflicts have occurred between the elderly parolees and members of the community and what are the main areas of conflict (contention)? Have any measures been established to address the conflict?

13. What type of support has the parolee received from the social workers in Department of correctional services?
14. Did the parolee receive any different treatment from social workers, if so, how did this make them feel or what happened?
15. What recommendation would you make for social workers in the Department of correctional services before releasing medical parolees?

To develop an in-depth understanding of family caregivers' experiences in relation to caring for elderly parolees during end-of-life care stage.

1. Take me through your daily activities in a normal day, what do you do from the morning to the evening in fulfilling your caring role?
2. What do you find difficult about caring for terminally ill elder parolee during end-of-life care?
3. Tell me more about the effects of caring for terminally ill elderly parolees on your physical, psychological and social wellbeing? How do you take care of yourself?
4. What is your understanding about end-life care stage?
5. Tell me more about the management and treatment of the terminally ill elderly parolee?
6. What is your understanding about the medication?
7. What are some of the rewards of this job?
8. How do you deal with the challenges of caring for terminally ill elderly parolee released on medical parole?
9. What do you think could/should be done to overcome these challenges?
10. I would like to hear more about the support structures in your community?
11. What kind of support do you feel that you should be receiving?
12. What support do you get from correctional services providers?
13. Do you have any other support systems, which you utilize?
14. What kind of training did you have on caring for elderly offenders following release on medical parole?
15. Do you feel equipped to care effectively for the elderly offenders released on medical parole?
16. If not, what do you think would help you to be better equipped?

To explore how the available reintegration social work services promote and improve the quality of life of ill elderly parolees and their caregivers during end-of-life care.

1. What is your understanding about social work services and which services are you familiar with?
2. Do think that these services assist you as a caregiver? If yes how so?
3. What part of these services are beneficial to you?
4. Do you think these services address the challenges that ill elderly parolees face during reintegration?
5. What are your thoughts on social workers who provide these services? Are they effective in rendering their services?
6. What services do you think should be rendered to support caregivers and seriously ill parolees?
7. Do you think the Department of correctional services should implement established specialised services that include caregivers and seriously ill elderly parolees? If yes, what needs should be addressed.
8. Tell me more about the medical parole policies and operations? How does that affect your work as caregivers?

THANKYOU SO MUCH!

D. University of KwaZulu-Natal Provisional Approval letter

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

27 May 2024

Sethenjwe Bonny Nduli (215007294)
School of Applied Human Sc
Howard College Campus

Dear SB Nduli,

Protocol reference number: HSSREC/00006622/2024
Project title: Exploring the end-of-life care, re-integration and resettlement of elderly offenders released on medical parole in eThekwini Municipality, South Africa.
Degree : PhD

Provisional Approval – Full Committee Reviewed Protocol

This letter serves to notify you that your response received on 22 May 2024 to our letter of 11 March 2024 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC). The protocol has been provisionally approved, subject to the following conditions set out below being addressed:

1. Please attach gatekeeper permission letters

Kindly upload your response on Tab 8 of the RIG online system as soon as possible. Please do not submit a new revised application.

This approval is granted provisionally and the final clearance for this project will be given once the above-mentioned condition(s) has been met. Note that data collection may not proceed until final ethics approval letter has been issued after the remaining conditions have been met and approved by the research ethics committee.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours faithfully

[redacted]

.....
Professor Dipane Hlalele (Chair)

/dd

Humanities & Social Sciences Research Ethics Committee
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Tel: +27 31 260 8350 / 4557 / 3587
Website: http://research.ukzn.ac.za/Research-Ethics/

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

INSPIRING GREATNESS

E. Ethics approval Department of correctional services letter

correctional services

Department:
Correctional Services
REPUBLIC OF SOUTH AFRICA

RESEARCH ETHICS COMMITTEE
Private Bag X136, Poynton Building, 124 W.F Nkomo Street, PRETORIA, 0001,
Tel (012) 307 2151/2770, Enquiries: Ms S.T Mahlangu; Sylvia.Mahlangu@dcs.gov.za
Ref: REC 2024/25

Dear Mr S.B Nduli,

RE: EXPLORING THE END-OF-LIFE CARE, RE-INTEGRATION AND RESETTLEMENT OF ELDERLY OFFENDERS RELEASED ON MEDICAL PAROLE IN ETHEKWINI MUNICIPALITY, SOUTH AFRICA

It is with pleasure to inform you that your application to conduct research in the Department of Correctional Services (DCS) on the above topic has been **approved.**

Kindly note the following:

- This ethics approval letter is valid from **16/08/2024 to 16/08/2025**.
- The relevant Regional and Area Commissioners where the research will be conducted will be informed of your proposed research project.
- It is your responsibility to make arrangements for your interviewing times.
- Your identity document/passport and this approval letter should be in your possession when visiting regional offices/correctional centres.
- You are required to use the terminology used in the White Paper on Corrections in South Africa (2005) and Correctional Services Act (No.111 of 1998) e.g. "Offenders" not "Prisoners" and "Correctional Centres" not "Prisons".
- You are not allowed to use photographic or video equipment during your visits, however an audio recorder is allowed.
- You are required to submit a copy of your final report to the Department of Correctional Services

Should you have any enquiries regarding this process, please contact Ms E Mohapi assistance at telephone number (012) 307 2151 /[redacted]

Thank you for your application and interest to conduct research in the Department of Correctional Services.

[redacted]
MR S ZIKALALA
DEPUTY COMMISSIONER: POLICY COORDINATION & RESEARCH (ACTING)
DATE: 19/08/2024

F. Internal Memo Department of Correctional services

correctional services
Department:
Correctional Services
REPUBLIC OF SOUTH AFRICA

RESEARCH ETHICS COMMITTEE
Private Bag X136, Poyntons Building, 124 W.F Nkomo Street, PRETORIA, 0001,
Tel (012) 307 2059/2222, Enquiries: Ms S.T Mahlangu
Ref: REC 2024/25

The Area Commissioner
Durban Westville Management Area

Dear Colleague,

EXPLORING THE END-OF-LIFE CARE, RE-INTEGRATION AND RESETTLEMENT OF ELDERLY OFFENDERS RELEASED ON MEDICAL PAROLE IN ETHEKWINI MUNICIPALITY, SOUTH AFRICA

This is to inform you that the DCS Research Ethics Committee has approved the application of the above-mentioned research.

You are kindly requested to grant permission to the following researcher: **Mr S.B Nduli** to conduct the said research at **Durban Westville Community Corrections.**

Kindly note the following:

1. The researcher is not allowed to use photographic or video equipment during his visits to the Correctional Centre(s) however the audio recorder is allowed;
2. It is the researcher's responsibility to make arrangements with the Centre for the visiting times. The researcher has been informed of this arrangement;
3. The security measures are still applicable and must be adhered to by the researcher.

Should you have any enquires regarding this process, please contact Ms Elda Mohapi for assistance at telephone (012) 307 2151 / 069 117 0309.

Y[redacted]

MR S ZIKALALA
DEPUTY COMMISSIONER: POLICY COORDINATION & RESEARCH (ACTING)
DATE: 19/05/2024

Page 1 of 1

G. University of KwaZulu-Natal Full ethics approval letter

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

23 August 2024

Sethenjwa Bonny Nduli (215007294)
School of Applied Human Sc
Howard College Campus

Dear SB Nduli,

Protocol reference number: HSSREC/00006622/2024
Project title: Exploring the end-of-life care, re-integration and resettlement of elderly offenders released on medical parole in eThekwini Municipality, South Africa
Degree: PhD

Approval Notification – Full Committee Reviewed Protocol

This letter serves to notify you that your response received on 20 August 2024 to our letter of 27 May 2024 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

Incidents of adverse events and serious adverse events (AEs and SAEs) should be reported in writing to HSSREC, the study sponsors, and any regulatory authority (where appropriate), within 7 working days of the occurrence for local sites and 14 days for all other South African sites.

This approval is valid for one year until 23 August 2025
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

HSSREC is registered with the South African National Health Research Ethics Council (REC-040414-040).

Yours faithfully

[redacted]

.....
Professor Dipane Hlalele (Chair)/nng

Humanities & Social Sciences Research Ethics Committee
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Tel: +27 31 260 8350 / 4557 / 3587
Website: http://research.ukzn.ac.za/Research-Ethics/

H. Recruitment letter for correctional service providers

correctional services
Department:
Correctional Services
REPUBLIC OF SOUTH AFRICA

RE: Request to Participate in Research Study (Recruitment Letter).

Dear Prospective participant,

I am writing to ask your help in participating in a research study I'm conducting **on Exploring End-of-life Care during Reintegration from the Perspectives of Correctional Social Workers and Caregivers Providing After-Care Services to Elderly Parolees Released on Medical Parole in eThekwini Metropolitan Municipality**.

You have been asked to participate in this study because you are an:

- The participant is a correctional social worker
- The participant is responsible for rendering post incarceration reintegration programmes in Department of Correctional Services to parolees.
- The participant is registered with the South African Council for Social Services Professions.
- The participant is willing to participate voluntarily and provide informed consent
- The participant has experience in delivering reintegration programmes to medical parolees

You were identified by from the organisational structure in Durban community correctional services as a potential participant. Your participation is confidential and voluntary and you are free to answer any questions you'd like, to withdraw your consent and/or to discontinue participation at any time without penalty. The general purpose of the study is to explore the experience of social reintegration faced by elderly parolee in the Durban Metropolitan.

If you volunteer to participate in this study, I would first ask for some brief background information phone in order to prepare for our interviews. With your consent, I would then ask you to provide about 1-1.5 hours of your free time for an audiotaped, face-to-face interview at

the Durban community corrections. The interview will consist of open-ended questions about childhood/ family experiences, past/current relationships and activities, school/workplace experiences, and views on identity, family and culture. The interview will be scheduled at a time and place that is most convenient for you. If you are available, I may also get in touch with you to cover any follow-up questions, although you are free to decline at any stage of the research. Other than potential discomfort in answering these questions, risks will be minimal, given these interviews are strictly voluntary and confidential and interview questions are open-ended. There is no monetary gain given to participants.

If you have any questions or concerns about the research, please feel free to contact contact Sethenjwa Bonny Nduli (Researcher) [redacted]/ email: 215007294@stu.ukzn.ac.za. I can also send you a copy of a consent form, which gives you more information on the study. If you are interested in participating in this study, you may either contact me directly or give me permission to contact you by filling out the information below. I greatly appreciate your help and look forward to meeting you.

Sincerely,
Sethenjwa Bonny Nduli
****

Please fill out the following information below and return to the Durban Community Correction.

Preferred method of contact (circle one): home/ cell/ office phone/ e-mail

Contact info: (phone) (e-mail):

I give permission for Sethenjwa Bonny Nduli to contact me at the above phone/e-mail contact:

_____ _____

Signature Print Name

I. Recruitment letter for elderly parolees

RE: Request to Participate in Research Study (Recruitment Letter).

Dear Potential participant,

I am writing to ask your help in participating in a research study I'm conducting **on Exploring End-of-life Care during Reintegration from the Perspectives of Correctional Social Workers and Caregivers Providing After-Care Services to Elderly Parolees Released on Medical Parole in eThekwini Metropolitan Municipality**.

You have been asked to participate in this study because you are taking care of under the care of an elderly parolee released on medical parole for a period more than 6 months Your name was obtained from the social workers casework reports. Your participation is confidential and voluntary and you are free to answer any questions you'd like, to withdraw your consent and/or to discontinue participation at any time without penalty. The general purpose of the study is to explore the experience of social reintegration faced by elderly parolee in the Durban Metropolitan.

If you volunteer to participate in this study, I would first ask for some brief background information phone in order to prepare for our interviews. With your consent, I would then ask you to provide about 1-1.5 hours of your free time for an audiotaped, face-to-face interview at the Durban community corrections. The interview will consist of open-ended questions about childhood/ family experiences, past/current relationships and activities, school/workplace experiences, and views on identity, family and culture. The interview will be scheduled at a time and place that is most convenient for you. If you are available, I may also get in touch with you to cover any follow-up questions, although you are free to decline at any stage of the research. Other than potential discomfort in answering these questions, risks will be minimal, given these interviews are strictly voluntary and confidential and interview questions are open-ended. There is no monetary gain given to participants.

If you have any questions or concerns about the research, please feel free to contact contact Sethenjwa Bonny Nduli (Researcher) [redacted] email: 215007294@stu.ukzn.ac.za. I can also send you a copy of a consent form, which gives you more information on the study. If you are interested in participating in this study, you may either contact me directly or give me permission to contact you by filling out the information below. I greatly appreciate your help and look forward to meeting you.

Sincerely,
Sethenjwa Bonny Nduli

****

Please fill out the following information below and return to Durban Community Corrections.

Preferred method of contact (circle one): home/ cell/ office phone/ e-mail

Contact info: (phone) (e-mail):

I give permission for Sethenjwa Bonny Nduli to contact me at the above phone/e-mail contact:

_____ _____

Signature Print Name

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