

# Chapter 5

## Growing Older: Challenges of Prison and Reentry for the Aging Population

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### Introduction

The United States is experiencing an aging crisis in its prisons, with an exponential increase in the number of older inmates (Aday, 2003; Anno, Graham, Lawrence, & Shansky, 2004). In 2003, only 4.3% of incarcerated inmates were aged 55 years or older, but this percentage is increasing dramatically every year (Harrison & Beck, 2004). There are many consequences of this change in demographics, including surging costs associated with incarceration. Older prisoners cost approximately \$70,000 per year—two to three times that of younger prisoners (Anno et al., 2004; Mitka, 2004).

In the community, geriatrics is the discipline of medicine specializing in care of the aged, defined as 65 years and older. In prison, the age at which an inmate is deemed “geriatric” varies from state to state (Lemieux, Dyeson, & Castiglione, 2002). In some states, inmates as young as 50 are defined as geriatric; in other states, inmates are not considered geriatric until they reach age 55 or 60 (Anno et al., 2004; Lemieux et al., 2002). Despite these differing definitions, there is consensus that inmates undergo a process of *accelerated aging* compared to their age-matched counterparts outside of prison (Aday, 2003).

The accelerated aging of inmates is reflected in their development of chronic illness and disability at a younger age than the general U.S. population (Aday, 2003; Baillargeon & Pulvino, 2000; Colsher, Wallace, Loeffelholz, & Sales, 1992; Fazel, Hope, O’Donnell, Piper, & Jacoby, 2001; Williams et al., 2006). This accelerated aging process is likely due to the high burden of disease common in people from poor backgrounds, who comprise the majority of the prison population, coupled with unhealthy lifestyles prior to and during incarceration (Aday, 2003; Hornung, Anno, Greifinger, & Gadre, 2002). These factors are often further exacerbated by substandard medical care either before or during incarceration (Aday, 2003). To account for accelerated aging, many state correctional departments now define prisoners aged 55 years and older as “geriatric” (Baillargeon & Pulvino, 2000; Fazel et al., 2001; Mitka, 2004; Voelker, 2004).

Outside of prison, people often encounter new physical, psychological, and social challenges as they age. In prison, an environment designed for younger inhabitants, aging introduces additional challenges in safety, functional ability, and health. As older ex-prisoners reenter their communities, they may face

additional challenges such as being frail in an unsafe neighborhood, having multiple medical conditions with limited access to medical care, and leaving the familiarity of the place they have lived in for decades.

In this chapter, we describe some of the special challenges related to the aging of the population both inside prison and on reentry into the community. Despite the public health and economic implications of the surging geriatric prison population, little research has been conducted in these areas, particularly regarding reentry.

## Demographics

In the United States, the rapid rise in the population of geriatric prisoners has been well documented (Aday, 2003; Anno et al., 2004). The states with the most older inmates are California, Texas, and Florida, reflecting the overall size of these state prison systems and their longer prison sentences (Lemieux et al., 2002). The aging of the prison population is not limited to the United States. An expansion in the aging inmate population is also described in England and Wales (Crawley & Sparks, 2006). The aging population affects the correctional system both within prison and throughout reentry.

Although the number of geriatric prisoners is still small relative to the overall prison population (4.3% of the overall U.S. prison population in 2003; Harrison & Beck, 2004), the growth rate for geriatric prisoners has been dramatic. The Bureau of Justice Statistics 2004 report states that the “US prison population is aging” (Harrison & Beck, 2004). For example, in California, the percentage of male inmates aged 50 and older increased from 4.7% of the census in 1995 to 10.2% in 2004; the percentage of female prisoners aged 50 and older increased from 3.7% of the census to 8.7% during the same period (*California Prisoners and Parolees 2004, 2005*). It is expected that by 2022, geriatric inmates will account for 16% of California’s inmate population (Strupp & Willmott, 2005). In some states, the percentage of geriatric inmates already far exceeds the national average. In Florida, the population of geriatric prisoners (aged 50 and over) represented 11.7% of the inmate population in 2005 (<http://www.dc.state.fl.us/pub/annual/0405/index.html>, 2005).

According to the Department of Justice, the number of geriatric persons sentenced to state or federal jurisdiction increased from 32,600 in 1995 to 60,300 in 2003, an 85% increase (Harrison & Beck, 2004). This rate of growth is expected to continue in part because of a burgeoning middle-aged inmate population (40–54 years) that comprised 28% of the overall prison population at the end of 2003, a 22% increase from 1995 (Harrison & Beck, 2004). In fact, the middle-aged population alone accounted for 46% of the total growth in the prison population between 1995 and 2003 (Harrison & Beck, 2004).

Reasons for the dramatic aging of the inmate population are manifold. First, more older people are being sentenced to prison (Anno et al., 2004; Harrison & Beck, 2004; Linder, Enders, Craig, Richardson, & Meyers, 2002). Second, the balance of sentencing and release has been tipped. Due to steadily increasing mandatory minimum sentencing laws, second and third strike legislation, strict drug-related sentencing, deinstitutionalization of the mentally ill, and the discontinuation of discretionary parole, an increasing number of people are sentenced to prison while fewer qualify for release (Anno et al., 2004; Hill, Williams, Cobe, & Lindquist, 2006; Mitka, 2004).

**Table 5.1** The mean age and average terms of inmates are rising (Harrison & Beck, 2004).

Year	Mean age of sentenced state inmates	Average term served among released inmates
1995	31 years	23 months
2003	33 years	30 months

The result is a rapidly increasing geriatric prison population marked by a “gradual rise in the average age of state inmates at the time of admission compounded by a sharp increase in time served in prison” (Table 5.1) (Harrison & Beck, 2004). Given these synergistic forces, current trends in the progressive aging of the prison population are not likely to be reversed without significant legislative changes.

### Cost of Care

The increased burden of illness, disability, and special needs among geriatric prisoners make them expensive. Nationally, the average cost for incarcerating a geriatric prisoner is approximately \$70,000 per year (Aday, 2003; Anno et al., 2004), two to three times that of younger prisoners. As it is in the community, older age is among the strongest predictors of morbidity and medical care utilization (Faiver, 1998; Lindquist & Lindquist, 1999). The high cost is due to higher health care expenses among geriatric prisoners including hospitalization, medications, diagnostic tests, and skilled nursing care. In addition, there are substantial custodial costs associated with off-site health care, primarily related to the cost of providing security (Hill et al., 2006). In California, inmates aged 55 and older represent approximately 5% of the inmate population, but account for 22% of the off-site hospital admission cost. California’s off-site hospital costs are 35% higher for inmates 55 and older than for younger inmates (Hill et al., 2006). Given the surging geriatric population and the consequent escalating costs of older inmates, expenses for sustaining the prison system are likely to soar.

### Special Challenges for Geriatric Prisoners

There are a number of special challenges faced by the incarcerated geriatric population. In prison, aging often introduces new medical and health care needs, geriatric syndromes, changes in functional ability, and personal safety and social considerations. Older inmates with health deterioration must also cope with loss of independence and recognition of the permanence of their medical conditions (Aday, 2003).

#### Medical and Health Care Needs

##### *Multiple Chronic Medical Illnesses*

On average, geriatric prisoners have more chronic diseases than adults of similar age living outside of prison (Anno et al., 2004; Baillargeon & Pulvino, 2000; Colsher et al., 1992; Fazel et al., 2001). Many of these chronic medical

conditions are similar to those also found in the older U.S. population such as chronic obstructive pulmonary disease, arthritis, diabetes, and heart disease. Geriatric inmates may also have conditions that have unusually high prevalence in prison, including: paraplegia secondary to gunshot wounds, advanced liver disease from alcohol use and/or viral hepatitis, and end stage renal disease from injection drug use and/or HIV. Geriatric inmates are also more vulnerable to acute infections in prison, such as influenza and pneumonia (Aday, 2003).

The likelihood of having more than one chronic medical condition is common among geriatric inmates. Having multiple chronic medical conditions, in turn, puts geriatric prisoners at special risk for “polypharmacy.”

### *Polypharmacy*

“Polypharmacy” means the inappropriate use of multiple medications. In the United States, it accounts for up to 27% of annual hospitalizations (Landefeld, Palmer, Johnson, Johnston, & Lyons, 2004). This is because the use of multiple medications increases the risk of adverse medication side effects (Landefeld et al., 2004). Older adults are at particular risk for adverse medication reactions due to age-related changes in the metabolism, clearance, and delivery of many medications (Landefeld et al., 2004). For this reason, medications that should be avoided or are contraindicated in older adults have been compiled into the “Beer’s Criteria” list (Fick et al., 2003). Despite this list and others similar to it, the prevalence of inappropriate drug use outside of prison is as high as 40% (Landefeld et al., 2004).

An example of a Beer’s list medication class that should be avoided in older adults is anticholinergic medication. Many medications have anticholinergic properties including antihistamines (diphenhydramine, hydroxyzine), some benzodiazepines (alprazolam, oxazepam), and some antibiotics (ampicillin, clindamycin). Anticholinergics’ myriad side effects in the elderly include falls, delirium (acute confusion), and urinary retention (Landefeld et al., 2004). Given these side effects and their associated costs, it is imperative that prison health care providers know which medications to avoid giving older inmates.

One way to prevent polypharmacy is to treat geriatric patients as whole patients, rather than as a sum of their multiple medical conditions. For example, many older inmates have multiple concurrent medical conditions such as diabetes, hypertension, heart disease, and COPD. Since many diabetic patients are on multiple medications, a geriatric patient who has diabetes and any additional medical condition is at great risk for polypharmacy.

In an effort to treat chronic disease, many prisons have developed high-risk chronic disease management programs for common illnesses instead of relying on sick call for chronic disease management. Such programs help to ensure the up-to-date treatment of chronic diseases. For example, under the California Department of Corrections and Rehabilitation chronic care program, any inmate with hypertension, diabetes, or asthma is seen on a regular basis in a clinic visit for that particular medical condition (Hill et al., 2006). The goal of the visit is to address the medications and treatment of only that particular disease.

Since the majority of older inmates have more than one chronic disease (Baillargeon, J., & Pulvino, 2000), they may be seen in more than one chronic care clinic. This compartmentalized health care approach runs the risk of increasing polypharmacy among geriatric inmates by focusing on the medications for

only one disease at a time rather than the medication list as a whole. Instead, for geriatric inmates the best way to minimize polypharmacy is to review the entire medication list, to add new medications cautiously, and to regularly assess the need for each medication while considering the possibility of drug–drug interactions with other concurrent medications (Landefeld et al., 2004). One approach would be to create a geriatrics clinic to periodically assess older adults with multiple medical conditions and/or disability.

### *Preventive Services*

Preventive health care can decrease the incidence of both disease and disability. Preventive interventions benefiting older people include screening for a risk of falls, depression, and hypertension, providing influenza, tetanus, and pneumococcal vaccines, and encouraging exercise. Preventive interventions also include cancer screening tests. Although screening and preventive services are covered elsewhere in this book, the approach to cancer screening for geriatric patients differs slightly from that for younger patients.

Selecting which cancer screening tests are appropriate for an individual older person requires consideration of his or her life expectancy (Landefeld et al., 2004). For example, a healthy older person with a favorable life expectancy should be offered cancer-screening tests such as colonoscopy or mammography. In contrast, an unhealthy older person with a limited life expectancy will be more likely to suffer the immediate harms of cancer screening, such as the workup of false negative test results, without having the time to accrue the benefits of screening (Walter & Covinsky, 2001).

The consideration of life expectancy and patient preferences is especially important when approaching the decision to screen for prostate cancer. There is currently no conclusive evidence that PSA screening reduces prostate cancer mortality at any age or life expectancy (Walter, Bertenthal, Lindquist, & Konety, 2006). When reviewing the evidence about PSA screening, the U.S. Preventive Service Task Force found “inconclusive evidence that early detection improves health outcomes” (<http://www.ahrq.gov/clinic/uspstfix.htm>). This is particularly true for people with limited life expectancies; the American Cancer Society and the American Urological Society only recommend annual screening for men 50 years if they have at least a 10-year life expectancy (Walter et al., 2006). Since it is not clear that PSA screening has any health benefit in younger men, the decision to perform PSA screening in older men with limited life expectancies exposes the patient more to the harms associated with screening rather than to the benefits (Walter et al., 2006). Thus, in geriatrics, preventive care follows a model of shared decision-making between patient and provider in which the focus is on discussing the risks and benefits of each test based on the patient’s life expectancy and individual goals (Table 5.2) (Landefeld et al., 2004).

**Table 5.2** Steps to individualize decision making for screening tests.

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1. Estimate the individual’s life expectancy
  2. Estimate the risk of dying from the condition
  3. Determine the potential benefit of screening
  4. Weigh the direct and indirect harm of screening
  5. Assess the patient’s values and preferences
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### ***Mental Health Issues in Aging***

Depression and depressive symptoms are common in the geriatric population. The prevalence of major depression in the United States is approximately 1–2% of community-dwelling older adults and is up to 27% for those who have significant depressive symptoms (Landefeld et al., 2004). The prevalence of depression rises among permanently institutionalized nursing home elders—43% have been found to have major depression (Landefeld et al., 2004). One study found that the prevalence of major depression was 50 times higher among incarcerated older men compared to community-dwelling men. The study also found that generalized anxiety disorders were prevalent and that, overall, 54% of the older inmates met criteria for psychiatric disorders (Koenig, Johnson, Bellard, Denker, & Fenlon, 1995). Another study showed that older female inmates more frequently experience social isolation than do older male inmates (Kratcoski & Babb, 1990). In prison, 15% of inmates of all ages have serious mental illness, such as schizophrenia (Aday, 2003; Lurigio, Rollins, & Fallon, 2004). In one report from a maximum-security hospital, 75% of elderly prisoners were admitted between age 20 and 30, and the majority were schizophrenic (Aday, 2003).

While not all older inmates have serious mental health diagnoses, many experience stress and psychological trauma related to incarceration (Crawley & Sparks, 2006). In the United Kingdom, a study of older male inmates investigated the psychological impact of incarceration. Elderly “first-timers” were frequently found to be anxious, depressed, and to experience incarceration as a form of psychological trauma (Crawley & Sparks, 2006). After a long incarceration, older prisoners may also lose contact with the outside world and become “institutionalized,” leading to significant anxiety about the possibility of release (Aday, 2003; Crawley & Sparks, 2006).

## **Geriatric Syndromes and Functional Ability**

### ***Geriatric Syndromes***

Complex problems that primarily affect older adults are referred to as “geriatric syndromes.” These include vision and hearing loss, falls, cognitive impairment, and urinary incontinence. Geriatric syndromes are common among older inmates and put them at risk for adverse events while in prison (Aday, 2003; Colsher et al., 1992; Fazel et al., 2001; Hill et al., 2006; Williams et al., 2006).

### ***Vision and Hearing Impairment***

Vision and hearing problems are common among older people. Common causes of visual impairment include presbyopia, cataracts, macular degeneration, glaucoma, and diabetic retinopathy (<http://www.ahrq.gov/clinic/uspstfix.htm>; Landefeld et al., 2004). Vision impairment can greatly decrease independence and is associated with falls, social isolation, depression, and physical disability (<http://www.ahrq.gov/clinic/uspstfix.htm>; Landefeld et al., 2004).

In prison, visually impaired geriatric inmates should be considered at risk for falls, especially in cluttered areas where there are unseen obstacles or in areas with poor lighting (Hill et al., 2006). In the community, home safety evaluations and rehabilitation programs are designed to help older adults with decreased visual acuity improve and maintain their independence (Landefeld et al., 2004). Similar interventions could be offered in prisons.

Routine vision exams with an eye specialist are recommended for all older adults (<http://www.ahrq.gov/clinic/uspstfix.htm>; Landefeld et al., 2004). Regular eye exams are especially important for those older adults at high risk for glaucoma or diabetes-related vision problems (<http://www.ahrq.gov/clinic/uspstfix.htm>). A vision exam should be performed on any older inmate who falls.

The prevalence of significant hearing impairment increases rapidly after the age of 50; 25% of adults aged 51 to 65 have hearing loss, increasing to 33% of adults aged 65 and older, and to nearly 50% of adults aged 85 and older (<http://www.ahrq.gov/clinic/uspstfix.htm>; Mulrow & Lichtenstein, 1991). Adult hearing impairment is associated with social isolation, clinical depression, and limited activity (Bogardus, Yueh, & Shekelle, 2003). Development of adverse reactions to hearing loss increases markedly with age (Bess, Lichtenstein, Logan, Burger, & Nelson, 1989; Bogardus et al., 2003; <http://www.ahrq.gov/clinic/uspstfix.htm>). People with significant hearing loss who receive hearing aids have improved communication, social function, and emotional status (<http://www.ahrq.gov/clinic/uspstfix.htm>). Audiology screening tests include whispered voice, finger rub, and use of a portable audiometer. Although the portable audiometer is the most reliable and accurate method, another practical approach is to administer a self-assessment questionnaire to patients (Landefeld et al., 2004). These questionnaires, such as the "Hearing Handicap Inventory for the Elderly," are reliable and valid methods for identifying patients with hearing loss and also patients who are willing to accept further evaluation and treatment (Landefeld et al., 2004). Older inmates should be screened periodically for hearing loss and, when indicated, offered hearing aids.

Hearing loss in prison can also affect an older inmate's safety. For example, a hearing impaired inmate might fail to respond to the request of another inmate and this could result in a physical confrontation. In addition, rule violation charges could be filed when hearing-impaired inmates do not hear orders from staff (Hill et al., 2006; Lemieux et al., 2002). Loss of hearing can also lead to social isolation and falls (Hill et al., 2006).

### ***Falls***

Falls increase in frequency with advancing age and are associated with serious injury, loss of function, increased health care usage, nursing home placement, and mortality (Brown & Norris, 2006b). Approximately 30% of community-living U.S. adults aged 65 and older fall each year (Marshall et al., 2005). In contrast, a study in California found that 51% of geriatric women prisoners aged 55 and older reported a fall in the past year (Williams et al., 2006).

Falls are the most common cause of hip fracture and contribute to the high health-care costs of the elderly (Hill et al., 2006). In the United States in 2001, the cost of hip fracture repair was \$8900 for the hospitalization and, with physician fees, follow-up care, and physical therapy, the total cost was \$81,300 (Braithwaite, Col, & Wong, 2003).

In the community, 44% of falls are associated with environmental factors including poor lighting, loose rugs, and lack of handrails (Brown & Norris, 2006a). In prison, there are additional environmental stressors that might contribute to falls such as strenuous work assignments, quickly moving younger inmates, and top bunk assignments (Hill et al., 2006; Williams et al., 2006).

### ***Cognitive Impairment***

Cognitive impairment in the elderly includes a spectrum of neurologic changes from normal age-related changes to severe dementia. Normal age-related neurologic changes include slower reaction times and slower performance on timed tasks (Landefeld et al., 2004). Dementia, the most severe form of cognitive impairment, leads to significant morbidity and mortality. The diagnosis of dementia includes memory impairment and the presence of at least one other impairment including language deficits, apraxia (inability to perform previously learned tasks), visuospatial deficits, and/or decreased executive functioning such as poor abstraction, planning, or judgment (Landefeld et al., 2004).

Approximately 15% of men and 11% of women aged 65 and older in the United States have dementia (Federal Interagency Forum, 2004). The prevalence of dementia doubles every 5 years after age 60, and by age 85 the prevalence is 25–45% (Landefeld et al., 2004). In older persons, dementia is one of the most expensive illnesses, as nearly 90% of patients with dementia are eventually institutionalized in long-term care facilities (Landefeld et al., 2004). Average annual costs for dementia range from \$4000 to \$10,000 (Taylor, Schenkman, Zhou, & Sloan, 2001) and in the last year of life the average Medicare expenses exceed \$25,000 (Newcomer, Clay, Yaffe, & Covinsky, 2005).

As the prison population ages, correctional officers and staff will encounter more inmates with memory impairment. Some older adults may enter prison already having cognitive impairment while others will develop it once incarcerated. One study of prisoners over age 60 found that nearly 15% had organic brain disorders (Aday, 2003), and court liaison referrals for older prisoners have found rates of dementia ranging from 19 to 30% (Aday, 2003).

With more cognitively impaired inmates, new approaches will have to be developed to discipline older adults with cognitive impairment. For example, if a demented, bed-bound inmate were to inappropriately grab a nurse, he might receive disciplinary action whereas in a community nursing home this occurrence would trigger a behavioral care plan (Hill et al., 2006). An accumulation of disciplinary actions could then delay release for cognitively impaired inmates (Hill et al., 2006).

### ***Urinary Incontinence***

Urinary incontinence is not a normal part of aging, but instead has numerous pathophysiologic causes including obstructive overflow incontinence due to prostatic hypertrophy, neurogenic bladder due to diabetes, medication side effects, and functional and cognitive impairment. In the U.S. community-dwelling population aged 65 and older, urinary incontinence affects 15–30% of women and 5–10% of men (Landefeld et al., 2004). After age 85, men and women are equally likely to be affected (Landefeld et al., 2004). Incontinence is also common in prison; one study found 13.9% of inmates aged 50–59 and 37.8% of inmates aged 60 and older reported urinary incontinence (Colsher et al., 1992).

In prison, urinary incontinence can pose special challenges for inmates. First, prisons do not always carry incontinence supplies such as incontinence briefs; when they do, inmates are sometimes charged a co-pay for them (Hill et al., 2006). Second, incontinence may lead to isolation among older inmates and could cause them to be ridiculed or even a target of violence. Since the majority of patients with urinary incontinence will improve with treatment (Landefeld et al., 2004),

asking patients about it, identifying the etiology of urinary incontinence, and treating it are of great importance in the geriatric prisoner population.

### ***Functional Ability***

Central to geriatric care and assessment is functional ability. Functional ability reflects the extent to which an older person is independent and is measured by assessing a person's need for help with their Activities of Daily Living (ADL: bathing, dressing, eating, transferring, and toileting). The prevalence of ADL dependence increases with advancing age; 15–25% of persons aged 65 and 50% of persons aged 85 and older need help in performing one or more ADL (<http://www.census.gov/hhes/www/disability/sipp/disab9495/ds94t1h.html>; Landefeld et al., 2004).

Functional impairment is common among geriatric inmates and is associated with high health care costs, future functional decline, and mortality (Carey, Walter, Lindquist, & Covinsky, 2004; Reuben et al., 2004). In Iowa, 11% of male prisoners aged 50 and older had limitations in self-care activities (Colsher et al., 1992) and in the United Kingdom, 10% of male prisoners aged 60 and older reported disability in one or more ADL (Fazel et al., 2001). In California, 16% of female prisoners aged 55 and older needed help in one or more ADL (Williams et al., 2006).

Independence is also affected by mobility. Mobility impairment is often defined as requiring aids such as canes, walkers, or wheelchairs or needing assistance during ambulation. Some inmates who would have no mobility difficulties outside of prison may face ambulation difficulties while in prison. For example, mobility aids may be difficult to acquire, or inmates may be reluctant to use such aids because they might appear weak and vulnerable. Even older inmates without mobility impairment might need protective housing and supervision or assistance in certain circumstances, such as walking while handcuffed since this is more difficult for older adults and can make them unsteady, putting them at increased risk for falls (Hill et al., 2006).

### **Environmental and Functional Mismatch**

It is difficult to accurately assess an older person's functional ability without accounting for the environment in which they live and the daily activities they need to perform in order to remain living independently (Verbrugge & Jette, 1994). Incarceration introduces daily physical activities necessary to independent functioning that are unique to prison life. For this reason, functional ability in prison should take into account the unique daily activities faced by geriatric prisoners. One study termed such prison-specific activities "prison activities of daily living" (PADL) (Williams et al., 2006). PADL included dropping to the floor for alarms, standing for head count, getting to the dining hall for meals, hearing orders from staff, and climbing on and off the top bunk.

When PADL were measured, functional impairment was much more common than measures of ADL would indicate; 69% of older women reported an impairment in daily activities of prison life whereas only 16% of women would be identified as functionally impaired based on traditional measures of ADL (Williams et al., 2006). Thus, people who are independent in the community might be impaired in prison.

An older person's functional impairment and their environment's functional requirements are frequently mismatched (Gill, Robison, Williams, & Tinetti, 1999). The extent of this mismatch is intensified in prison. Prisons, which are designed for young, healthy inmates without functional limitations (Mara, 2003), raise the physical level at which older adults must function by requiring physically challenging activities such as climbing onto a top bunk and dropping to the floor for alarms. Adaptive devices that can help older adults maintain independence such as bathroom handrails, nonslip surfaces, and doorknobs that can easily be turned even with arthritic hands are frequently unavailable in prison. [Such devices should be considered accommodations for the disabled, and are required by the Americans with Disability Act (ADA, 1990).] The environmental demands of the prison setting can lead to decreased independence among older inmates.

### **Personal Safety and Social Considerations**

The relationship between older and younger inmates is complex. Older inmates often report a fear of victimization by younger inmates (Aday, 2003; Williams et al., 2006). This fear is especially prevalent among older inmates who are new to prison (Aday, 2003). Chronic illness may also contribute to the sense of vulnerability among older inmates (Aday, 2003). Yet in prison there is also often an informal caregiving system in which younger inmates provide care to frail, older inmates (Crawley & Sparks, 2006; Mara, 2003; Williams et al., 2006). In addition, studies indicate that older inmates frequently attain prestige and respect from younger peers (Lemieux et al., 2002) and that older inmates can function as a stabilizing influence in the general prison population (Mara, 2003).

### **Geriatric Prisons**

A common debate about aging prisoners is whether they should be placed in specialized, segregated housing units. Advocates point to the common fears that geriatric inmates have about victimization from younger inmates (Aday, 2003; Mara, 2003). In one study, 65% of older inmates stated that if their health declined, they would feel more comfortable in a segregated unit (Marquart, Merianos, & Doucet, 2000). Specialized housing units can also offer more adaptive aids such as ramps, grab bars, and nonslip surfaces to mitigate some of the functional demands of prison. However, those opposed to segregating geriatric inmates point to the stabilizing force of elders in the prison community, and that separate housing would eliminate this positive influence (Mara, 2003). Segregated units also may contribute to social isolation and boredom due to the lack of programming. Some older inmates perceive integration within the general population as enhancing independence (Aday, 2003). Finally, many older inmates have biological family members or friends in the general prison population and segregation could compromise these social ties.

### **Long-Term and Skilled Nursing Care**

Long-term and skilled nursing care describes the care provided in assisted living facilities or nursing homes to adults with limitations in independence.

Such limitations are usually due to functional dependence or severe cognitive impairment such as dementia. Community-living older adults move into skilled nursing facilities when they cannot function independently and have no one to give them adequate assistance. In the United States, nearly 50% of adults reaching age 65 will spend some time in a nursing home (Landefeld et al., 2004). In prison, most inmates requiring long term care are geriatric, although some younger inmates, such as those paralyzed by a gunshot wound, may also require long term care (Mara, 2003).

In prison, informal or formal systems of inmate-provided care are used to help older inmates continue living in the general population (Mara, 2003; Williams et al., 2006). When an inmate is no longer independent, the options for long-term care depend on the prison. Some inmates stay in the general population despite multiple needs, others are moved to special housing, the infirmary, the prison hospital, or a long-term-care/skilled nursing prison (Mara, 2003). In recent years, more prisons are building nursing-home type environments in which to house older, functionally dependent inmates (Aday, 2003). In rare cases, an inmate is moved temporarily to a contracted community hospital for nursing-level care if no appropriate prison bed is available. This is a costly option.

### Hospice

Much like older people in the community, “older inmates in poor health are more likely to think frequently about death” and the probability of dying in prison is a significant stressor (Aday, 2003; Crawley & Sparks, 2006). This fear is grounded in reality; with the aging of the prison population and strict release policies, more and more people are dying while incarcerated (Linder et al., 2002). At Angola State Prison in Louisiana, 97% of inmates die in prison (Fields, 2005). Increasing attention has thus been paid to prison hospice, or end of life care (Enders, Paterniti, & Meyers, 2005; Linder et al., 2002).

Although individual prisons have different rules governing who is hospice eligible, all hospice-eligible inmates must minimally have a physician certification that they have a life expectancy of 6 months or less, a do-not-resuscitate (DNR) order, and the inmate must consent to the transfer (Aday, 2003; Linder et al., 2002). The hospice-eligibility criteria can be problematic in prison (Aday, 2003; Linder et al., 2002). Inmates may feel conflicted about DNR orders because they fear dying in prison (Boyle, 2002). This is not so much a denial of impending death as it is a “struggle to come to terms with dying in prison. Many inmates cannot surrender the hope that, somehow, they can die free people” (Boyle, 2002). In addition, inmates might be reluctant to use prison hospice services since they often do not trust the health care staff.

Many variations are seen among prison hospice programs. All programs should adhere to the national hospice guidelines and standards. Correctional agencies have to consider various options to determine whether hospice patients should be integrated with hospital patients; how to best balance comfort care with security needs; and how to provide appropriate pain control in the setting of restrictive opioid medication dispensing policies (Aday, 2003; Linder et al., 2002). Also, prisons differ as to whether they allow other inmates to assist with activities of daily living. Most hospice programs utilize inmate volunteers (Aday, 2003).

### Release and Parole of Older Inmates

Citing the very low recidivism rate of this population (Holman, 1998; Turley, 2003), and in order to relieve overcrowding in prison and the rising cost of incarcerating older inmates, some have called for the early release of non-violent geriatric inmates. Proposed alternatives to incarceration have included house arrest or community release with an electronic bracelet (Aday, 2003; Strupp & Willmott, 2005), expansion of the compassionate release programs to include people who are permanently disabled or mentally incapacitated (Strupp & Willmott, 2005), and early parole with more frequent intervals for parole review (Aday, 2003; Legislative Analyst's Office, Analysis for the 2003–2004 Budget Bill, 2003).

One parole program targeted specifically to the aging inmate is the Project for Older Prisoners (POPS), run by George Washington University law professor Jonathan Turley, which partners law schools and state departments of corrections to allow early release for nonviolent older inmates (<http://www.gwu.edu/~ccommit/law.htm>). According to Aday, “POPS is first and only organization in the country to work exclusively with the elderly and infirm to influence their early release” (Aday, 2003). As of 2003, the POPS program had organized the early release of more than 200 older prisoners without a single instance of recidivism (Aday, 2003).

### Aging and Reentry Issues

As the prison population ages, so does the parole population. Between 1990 and 1999, the percentage of new parolees aged 55 and older increased from 1.5% to 2.1% of the total U.S. parolee population and the number of state prisoners aged 55 or older leaving custody on parole nearly doubled from approximately 5000 in 1990 to approximately 9000 in 1999 (<http://www.ojp.usdoj.gov/bjs/pub/pdf/reentry.pdf>, 2003). Despite these changing demographics, little research has been done on the care and well-being of older ex-prisoners.

On release, geriatric ex-prisoners may face unique challenges reentering the community. These challenges are social as well as medical, and include: frailty in an unsafe neighborhood; concerns about employability as an older person; multiple chronic illnesses with functional limitations; and/or lack of medical insurance or prescription drug benefits. In addition, serious mental illness and the psychological syndrome of institutionalization cannot be underestimated as challenges to long-term inmates when they are released to the community. With long-term incarcerations, older adults who are to be released may not have made up for opportunities missed in their life such as education, job advancement, and strengthening family relationships (Aday, 2003). Despite this, the Bureau of Justice reports that geriatric parolees have lower recidivism rates (54%) during their parole terms, and increasing age is one of the most reliable predictors of low recidivism as older ex-prisoners are the least likely to return to prison (Turley, 2003).

A series of interviews with elderly male prisoners aged 65 to 84 in England and Wales revealed that inmates commonly had concerns about release. These concerns were predominantly social and medical and centered on discharge planning. They included where they would live, how they would get there, and

with whom they would be living. They were also fearful for their personal safety and about where they would get medical care (Crawley & Sparks, 2006).

### **Social Factors**

Ex-prisoners usually reenter communities that are similar to those from which they came (Pogorzelski, Wolff, Pan, & Blitz, 2005). Many of these communities are unsafe. In contrast to when they were young, older ex-prisoners may now be less physically fit and less able to defend themselves. Some may have lost contact with family and friends. There may be no one to turn to for financial, physical, emotional, or economic support; for many older ex-prisoners, family and friends remain in prison (Aday, 2003; Crawley & Sparks, 2006).

When older adults reenter the community, finding employment can be difficult due to their age, especially if they used to work as hard laborers. The stigma of incarceration is a substantial barrier to a smooth reintegration into the community. In addition, job prospects may be further limited by educational attainment; studies show that fewer older probationers have completed high school or a GED than their younger counterparts (Aday, 2003). Also, after being in prison for many years and possibly for the majority of their lives, older adults many have acquired very few independent living skills such as cooking, shopping, and balancing a checkbook and would benefit from “community placement orientation” before release (Aday, 2003; Crawley & Sparks, 2006; Terhune et al., 1999).

### **Medical and Psychological Factors**

Older ex-prisoners frequently have multiple medical conditions and may encounter several obstacles in optimizing their medical care. While older inmates are often on multiple medications at the time of release, many are discharged with little or no medication (Hornung et al., 2002). Insufficient health-related discharge planning may lead to release without a health care appointment. Reinstating Medicare and/or Medicaid can take many weeks to months, so the only health care option for many older parolees with chronic health care needs may be to use high cost emergency services for routine care or after medical decompensation (Hornung et al., 2002). In addition, some older parolees will require discharge to a nursing home or other long term care facility. This entails a special discharge coordination effort to find an accepting location and enrollment in Medicaid to obtain the funds necessary to pay for the care (Terhune et al., 1999).

Older inmates transitioning into the community may also have new health care providers who do not know of their incarceration history. This can pose a significant problem as ex-prisoners are at particularly high risk for certain diseases such as STDs, hepatitis, and HIV (Hornung et al., 2002; <http://www.ojp.usdoj.gov/bjs/pub/pdf/reentry.pdf>, 2003). Although all older adults should be screened for these diseases, they often are not because health care providers rarely consider older adults at risk (Skiest & Keiser, 1997). Thus, without knowledge of a history of incarceration, many health care providers might fail to screen older ex-prisoners for STDs or infectious disease.

Older parolees are also at higher risk for adverse psychological reactions to prison release. They display high rates of anxiety about release (Crawley & Sparks, 2006), and are also at increased risk for post-release suicide (Pratt, Piper, Appleby, Webb, & Shaw, 2006). Parole officers and health care providers should

be familiar with these increased risks so that mental health crises can be avoided or identified early. In addition, older parolees with dementia could violate parole by missing their parole officer meetings, or might intentionally violate parole hoping to be returned to prison due to their inability to function on the outside (Terhune et al., 1999). For these reasons, some advocate changing the role of parole officers to serve as bridges and support systems for older parolees transitioning back into the community (Terhune et al., 1999).

### **Preventive Measures that Can Be Taken Before Release**

Steps can be taken before prison release to smooth the transition back into the community. Prior to release, older adults who have been incarcerated for a long time may benefit greatly from training in independent living skills such as cooking, shopping, banking, and money management. It is imperative that older adults have a transition plan that includes health care and medication access. Ideally, a summary of the individual's medical problems would be provided to their post-release physician. In addition, classes in health care promotion and, for those who have a chronic disease, education about their illness and disease self-management can be valuable.

Intensive case management that links the older inmate to community resources can be a helpful step in promoting a smoother transition. Community-based organizations can also reach out to older adults who are being paroled or released. An example program is the Senior Ex-Offenders Program (SEOP) in San Francisco. SEOP helps the older ex-prisoner identify his or her needs, such as medical or mental health referrals or assistance with Medicare applications, and then mobilizes the necessary resources to meet these needs. Innovative organizations like SEOP also help ex-prisoners identify meaningful contributions that they can make to the community, such as being anger management counselors, HIV test counselors, or soup kitchen volunteers, and train them to develop these skills. In this way, such transition programs can provide purpose and a social network to older individuals as they reenter the community while also having a positive impact on the community to which they return.

### **Conclusion**

The exponential growth of the aging inmate population has broad-reaching public policy, economic, and community health consequences both within prison and throughout the reentry process. The fundamental principle in caring for any older adult is to maintain independence and functional ability. In order to do so, attention must be paid to physical and mental health through chronic disease management, environmental modification, and social support. While this approach to geriatric care may be used to promote the health and safety of older prisoners, the special challenges facing older adults in the prison environment and during community reentry need to be addressed as well. These challenges must be met with innovative collaboration between many different disciplines including correctional staff, parole officers, community organizations, and health care providers. Improved coordination between these groups coupled with training in geriatric issues could lead to policies that will promote the health and safety of geriatric inmates and of the communities to which they return.

- Prisoners are often considered “geriatric” at age 55
- Consider the aging of the population when planning health and safety interventions
- Project physical plant and staffing needs for a population with increased illness and disability
- When projecting future medical care costs, consider that geriatric prisoners are more expensive than younger prisoners
- Monitor the use of potentially risky medications in older adults
- Design a geriatrics clinic for older prisoners with chronic disease and/or disability
- When using screening tests, discuss the risks and benefits and consider life expectancy and individual goals
- Assess physical and mental health status and risk by focusing on common geriatric syndromes
- Develop approaches to address behavior infractions among prisoners with cognitive impairment
- Adapt the environment to mitigate physically challenging tasks
- Remember that people who are independent in the community might be impaired in prison
- For reentry, provide bridge medications, postdischarge medical appointments, summarized health records, and community agency referrals

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