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Prison Boomers: Policy Implications of Aging Prison Populations

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Abstract

Prison populations worldwide are aging at an unprecedented rate, and associated age-related medical costs have had serious consequences for jurisdictions struggling to respond to the changes. Our examination of the situation in California shows that recognizing the changing healthcare needs of aging prison populations is critical to achieving effective and efficient policies and practices that affect this medically vulnerable and costly population. Chronic prison overcrowding usually accompanies the aging trends, and there is evidence that aging is strongly correlated with desistance from criminal behavior, suggesting an opportunity to at least partially address the challenges through early release of appropriate persons. Some relevant policies do exist, but they have not achieved this goal on a sufficient scale. Drawing lessons from California and available scholarship, we conclude with recommendations for those faced with responding to the unprecedented number of older adults now in prison, most of whom will eventually be released.

Keywords

Aging prison populations; criminal justice health; prison overcrowding; public policy

Introduction

Incarcerated adults in their fifties or older – a group we call “prison boomers” in recognition of their age and important contribution to the “prison boom” that characterized many jurisdictions worldwide in recent decades – are the fastest growing group among prisoners in countries including Australia, Japan, the United Kingdom, and the United States. To illustrate, a recent nationwide study in the U.S. found adults age 55 years and older grew

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from 3% to 10% of the total state prison population between 1993 and 2013, representing a 400% increase in number, while the median age of incarcerated adults grew from 30 to 36 years old (Carson and Sabol, 2016). The aging of general populations helps explain "graying" prisons, as in the U.S., where as much as half of the aging trend in prisons can be explained by the "baby boom" generation growing older (Luallen and Cutler, 2015). However, the graying occurred most in jurisdictions that employed "tough on crime" policies that increased the number of people incarcerated *in* and *into* old age and drove a boom of prison construction to accommodate the growing number of people serving long prison sentences (Carson and Sabol, 2016; Fellner and Vinck, 2012; Maschi, Viola, and Sun, 2013; Rikard and Rosenberg, 2007). Many prison boomers were among the first people to become entangled in the prison system during what has come to be known as the "era of mass incarceration," and many have cycled through the system for decades, or are currently incarcerated for crimes committed decades ago. Thus, in the absence of meaningful reform, the aging trend can be expected to continue for years to come.

Prison Boomers Compound Problems in Prisons

Prison boomers are important to consider as a distinct group from other incarcerated people because they experience rates of chronic illness and disability more typical of people chronologically much older. Consequently, most research in the area, corrections departments in many U.S. states, and many European countries consider incarcerated people "older" or "aging" beginning around age 55 (Vallas, 2016; Williams et al., 2009; 2012). The special needs of aging incarcerated populations have been recognized by the United Nations as critical, both because realigning policy and practices to account for them improves their effectiveness and efficiency, and also because not addressing them can result in human rights violations (Maschi et al., 2013).

These increased medical risks are often particularly difficult to manage in the prison setting. A study conducted in Switzerland, for example, documented the significant increase with age in rates of cardiovascular and endocrine problems (Wangmo et al., 2016), which can pose serious challenges for correctional staff who must treat the problems or respond to related emergencies. David Runnels of California's Correctional Health Care Services describes the unique care older people require in a 2012 Human Rights Watch report on aging prison populations:

> "In young people, disease tends to be an acute, single episode to be treated [and which once treated] requires little further care. In older individuals, disease is often a chronic, progressive process. Recovery is slower and the care of these illnesses must be over years or even a lifetime. Surgery, medications, therapy, and multiple types of medical providers and specialists are involved. Hospitalizations, nursing home stays, and procedures are needed. All this must be coordinated to provide good care" (Fellner and Vinck, 2012, p. 74).

Medical and correctional experts describe other ways health problems are more difficult to manage in prison (Bretschneider and Elger, 2014; Mann, 2013; Williams et al., 2009; 2012). For example, they often go undetected and undertreated in correctional facilities, or may be unnecessarily exacerbated by conditions of confinement like shackling for transport or long-

term isolation. Incarcerated people who have difficulty independently performing daily activities like eating, bathing, toileting, dressing, continence, and walking require ready access to restrooms, living spaces free of stairs and other obstacles, and showers retro-fitted for people with limited mobility. Some may require specialized diets and frequent physical activity – individualized needs that are often difficult to meet on a regular basis amidst swelling prison populations.

Mental health and wellbeing are also important concerns for elderly people in with (Williams and Abraldes, 2007), even beyond the well-established association between mental illnesses like depression or chronic anxiety and declining physical health with age (O'Hara et al., 2016; Speer and Schneider, 2003). While the evidence describing mental illness prevalence among older prisoners is limited, a study conducted in the U.S. found rates of depression among older men in prison that were 50 times those of non-incarcerated men (Koenig et al., 1995). A study conducted in the U.K. found older incarcerated men experienced substantial stressors related to losses resulting from their incarceration, the threat of violence from younger prisoners, and a fear of dying in prison (Crawley, 2005; Crawley and Sparks, 2006). Finally, a study of this group in Australia found they were six times more likely than their peers to have utilized mental health services prior to their sentences, but that many discontinued treatment after release (Sodhi-Berry et al., 2015).

These and other age-related problems (e.g., dementia) often combine with conditions including chronic poverty and substance abuse to form especially complex cases. The compounded problems that prison boomers face during and after incarceration lead experts to recommend that geriatric models of healthcare be adopted for their care in prison and during the transition to the community (Williams et. al., 2012). Some such programs designed especially for older criminal justice populations have been implemented in counties including Canada, the Netherlands, India, the United Kingdom, the United States, and Uruguay (Maschi et al., 2013), but they remain limited.

Delivering Age-Appropriate Healthcare in Prisons is Likely Cost-Effective

The "prison boom" occurred during a time of widespread social unrest and high rates of violent crime, and new prisons were usually designed with the primary aim of controlling violent young people (Simon, 2014). The subsequent "graying" trend led to a corresponding shift in the basic needs for which prison facilities must provide, with age-related health emergencies becoming more common. Yet the design and physical construction of prisons makes it difficult to retrofit these spaces to meet the changing needs (Crawley, 2005), and prison overcrowding often precludes adjustments like repurposing entire facilities for the elderly, seriously disabled, or chronically ill.

Prison boomers have been a major driver of the rising costs of incarceration (Ahalt et al., 2013; Maschi et al., 2013), and the patterns described here suggest that expenditures on their behalf will only rise absent a shift in policy aimed at addressing the disproportionate number of older adults currently incarcerated worldwide (Chiu, 2010). Yet corrections budgets generally shrank following the global financial crisis of 2008. This may reflect growing ambivalence regarding continued funding of status quo policies (Aviram, 2015; Grattet,

2014; Ouellette, Applegate, and Vuk, 2016). Importantly, despite the often-punitive stance that voters have sometimes taken in the past, they nonetheless consistently support rehabilitation in most cases (Cullen et al., 2002). Thus, clear understanding and articulation of the costs of incarcerating and benefits of releasing some prison boomers to obtain services in the community has the potential to gain broad popularity (Sundt et al., 2015).

Many Prison Boomers Pose Little Risk to Public Safety if Released From Prison

Despite these challenges, prison boomers also provide opportunities for reforms aimed more generally at reducing prison populations without seriously jeopardizing public safety because age is one of the most consistent predictors of desistance from criminal offending. A large body of criminological research shows that the vast majority of people who offend as juveniles or young adults desist by middle age, and those who continue offending usually do so at low rates (Farrington, 1986; Laub and Sampson, 2003; Steffensmeier et al., 1989). Recent statistics on recidivism reflect this relationship between age and crime; for example, Californians who are paroled after being given a “term-to-life” prison sentence are, on average, 50 years old and have generally been convicted of the most serious crimes (Weisberg, Mukamai, and Segall, 2011). Yet less than 5% of them commit new crimes within their first three years after release, about a tenth the rate of the general parole population (CDCR, 2013). The infrequency with which older adults commit new crimes post-incarceration is in spite of the compounded barriers they face to successful reintegration. For example, they often have long incarceration histories, serious convictions, and weak social support networks that are major obstacles to obtaining employment and stable housing, and physical disability and chronic illness reduce employability and diminish opportunities to form prosocial bonds (see also Chiu, 2010; Fellner and Vinck, 2012).

Past work describes a contradiction in the practice of criminal risk assessment – often used to inform release decisions – with some groups being treated as dangerous irrespective of their assessed risk of reoffending (Simon, 2005). Many existing risk assessment instruments will identify most older adults in prison as “high risk” due to their lengthy criminal histories, limited social bonds, and other characteristics assumed to predict future offending. Frequently, however, these risk assessments do not adequately factor age and health status into their determinations, despite evidence that these are critical factors in predicting public safety risks (Farrington, 1986; Laub and Sampson, 2003; Steffensmeier et al., 1989). This presents an opportunity to improve upon most existing assessments, which can expand eligibility for parole, diversion, and other related policies and practices.

Policies for Releasing Prison Boomers Can be Created, Expanded, and Optimized

Reconsideration of the costs and relatively few public safety benefits associated with incarcerating large numbers of older adults has led many jurisdictions to create mechanisms for allowing geriatric, seriously ill, and dying prisoners to be released from custody (Chiu, 2010; Maschi et al., 2013). The laws fall into three broad categories and typically highlight

age, health status, and time served in release decisions. *Geriatric parole* policies consider age, criminogenic risk, and time served and are aimed generally at reducing prison populations by releasing people who pose little threat to public safety regardless of health. *Medical parole* may be granted to people who require especially expensive or specialized medical care but are not necessarily terminally ill. Finally, *medical* or *compassionate release* policies are intended to allow people with terminal diagnoses to die in the community, which reduces costs associated with delivering complex end-of-life care in prison and avoids the potential for violating national and international legal standards of humane treatment (Maschi et al, 2013).

Despite their appeal to overburdened prison systems, these early release policies often fall short of their intended purposes. Factors known to reduce their effectiveness include the lack of broad political and public support, overly narrow eligibility requirements, and application procedures that discourage eligible people from seeking release. Complicated referral and review processes can delay release, with dire consequences in the case of the terminally ill (Chiu, 2010; Williams et al., 2011). Thus, while additional mechanisms for release might be created, existing policies also require assessment within jurisdictions to ensure they are being implemented in a fashion consistent with their stated goals.

California's Prison Boomers: A Case Study for Jurisdictions Facing an Aging Crisis

California, a state with the second largest prison system by population in a nation that incarcerates approximately one fifth of the world's prisoners, offers a compelling case study of the challenges that prison boomers pose to corrections professionals and policymakers. The causes and consequences of aging prison populations, including the major increase in demand for health care and the serious legal consequences of failing to meet such demands, are typified in California (Simon, 2014). Further, the state's prison population aged more rapidly than many other U.S. states (Carson and Sabol 2016), with the percentage of people aged 55 years and older in California prisons growing from 4% to 21% between 1990 and 2014 (Grattet and Hayes, 2015). Though California's prison crisis is ongoing and evaluation of the state's initial countermeasures is still underway, much has already been learned.

Following an especially rehabilitative period in the 1970s, California witnessed a punitive turn toward harsh crime policies during the final decades of the century (Simon, 2014). California's prison population ballooned following the implementation of policies like "three strikes and you're out law," mandatory minimum sentences, and legislation broadly limiting alternatives to imprisonment. The capacity of the two dozen new prisons that were built between 1984 and 2005 failed to keep pace with the growing numbers of incarcerated people, with the population peaking in 2006 at 163,000 people, around double the system's design capacity (Grattet and Hayes, 2015). This impeded adequate medical and mental health care service delivery, and, in 2009, the U.S. Supreme Court, citing 8th Amendment protections against cruel and unusual punishment, concluded that the state had violated prisoners' constitutional rights (see *Brown v Plata* and *Coleman v Brown)*. A key element of this litigation was the plaintiff's ability to demonstrate that these releases would not

negatively affect public safety, showing that prison conditions had deteriorated to the point of actually *increasing* the likelihood of reoffending in many cases. The federal government intervened, and California has since reduced its prison population by more than 42,000 people (to around 137% of capacity) primarily by releasing and not incarcerating people convicted of non-serious, non-violent, and non-sex crimes (Lofstrom, Bird, and Martin, 2016).

Many of the conditions that contributed to the rapidly aging prison population and related challenges remain unaddressed. For example, because the vast majority of people (90%) who remain in prison in California have been convicted of violent offenses (Grattet and Hayes, 2015), they tend to be serving long sentences, are generally excluded from early release policies, and will age through the system as a result. Policies that include a blanket exclusion from early release for people convicted of serious crimes will hamper the otherwise achievable goal of further reducing prison populations, and prison boomers, who cost far more than their younger peers to incarcerate (CDCR, 2010; Simon, 2016), will comprise a greater proportion of overall prison populations. In addition, correctional health services have not adapted to the shifting demographics of prisoners by, for example, providing clinicians with continuing education in geriatric assessment or palliative care. Consequently, services will continue to be delivered at an unnecessarily high cost to taxpayers, such as when older prisoners with undertreated chronic health conditions experience avoidable acute health events that require treatment in community hospitals and incur additional costs associated with transport and security.

Reforms to reduce prisoner populations like those that have been enacted in California also do not address structural factors like the remote locations of most prisons, which hinders access to appropriate and cost-effective care for older adults with complex conditions. Further, many correctional officers remain ill-equipped to identify and respond to those in need of healthcare or at risk for adverse health events like falls (Williams et al., 2009). County jails are often even less prepared to provide adequate health care, but as prison reform in the U.S. focuses on decarceration at the state and federal level, these local facilities – as has happened in California – are likely to experience recurring problems related to overcrowding and an influx of aging inmates (Bird and McConville, 2014; Lofstrom et al., 2016).

Recent health policy reforms create both opportunities and challenges for responding to these changes. Upon release, the vast majority of prison boomers in the U.S. qualify for federal health coverage under Medicare and/or Medicaid (Somers et al., 2014), meaning states could reduce costs associated with correctional health care by allowing older adults to complete their sentences under community supervision. However, members of this group are often among the most difficult to enroll in insurance plans, meaning serious attention should be given to maximizing federal contributions by expanding enrollment opportunities for criminal justice populations (McConville and Bird, 2016). Regardless of insurance coverage, though, the increasing fluidity between state prisons, county jails, and the community exacerbates the challenge of ensuring people involved in the prison system can access medical care through the most cost effective means.

Policy Recommendations for Responding to Prison Boomers

Several recommendations for policy and best practices follow from the preceding discussion. Because the size of this medically vulnerable and costly group is projected to grow in systems around the world for years to come, this is a critical time to invest in corresponding reforms that can improve care and lower costs. Several critical recommendations can be undertaken at relatively minimal cost to correctional facilities and systems that would immediately prepare them to more effectively care for aging prison populations. First, policies affecting criminal justice populations should consider incarcerated and formerly incarcerated people “older” or “aging” beginning in their fifties. Second, the correctional workforce – both health and non-health – should be retrained to identify and respond to the complex diagnoses often associated with old age, which are especially problematic in prison settings. This is particularly crucial in light of the practical reality that budgets are unlikely to support the conversion of prisons into institutions more closely resembling nursing homes, which is the legal standard of care for many of the oldest and most medically fragile incarcerated people. Third, prison officials should identify low-cost ways for current facilities and facility policies to be redesigned and retrofitted to meet constitutional and other legal standards of physical and mental health care for this population. For example, support handles in showers can reduce the risk of falls, as can a prohibition on ankle shackles for incarcerated adults over a certain age or at a certain level of functional impairment. Housing assignments that prioritize access to dining halls, exercise facilities, and health services can also improve outcomes by minimizing barriers to proper self-care.

We further recommend that jurisdictions more frequently utilize release mechanisms for incarcerated people who are elderly, disabled, chronically ill, and terminally ill. Often, this may require making greater use of age and health status in risk assessments. Where early release policies already exist, they should be evaluated to determine whether they are meeting their intended purposes. Finally, to minimize inefficiencies and remove barriers to the effective implementation of these and other improvements, all reforms should ensure proper coordination and cooperation between local, state, and federal agencies.

Conclusion

A series of criminal justice policies enacted in California and elsewhere beginning in the 1980s created a set of conditions that led to the current aging crisis in corrections. The historically unprecedented group of people we have called “prison boomers” grew out of this era. Their extensive criminal histories are often not the most salient factor for policymakers and practitioners to consider in light of their extensive medical histories. Their high rates of serious health problems threaten jurisdictions slow to adapt with major financial and legal costs. Today, historically low crime rates, tighter government budgets, and broad recognition that past prison policies in many ways failed to create a more just and safe society have fostered bipartisan political and public support for reform and a climate welcoming evidence-based, pragmatic solutions. Our recommendations serve as a starting point for those ready to engage this pressing policy challenge.

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Key Points

- An unprecedented number of people age 55 years and older are now incarcerated worldwide, a result of rapid aging among prison populations over the past several decades.
- The associated increased demand for health care in prisons has strained correctional health resources, affecting the ability of some systems to provide legal and humane levels of basic medical care.
- Releasing older adults who are unlikely to reoffend due to their age and health status provides an opportunity to reduce corrections spending during an ongoing period of criminal justice reform.