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The Growing Geriatric Prison Population: a Dire Public Health Consequence of Mass Incarceration

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Graphical Abstract

Clinical Case and Background.

In 1985, Mr. Jackson (name and some features changed to protect patient identity) and another man got into a fatal drug-fueled fight; Mr. Jackson received an “indeterminate prison sentence” (7 years to life) for unintentional murder. In prison, he became sober, engaged in rehabilitative programming, became a mentor guiding young men in distress, and assumed if he followed the rules, he would one day return home. Yet, despite 10 parole board

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appearances, an unblemished prison record, and letters of support from staff, Mr. Jackson was repeatedly denied his freedom. His wife of 60 years died alone, and at age 86 he died in prison hospice after four decades of incarceration.

Mr. Jackson's story is not uncommon. Nor is Mr. Bertch's (see photo). Between 1990 and 2013, the U.S. prison population nearly doubled while the number of incarcerated adults aged 55 or older increased by 750%.[1] This aging of the prison population has occurred during an era of "mass incarceration," in which decades of racially biased sentencing laws resulted in a disproportionate number of Black or Latino people in prison.[2] These "tough-on-crime" policies (including the indeterminate sentence Mr. Jackson received) are coupled with exceedingly low parole release rates (also plagued with racial bias), as parole boards – largely staffed by retired law enforcement[3] – often deny parole for people convicted of a violent crime regardless of their current behavior or low risk assessments. Mass incarceration and overcrowding have culminated in massive COVID-19 outbreaks in prisons; over 400,000 incarcerated people have been infected with COVID-19 and at least 2,500 died. COVID-19 infections in prisons also have fueled outbreaks in surrounding communities,[4] making the need to end to mass incarceration even more urgent for our public health.

Older adults confer a profound strain on correctional healthcare systems. Cognitive impairment and dementia are disproportionately common, and other geriatric syndromes (e.g., incontinence, falls and functional impairment) are present at relatively young ages, a state referred to as "accelerated aging."[5] Difficulty performing everyday prison activities, such as getting on the floor for an alarm and climbing onto a top bunk, cause older adults to be impaired who would be independent in the community, and put them at risk for victimization. Geriatric challenges (such as not hearing staff orders) can lead to inadvertent rule violations adding more prison time. Meanwhile, we are paying a high price for this population, as incarcerated older adults generate up to nine times the cost of incarcerated younger adults.[6] Yet there is clear evidence that older adults are the least likely to commit crimes if released.

What can healthcare professionals do to address the geriatric public health consequences of mass incarceration?

1. Engaging in Advocacy

Healthcare professionals can advocate for criminal justice programs and policies designed for older adults, including diversion programs that connect people with mental health or substance use disorders to healthcare rather than prison and to target these programs to older adults (in "geriatric courts").[7] We can advocate for public defender offices to fund cognitive testing of clients when needed,[8] and for the deployment of mental healthcare professionals, rather than only police, to community disturbances involving older adults to connect those in need to healthcare services for substance use disorders, mental health conditions, or dementia rather than funneling them into the criminal justice system. During incarceration, most states have policies to evaluate people of advanced age or with serious illness for suitability for early release ("elder parole" or "compassionate release"). Yet bureaucratic

hurdles undermine use of these policies.[9] Health care professionals can provide the medical knowledge needed to improve these policies. Others can support parole reform legislation or join a parole board to ensure the presence of a healthcare perspective when cases are reviewed.

2. Engaging in Educational Partnerships around Geriatrics and Correctional Healthcare

Geriatrics specialists can forge alliances with correctional healthcare professionals to address each other's educational needs. Many correctional healthcare professionals would benefit from additional geriatrics and palliative care knowledge, while correctional professionals and bioethicists can help community hospitalists improve the care provided to incarcerated patients including agitating to minimize the practice of shackling hospitalized patients and ensuring that incarcerated patients are engaged in advance care planning.[10] Correctional healthcare professionals can educate community professionals about formerly incarcerated older adults' needs, since decades behind bars can erode social ties; make seemingly simple tasks (like filling prescriptions) overwhelming; and strict daily prison regimes can mask cognitive impairment until people return to community.

3. Engaging in Aging-Related Research

Evidence-based knowledge to inform correctional programs and policies for older adults is limited. Few studies have assessed the geriatric conditions (e.g., functional and cognitive impairment, falls, elder abuse) key to understanding the health of older adults at each phase of criminal justice involvement (from arrest through community reintegration). Research is needed to inform services to meet the needs of this growing population.

Conclusion.

Many mistakenly believe that people who serve their prison sentence and engage in rehabilitative programming will have an opportunity to return to society. Instead, mass incarceration has been disproportionately shouldered by people of racial or ethnic minority who are subject to extraordinarily long sentences with little hope of ever gaining their freedom. The result is a growing number of older adults who are warehoused in prisons not designed to accommodate their physical needs.

Healthcare professionals can lend our knowledge to address this dire public health challenge. We can advocate for a criminal legal system that focuses on rehabilitation; creation of stronger communities through expanded healthcare services including substance use treatment, mental healthcare, job training and education; and parole reform. We can educate each other so that older adults receive appropriate care in prisons, community hospitals, and clinics after release. And we can design clinical research to understand the healthcare needs of this population.

Keeping older adults incarcerated for decades, even after they achieve their rehabilitative goals, is financially unsound, steeped in racial biases, and a tremendous loss of human potential.[11] As healthcare professionals, we should call for an end to mass incarceration as a critical matter of geriatric public health.

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Conflicts of Interest:

Dr. Williams has served as a consultant to improve prison conditions of confinement and correctional healthcare for state prison systems, including the Office of the Federal Receiver of the California Department of Corrections and Rehabilitation, county jails, the U.S. Department of Justice, and in legal cases related to prison and jail conditions of confinement (including the National American Civil Liberties Union and the Center for Constitutional Rights). None of these entities supported or influenced the submitted work. Dr. Williams' time was covered, in part, by grants from the National Institute on Aging (the Aging Research In Criminal Justice Health Network, Grant #R24 AG065175 and the UCSF Older Americans Independence Center Grant #P30 AG044281).

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