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Aging Inmates: A Convergence of Trends in the American Criminal Justice System

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ABSTRACT

During the past 30 years, American prisons have experienced rapidly expanding numbers of inmates, including more who are elderly. Elderly inmates present unique management challenges to the extent they experience age-specific adjustments and adaptations to prison life. Accommodating this "special needs" population, which places a disproportionate strain on available correctional resources, raises both prison environment and policy-level questions. Although some advocate early and/or medical release for older inmates who are seen as no longer posing a threat to society, state and federal correctional data indicate that early release is not a dominant trend. This article reviews the causes of the growth in the older male inmate population and then applies tools from gerontology to provide a perspective for evaluating current or prospective correctional system responses and programs, and to raise issues and suggest policies that might benefit older inmates as well as correctional systems.

ARTICLE

A three-decade convergence of trends in the American correctional system has led to significant growth in the population of aging inmates. As the number of aging inmates grows, so do financial and facilities costs to state departments of correction (DOCs) and the Federal Bureau of Prisons (FBOP). Even if forethought was given to the growth of this "special needs" inmate population, current federal and state budget difficulties hinder the ability to address the environmental, health-related, and social needs of these inmates.

This article has five goals. First, the increase in the number of older persons in America and in U.S. prison systems will be documented, an operational definition of the aging inmate will be provided, and the characteristics of this special needs population will be described. Second, a historical review presents the convergence of three trends that have led to an increase in the aging inmate population. Third, the increasing costs of caring for and managing this population will be described, showing the increasing financial burden aging inmates place on state DOCs and the FBOP. Fourth, policies and programs that state DOCs and the FBOP use to manage and provide care for aging inmates will be described. Finally, a gerontological perspective, focusing on age, period, and cohort effects, will be presented and employed to suggest a disaggregation of aging inmate care and management issues that will optimize policy and program responses. A multidisciplinary approach should both enhance our understanding of aging inmate issues and challenges and help us evaluate potential policy responses.

THE GRAYING OF AMERICA: DEMOGRAPHICS AND DEFINITIONS

In 1900, only 4% of Americans were age 65 or older (Hooyman & Kiyak, 1999). By 2000 the older population had more than tripled, to about 13% of the U.S. population. Over the same period, life expectancy increased from 47 to 78 years, due largely to advances in medical science and technology. As 80 million baby boomers (those born between 1946 and 1964) become the new generation of senior citizens, the population age 65+ will roughly double (Hooyman & Kiyak, 1999). By the time all the baby boomers have turned 65, about 1 in 5 Americans will be in that age group.

Increases in life expectancy have not bypassed prison populations. Although several factors contribute to the size of the elderly inmate population, the number of older inmates and the percentage of the incarcerated population they comprise will grow rapidly. Formby and Abel (1997) note that in 1990, approximately 19,610 persons age 55 and older were incarcerated in state and federal correctional institutions; in 2 years this number grew to 23,025 older inmates, and to 25,004 in 1993. Texas saw an estimated 86% increase in the older inmate population from 1994 to 1998, compared to a 35.4% increase in the general prison population for the same given time period (Schreiber, 1999). Zimbardo (1994) found that in 1994 elderly inmates represented 4% of the total prison population in California. However, by 2020, California will see a projected increase in its elderly inmate population of more than 200%. Other authors have estimated that by 2020, older inmates will represent 21% to 33% of the U.S. prison population (Chaneles, 1987; Durham, 1994; Neeley, Addison, & Craig-Moreland, 1997).

The increase in the number and percentage of aging inmates is due in part to medical advances. Yet such inmates often have long histories of alcohol and drug abuse, insufficient diet, and lack of medical care (Williams, 2001). The combination of physical and mental declines makes aging inmates, on the average, 10 to 11.5 years older physiologically than their nonincarcerated age peers (Doughty, 1999; Southern Legislative Conference, 1998). This is why most recent studies consider either age 50 or 55 as the onset of old age for inmates (Aday, 1994a, 2003; Auerhahn, 2002; Barnes, 1999; Bouplon, 1999; Durham, 1994; Goetting, 1983, 1984a, 1984b, 1985; Holeman, 1998; Merianos, Marquart, Damphouse, & Hebert, 1997; Morton, 1992; Rosefield, 1993; Wheeler, Connelly, & Wheeler, 1995; Zimbardo, 1994). For our purposes, then, an elderly male inmate is defined as age 50+.

Compared to younger inmates, older inmates have poorer health, especially regarding chronic conditions, substance abuse, and psychological disorders (Aday, 1994a; Bouplon, 1999; Rosefield, 1993). Formby and Abel (1997) found that older inmates suffered an average of three chronic illnesses during their incarceration. Because of health and other aging-related needs, older prisoners are up to 3 times more costly to maintain than younger inmates; older inmates use more prescription drugs than younger inmates and spend twice as much time in medical facilities (Morton, 1992; Sheppard, 2001). Older inmates also are more likely to have committed violent crimes; 75% are still serving time for their first offense (Sheppard, 2001). This is at least in part because of the greater odds of parole or release of nonviolent offenders in the same age cohort.

THE CRIME CONTROL MODEL IN CRIMINAL JUSTICE

Before the Vietnam War years, correctional policy and sentencing guidelines were based on the rehabilitative model, which emphasized treatment programs to reform the “sick” offender. Griset (1991) notes that a medical model was frequently invoked to treat the offender for an indeterminate time until the inmate was considered “well.” However, after the socially turbulent 1960s there were changes in sentencing policies prompted by antirehabilitationists’ claims that inmates were not “sick” and that the criminal justice system could not “prescribe a cure” through treatment in the correctional system (Griset, 1991).

The passage of the 1984 Federal Sentencing Reform Act provides further evidence of the shift from rehabilitation toward incapacitation (King & Mauer, 2001; Rausch, 1996). The Act implemented mandatory minimum sentences and specified periods of incarceration for specified federal offenses. By the mid-1990s, 13 states had passed their own form of sentencing reform acts (Flynn, Flanagan, Greenwood, & Krisberg, 1995; Mackenzie, 2001). In 1994, the Federal Violent Crime Control and Law Enforcement Act was passed, allocating \$9.7 billion for prison construction and \$6 billion for prevention programs. The largest impact of this bill was its mandate that 50% of the funding for all programs go to states that adopted truth-in-sentencing laws, including the condition that such laws require offenders to serve at least 85% of their sentence before being eligible for release (Violent Crime Control, 1994). Judicial discretion in sentencing was virtually eliminated—no longer could judges or prosecutors consider such factors as age, health, or perceived risk to the community. This shift in the dominant rationale

for imprisonment keeps more convicts incarcerated for longer periods of time, leading to growth in the proportion of older inmates (Auerhahn, 2002).

Thus, beginning after the Vietnam War years and continuing to the present, there has been a movement in the criminal justice system away from an overarching philosophy of rehabilitation toward one of incapacitation. Indicators of this shift include mandatory sentencing, “three-strikes” programs, and various “get-tough” crime policies. These factors—more sentences, longer sentences, mandatory sentences—when coupled with medical advances that keep aging inmates alive longer, have led to the current growth of the older inmate population (Chaneles, 1987; Flynn et al., 1995; Holeman, 1998; Merianos et al., 1997; Zimbardo, 1994).

The challenge of the aging inmate thus results from multiple trends: the historical evolution of America’s criminal justice philosophy, the resultant explosion of the prison population, and the significant current and future growth of the older inmate population. Additionally, this challenge must be addressed in an era of large federal deficits and shrinking state budgets. Given the convergence of these trends and the disproportionate costs of incarcerating older inmates, an examination of the policies and programs of state DOCs, the FBOP, and independent organizations should shed light on current approaches to managing, housing, and caring for older inmates.

THE CHALLENGE: NUMBERS AND COSTS

If federal and state policies remain unchanged there will be a significant growth in the number of older inmates, a population with disproportionate medical needs and costs. Adequate equipment and services needed to provide medical care for aging inmates include 24-hour nursing coverage, infirmary beds, physician availability, pharmacy, laboratory, x-ray, and rehabilitative physical care resources (Rosefield, 1993). For the elderly offender, kidney dialysis costs at least \$122 per treatment; a pacemaker implant costs \$15,000 to \$50,000 (Krane, 1999a, 1999b).

Thus, the responsibility of federal and state correctional departments to provide adequate medical care and housing for older inmates will be more complex—and more expensive—than ever. In fact, at both the federal and state levels, the cost of inmate health care has increased dramatically. The FBOP spends more than \$400 million annually to imprison and care for elderly inmates (Holeman, 1998). However, states also bear the burden of providing care for the aging inmate population. For example, Pennsylvania’s spending on prison health services grew from \$1.23 million in 1973 to \$16.7 million in 1986, largely because of older inmate expenses such as eyeglasses, dentures, open-heart surgery, and care for the terminally ill (Chaneles, 1987). More than a decade ago, Zimbardo (1994) found the annual cost to incarcerate an inmate age 60+ in California to be about \$69,000, compared to \$21,000 for an inmate age 30. A 50-year-old person convicted in 1994 who serves a 25-year sentence at an average cost of \$60,000 per year would cost the state of California about \$1.5 million. More recently, a Georgia study (Georgia Department of Corrections, 2000) found that inmates age 50+, who represent only 6%

of the incarcerated population, consume more than 12% of the inmate health care budget. Consequently, the mean annual cost was \$69,000 per older inmate.

STATE AND FEDERAL POLICIES AND PROGRAMS

In discussing the management and care of elderly inmates, there are two areas of general interest for both scholars and practitioners: release and reintegration, and prison facility design and management (Drummond, 1999; Duckett, Fox, Harsha, & Vish, 2001; Goetting, 1983; Holeman, 1998; Ornduff, 1996; Yates & Gillespie, 2000). However, current policies and programs at state and federal levels exhibit little consensus regarding either release or management of the aging inmate (Adams, 1995; Aday, 2003; Coalition, 1998; Drummond, 1999; Duckett et al., 2001; Goetting, 1983; Ornduff, 1996; Yates & Gillespie, 2000). What follows is a review of current policies and programs employed to care for the aging inmate population.

“COMPASSIONATE”/MEDICAL/NONMEDICAL EARLY PAROLE

Perhaps the most controversial aging inmate issue is release from prison before serving the complete term of incarceration (Goetting, 1983; Ornduff, 1996). Early release usually occurs for one of two reasons: terminal illness or record of incarcerated behavior. Medical parole, also known as “compassionate” release, refers to the release of an inmate who suffers from a terminal disease and whose remaining life expectancy is within a specified threshold (Ornduff, 1996). As Russell (1994) noted in her survey of all 50 states, the District of Columbia, and the FBOP, only Kansas, Maine, and the District of Columbia allowed medical release of inmates. In some other states, medical release for the elderly inmate is valid only during the term of illness or until death. If the medical condition improves, medical parole is revoked and the inmate is returned to the correctional atmosphere, a practice found in Georgia, New York, Ohio, Oklahoma, Oregon, and Texas (Russell, 1994).

When examining this perhaps morally justifiable approach from a financial standpoint, one can question whether state DOCs are merely cost-shifting, transferring the economic burden of the ailing inmate from correctional facilities to the inmate’s family or, more commonly, community health and social services. Ornduff (1996) notes that states disagree on where the prisoner may go after being released on medical parole. Delaware’s relatively stringent policy mandates the inmate be released on medical parole only when arrangements have been made for the treatment of the person in some other institution. Montana’s moderate policy requires that the prisoner agree to a designated facility recommended by the state parole board. Connecticut’s lenient medical release policy permits inmate release into an environment “suitable to his medical health,” which can include the residence of the inmate’s family. Thus there is no clear medical parole policy that all—or even most—state DOCs follow.

There are currently few early release policies for chronically but nonterminally ill aging inmates. As noted above, such inmates are a financial burden on correctional systems, yet are likely to remain incarcerated barring a change in criminal justice system policy. Therefore an area of

future research could focus on policy adaptations that address not only medical parole but also an overall cost-effective integration of services (vs. cost-shifting) for these aging parolees. Innovative policies or programs that result from such initial efforts can serve as a guide for national policy development.

One such innovative program for nonterminally ill aging inmates that challenges the public opinion trend is the Project for Older Prisoners (POPS; Aday, 2003; Coalition, 1998; Drummond, 1999; Duckett et al., 2001; Goetting, 1983; Yates & Gillespie, 2000). Founded in 1989, POPS operates primarily through law schools in the District of Columbia and five states: Louisiana, Maryland, Michigan, North Carolina, and Virginia. The stated goals are to reduce prison overcrowding and costs to taxpayers. As of 2002, POPS had counseled more than 500 older inmates and won release for nearly 100, with no reported recidivism (Duckett et al., 2001; Florida House, 1999; Goetting, 1983; Yates & Gillespie, 2000).

To be eligible for the POPS program, an inmate must be at least 55, have served the average time of his or her sentence, and be deemed no longer a present danger. The victim or victim's family must agree to the inmate's early release (Coalition, 1998; Drummond, 1999; Duckett et al., 2001; Goetting, 1983; Yates & Gillespie, 2000). On the inmate's release a POPS volunteer—typically a law school student—is assigned to work with the former inmate to establish a network of reintegrative support services, such as Social Security or the Veterans Administration.

The POPS program is creative and apparently effective, yet limited in geographic reach, and the basic requirements for inmate selection are quite specific (Ornduff, 1996). Expansion of POPS to all other states could yield a cost-effective and arguably humane reduction in the number of elderly inmates. The success of current POPS programs plus data showing that released elderly inmates have the lowest rates of recidivism of any age category support further exploration of this idea (Florida House of Representatives, 1999; Turley, 1989; Yates & Gillespie, 2000; Zimbaro, 1994).

PRISON FACILITY DESIGN AND MANAGEMENT

If the aging inmate is not to be released, a key question is whether aging inmates should be segregated from or consolidated into the general inmate population. There is no uniform policy from any of the state DOCs regarding consolidation versus segregation. According to a 1997 National Institute of Corrections study on the health needs of aging inmates, 23 states have specific services for older inmates. Of these 23 states, 15 provide segregated medical facilities for elderly inmates (U.S. Department of Justice, 1997). Moreover, scholars do not agree on whether aging inmates should be consolidated into or segregated from the general inmate population (Adams, 1995; Aday, 1994a, 1994b, 2003; Duckett et al., 2001; Goetting, 1984a, 1985; Johnson, 1988; Merianos et al., 1997; Neeley et al., 1997; Ornduff, 1996; Rosefield, 1993; Wiegand & Burger, 1979; Yates & Gillespie, 2000).

A prison management perspective asks whether the presence of aging inmates improves the atmosphere of a facility or makes them potential victims for younger inmates. Support for consolidation comes from prison administrators who believe that older inmates have a calming effect on younger inmates (Adams, 1995; Aday, 1994b, 2003; Ornduff, 1996; Yates & Gillespie, 2000). However, Ornduff (1996) and Johnson (1988) found that prison administrators consider “older” inmates to be 35 to 50 years old. Additionally, administrators prefer consolidation because it allows the older inmates to participate in work details and educational/vocational programs, and because it provides easier access to the aging inmate for family and friends (Adams, 1995; Aday, 1994b; Goetting, 1983; Ornduff, 1996; Yates & Gillespie, 2000). Thus, the safety issue is not directly addressed.

There are also arguments favoring segregation of older inmates. Segregation minimizes the odds that older inmates will fall prey to younger, more aggressive inmates (Adams, 1995; Aday, 1994b, 2003; Ornduff, 1996; Yates & Gillespie, 2000). Segregation also provides elderly inmates the opportunity to build friendships and support networks with their age peers, reducing feelings of loneliness and despair and building self-respect (Adams, 1995; Goetting, 1984b; Morton, 1992; Ornduff, 1996; Yates & Gillespie, 2000). Age-based segregation allows the designation of one central unit that can be adapted as an “elder-friendly” physical environment, with such features as fewer stairwells, more ramps and handrails, lower bunks or bunk assignments, quiet and well-lit communal areas, and nonwaxed floors to reduce falls. These and other physical environment modifications in a segregated geriatric unit address older inmates’ safety needs and physical limitations (Bouplon, 1999; Duckett et al., 2001; Neeley et al., 1997; Rosefield, 1993; Wiegand & Burger, 1979).

STATES’ RESPONSE TO PAROLE, FACILITY DESIGN, AND MANAGEMENT

Our review of state policies for older inmate segregation/consolidation found that some state DOCs have developed programs to meet the housing and management needs of aging inmates. Eighteen states provide age-segregated facilities. Eight states and the FBOP consolidate older inmates into the general inmate population. The remaining 24 states have no documented segregation/consolidation policy. The housing programs of five states, covering the range of residential arrangements from “most” to “least” accommodating, are described below.

Ohio. Ohio has six correctional facilities that house older inmates, the majority being located at Hocking Correctional Facility (HCF), a 450-bed age-segregated facility for inmates 50 years of age or older (Ohio Department of Rehabilitation and Correction, 1997). Programming for older inmates at HCF includes (a) prerelease programming, in which inmates receive a “Golden Buckeye Card” as well as information on how to file for Social Security benefits, listings of area human service providers, and job-seeking skills; (b) vocational building and property maintenance training courses; (c) Maturing With Understanding While Behind Bars, a program that educates inmates on the physical, psychological, and social issue of aging; (d) adult basic education and literacy courses; and (5) Self Care, a program that provides material on medical issues and problems of aging, as well as recognizing and dealing with issues of aging (Ohio, 1997).

In conjunction with these programs, HCF has developed correctional staff training programs that emphasize age sensitivity, legal issues, grieving, death and dying, prerelease and aftercare, supervision of older prisoners, programming, and medical and nutritional concerns (Ohio, 1997). When necessary, the Ohio DOC provides nursing home placement. Although there are strict guidelines for placement, aging inmates are placed in nursing homes if they need assistance with two or more Activities of Daily Living (ADL; described below). Currently there are no halfway houses for older inmates.

Pennsylvania. At the time of this writing, Pennsylvania had one correctional facility—State Correctional Institute at Laurel Highlands—that segregates older inmates from the general prison population. Inmates are eligible to reside at State Correctional Institute at Laurel Highlands when they turn 55. These elderly inmates have access to age-targeted medical services (including substance abuse), psychological counseling (e.g., death and dying issues), and a reintegration program called Life Skill, which develops skills necessary for older inmates to successfully reintegrate into their communities (Aday, 2003).

Virginia. Virginia has one specialized facility for inmates age 55 and older. Deerfield Correctional Center provides assisted living care, skilled nursing care, and special training for guards who interact with older inmates. Because of the increasing costs of caring and providing housing for elderly inmates, Virginia state officials place the inmates in extramural assisted living care; the state pays \$30 per day per aging inmate, versus \$100 per day to maintain the same inmate inside the prison facility (Baker, 1999; Florida Corrections Commission, 2001).

Florida. The Florida DOC evaluates inmates based on their overall medical classification. It does not have an age-specific set of policies and procedures, except those relating to its specialized (e.g., segregated) facility at River Junction, which was legislatively designated a geriatric facility in 2000. The legislation, however, stipulates that inmates qualify for transfer to River Junction only if they are “generally healthy.” This biases assignment to River Junction in favor of “relatively younger” older inmates. The River Junction Correctional Institution staff complete a required training program titled Aging Inmate Supervision. In addition, an Elder Abuse, Neglect, and Exploitation program has been approved by the Florida Department of Elder Affairs for correctional officer training (Correctional Medical Authority, 2000; Florida Corrections Commission, 2001).

Montana. Montana lacks a policy on housing aging inmates and does not provide a separate facility for them. However, the Montana State University–Bozeman nursing program has a cooperative program with the Montana DOC wherein nurses intern at the Montana State Prison. This allows nursing students to learn about geriatric medicine and reduces DOC costs, because elderly inmates do not need to be transported out of the prison for medical care (Boswell, 2001).

APPLYING A GERONTOLOGICAL PERSPECTIVE

As the American population ages, gerontology becomes a more relevant field of study. As the American prison population ages, it becomes more likely that a gerontological perspective can

inform criminal justice policies and political action. This section addresses four topics: how age is defined (how people are “age-graded”), how differences between younger and older persons are explained, how the functional status of the older inmate is assessed, and a theoretical model of the relationship between the inmate and his environment.

Defining Age

Using chronological age to identify older inmates or to make them eligible for certain programs or resources, as many scholars and policy makers have done, may need to be reconsidered. Most people are familiar with defining age chronologically. One advantage to such a definition is that it provides easily measured thresholds for social activities, opportunities, or privileges. It also allows us to precisely allocate people to life stages, such as teenager (ages 13-19 inclusive) and elderly (age 65 and over). On the other hand, defining age chronologically is an imperfect measure of life stage or ability. Of particular relevance to the issue of aging inmates is the fact that, although health does in general decline with age, chronological age may not be the best predictor of inmate health and thus of inmate needs. Consequently, resources targeted to prisoners “of a certain age” are likely to benefit some prisoners who do not need them and omit others who do.

A second way of age-grading is biological/physiological. People are assigned to age categories (e.g., young, middle-aged, old) based on biological traits and physiological indicators (e.g., cardiovascular fitness, neuromuscular response, bone density, or chronic health problems such as high blood pressure, diabetes, and prostate or breast cancer). A third age-grading method addresses functional age. This focuses on one’s ability to perform necessary tasks (e.g., personal hygiene, job) and is related to but not identical to physiological aging.

Chronological age is a highly reliable indicator but not necessarily a valid one regarding physiological status and functionality. If the best use of resources is to assist all who need assistance and no one who doesn’t, allocating resources based on chronological age is a mistake.

Explaining Differences Between Older and Younger People: Age, Period, and Cohort Effects

When trying to understand how people change as they age or why older and younger people differ, gerontologists often use age, period, and cohort effects as analytical tools. An age, or maturation, effect is a change that occurs essentially because of the aging process.

Physiological changes, such as graying hair or immune system deterioration, are examples. Some challenges posed by the increase in numbers of older inmates are largely age effects: changes in health status, needs, and costs together with a growing need for environmental adaptations such as ramps, handrails, or widened doorways.

A period or historical effect is a change across a population because of a historical event. For example, the passage of Social Security changed the nature of retirement and image of retirees in America, and it can be argued that the entire population underwent and was affected by these changes. For our purposes, period effects would include the 1970s shift from a rehabilitation

model to an incapacitation model in the criminal justice system, which led to a prison construction boom. The Sentencing Reform Act (1984) and the Law Enforcement Act (1994) toughened and extended sentences and reduced judges' discretion. At the confluence of these events we find a prescription for an increase in older inmates: more prisoners, more prison beds, more lifers, and less parole.

A cohort effect typically refers to differences between generations that can be attributed essentially to the unique experiences of each generation during its formative years. In prison, for example, different cohorts may view the Con (Convict's) Code—an unwritten set of values and norms that guide de facto prison life and is passed down orally from senior inmates to new arrivals—differently. Senior inmates are no longer viewed by more junior inmates, relatively unquestioningly, as wiser and more steeped in prison culture, and thus older inmates are no longer guaranteed the respect and protection historically mandated by the Con Code. Thus, generational differences in the value accorded the Con Code are making consolidated (age-integrated) prison life more problematic for older inmates (Clemmer, 1958; Sykes, 1971).

It is important for criminologists and decision makers to determine which effect best explains aging inmate issues and challenges. For instance, an age effect, such as increased need for dialysis as the older inmate population rises, will continue as long as prisons hold significant numbers of older inmates. Such ongoing needs must be addressed and planned for, essentially, in perpetuity. A cohort effect, however, means that a trait or need that characterizes today's older prisoners essentially "belongs" to that generation, and as it dies out the trait or need may disappear as well. Thus a cohort explanation implies a short-term need that should be addressed now but which may not be an ongoing drain on resources. Finally, a period effect tells us that there are historical events (e.g., the shift from a rehabilitation model to an incapacitation model) that created current conditions, and thus new historical events (e.g., changes in policy or law) can change the conditions.

Assessing Inmate Age

For more than 30 years gerontologists have assessed functionality via two indexes: Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). The ADL instrument measures the level of functional independence regarding bathing, dressing, toileting, transferring (e.g., into and out of bed or a chair), continence, and feeding (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963). The IADL instrument assesses functional ability in using the telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for medications, and ability to handle finances (Lawton & Brody, 1969). Both indexes are used to assess older persons' needs and thus the residential placement and types of services they require and that will be reimbursed.

Although one or more IADL categories may not be applicable to the prison environment, or may need to be adapted, these instruments have proven over the years to be reliable and valid means of assessing functionality and thus the need for assistance.

The Older Inmate and His Environment

The Person-Environment Model (Lawton & Nahemow, 1973) illustrates how differing levels of personal competence and environmental press influence behavior and affect. For people to function successfully and have positive affect, there must be an approximate balance between competence and press. The relevance for those charged with responding to the challenges posed by increasing numbers of older inmates is that unacceptable imbalances between personal competence and environmental press can be addressed either by increasing competence or by decreasing press. Thus the problems caused by growing numbers of elderly prisoners can be addressed by teaching new behaviors or problem-solving skills or by modifying the residential prison environment to reduce its press on aging inmates.

CONCLUSIONS

We contend that applying gerontological tools—particularly the analysis of age, period, and cohort effects—can help untangle the multiple causes that have contributed to the growth and, especially, the challenges of an aging inmate population. Such analysis also can help evaluate the odds of and reasons for the success of extant or proposed programs and policies, and ideally will inform future studies of aging inmates. We conclude by highlighting three focal concerns for aging inmates and then offer policy recommendations.

Three Concerns

Inmate capacity: The quantity issue. For three decades, due largely to the shift from a rehabilitation to an incapacitation model of crime control, America has been building prisons, tightening laws and sentencing restrictions, and imposing longer sentences. Current state budget shortfalls are forcing states to adjust. Options now under consideration include closing prisons, laying off correctional officers, delaying new prison construction, and cutting inmate education programs (Butterfield, 2002). Thus, because of legislation, we now find rapidly rising numbers and percentages of older inmates, whose aging leads to higher and increasingly burdensome costs.

Prison environment: The quality issue. Age effects include physical and mental health needs, adult protective services, and adapted housing. These are real needs and entail additional costs. There are also period effects—the shift to a crime control model led to a prison building boom, but it appears the needs of aging inmates were not taken into account in new prison construction.

Probation and parole: The reintegration issue. Tight budgets are leading states to reconsider sentencing and parole (Butterfield, 2002). Several studies show recidivism is inversely related to age at time of release. But most states have no programs like POPS, specifically designed to help older offenders adjust back into civilian life. Cost-cutting measures, such as eliminating GED and vocational education courses for inmates, hinder reintegration. Older parolees often qualify for one or more state assistance programs but may not know they are available or how to access them. Finally, family support is less likely for older offenders; either family has died or

cannot accommodate the older person's needs, or family members were the victims and are understandably reluctant to support the perpetrator.

Policy Recommendations

Based on our use of a gerontological perspective to examine the growth of the aging inmate population, we make five policy recommendations. First, to the extent the crime control model is not changed and sentencing/parole policies are not age-targeted, existing and new prisons must prepare to adapt to increasing numbers of older inmates by providing age-targeted physical plant adaptations, staffing and staff training, and programming for inmates. Second, future research should focus on new policies that not only address medical parole for aging inmates but also focus on the placement of aging parolees that proves to be the most cost-effective for all social service agencies. Third, new policies or programs that are outcomes of the previously mentioned research should serve as a guide for a national policy. Fourth, age-specific reintegration programs should be encouraged and supported: parole officers should be trained to help meet the needs of older parolees, and halfway houses should be able to accommodate their environmental needs. The POPS program could serve as a national model for such programs. Finally, states should consider exempting older inmates, who are least likely to reoffend, from parole once released.

In the best of all possible worlds, core values and philosophies guide policy development, and policy is accurately and effectively operationalized in programming at national, state, and local levels. In reality, it seems that the conditions that have led to a rapid rise in older inmates and their housing in facilities designed for younger persons are gradually and sporadically being ameliorated, and we welcome this, even if it is happening for financial or political reasons or reasons not directly related to criminal justice philosophy or society's moral position on incarceration. We hope that our recommendations, based on an integration of criminal justice and gerontological analysis, might serve as a more overarching and integrated guide to inform the policy and practice of incarceration in America.

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