

The High Costs of Low Risk:
The Crisis of America's Aging Prison Population

Prepared by the Osborne Association for:
The Florence V. Burden Foundation
July 2014

Executive Summary

For the past four decades, we have witnessed the most sustained and widespread imprisonment binge known throughout recorded human history. The facts are all too familiar: the United States has roughly 5 percent of the world's population, yet is responsible for 25 percent of the world's incarcerated population. With an estimated 2.3 million adults in jail or prison and 1 out of every 32 adults under correctional or community supervision, the U.S. surpasses all other countries in sheer numbers and per capita incarceration rates.

The immense costs of incarceration have increasingly framed the conversation around reducing the prison population as a matter of fiscal responsibility and budgetary necessity. This discussion is often centered around reducing the arrest and prosecution of so-called “non-violent drug offenders.” But these issues belie a much more pressing human and economic concern: the aging prison population, whose costs for incarceration and care will soon prove unsustainable if meaningful action is not taken. And though prison is expensive, cost is far from the only justification to move away from our reliance on incarceration, as the continued long-term incarceration of aging citizens has serious moral, ethical, public health, and public safety implications.

This paper aims to provide a brief contextual framework of the issues affecting elders in prison; to illuminate the ongoing efforts being undertaken to improve conditions within correctional facilities, increase mechanisms for release, and develop robust post-release services specifically targeting the unique needs of the aging population in reentry; and to sketch out preliminary recommendations to serve as a basis for further work to be done throughout several key sectors.

Despite their apparent interrelated interests in the aging prison population, the fields of gerontology, medical and mental health, philanthropy, and corrections have only sporadically interacted around this issue, and never as a unified voice. Thus, a primary objective of this work is to encourage multi-sector dialogue, cross-pollination of ideas, and a shared foundational knowledge that will strengthen the connections among these fields and form a basis for unifying action.

We believe such a partnership will be well equipped to identify and engage in appropriate measures that will immediately impact the aging prison population, while also developing and implementing the necessary socio-structural architecture to effectively address long-term mechanisms of diversion, release, and reentry.

Austerity-driven approaches to shrinking budgets and increasing public discomfort with mass incarceration create an opportunity to seriously address the epidemic of America's graying prison population and to imbue our criminal justice system with values and policies that are humane, cost-effective, and socially responsible.

A Spectre is Haunting America

The aging prison population represents a national human-made epidemic decades in the making. Although there is no commonly agreed-upon age at which an incarcerated individual is “old”—definitions range from 50 to 65—it is clear that regardless of the age metric, the number of people in prison requiring significant age-related medical care has risen and will continue to rise at a substantial rate given existing population trends. From 1995 to 2010, the U.S. prison population aged 55 or older nearly quadrupled. By 2030, this population is projected to account for one-third of all incarcerated people in the U.S., amounting to a staggering 4,400 percent increase over a fifty-year span.¹ Even as crime has drastically declined and the U.S. prison population has begun to shrink, the aging prison population continues to rise at a disproportionate rate: while the overall prison population grew 42 percent from 1995-2010, the aging population increased by 282 percent and shows no signs of slowing down.² Today, there are an estimated 246,600 prisoners age 50 or older in the United States and nearly 9,300 aging incarcerated individuals in New York, comprising roughly 17 percent of the state’s total prison population.

The scale of this crisis is not limited to a handful of states with exceptionally poor policies, but affects the entire nation: at present, twenty-eight states hold more than 1,000 older prisoners, up from just two states in 1990.^{3,4} We have now reached what Fordham University Professor Tina Maschi calls a “critical Omega point”⁵ in which both the sheer number and the specialized needs of the aging prison population have begun to surpass correctional facilities’ capability to provide effective and humane care. This sustained mass incarceration of elders bears major economic, social, ethical, and health implications – and without decisive action, our criminal justice system is at serious risk of collapsing under its own weight.

Economic Costs

Unsurprisingly, the large-scale incarceration of the elderly has proven to be enormously expensive. The United States currently spends over \$16 billion annually on incarceration for individuals aged 50 and older – more than the entire Department of Energy budget or Department of Education funding for school improvements.⁶ Existing analyses calculate that, on average, it costs approximately twice as much to incarcerate someone aged 50 and over (\$68,270) than a younger, more able-bodied individual (\$34,135)—and in some cases, may actually cost up to five times more.⁷ These runaway costs cannot be attributed to any single factor, but are the expected consequence of current policies imposed upon a population that has significant physical, medical, and holistic needs.

It is much more expensive to provide medical care to aging individuals in prison. Security adds an additional layer of cost, planning, and complexity, as medical procedures that cannot be accomplished on-site require a secure trip to a medical facility under the constant and costly supervision of corrections officers. Once there, it costs approximately \$2,000 per 24 hours to guard individuals receiving medical care outside of prison.⁸ In short, the unique needs of the elderly and the commensurate costs for their care are compounded by additional and unavoidable expenses of correctional supervision; it is clear that any long-term use of prisons as makeshift nursing homes is financially unsustainable.

Health Impact

Even if the mounting fiscal crisis could be swiftly addressed, the health implications associated with incarcerating older adults are no less troubling. Compared to their non-incarcerated peers, aging individuals in prison present with an array of serious medical issues that are simultaneously obscured and exacerbated by their incarceration. We must also bear in mind that aging individuals in prison have health issues that correlate with socioeconomic factors. That is, the same demographic groups that are disproportionately arrested and incarcerated—people of color and individuals from lower socioeconomic status—are also more likely to be at risk for poor health *prior to* their incarceration. Thus, the composition of (and relative health status within) today’s prison population has quite accurately been called a “distorted reflection of the general population” in that its constituents typically enter prison having had less access to primary care, a greater likelihood of co-morbid factors such as substance abuse, and greater health needs.⁹ Within prison, we see a high prevalence of communicable and chronic diseases (including hepatitis, HIV, tuberculosis, arthritis, hypertension, ulcer disease, prostate problems, respiratory illnesses, cardiovascular disease, strokes, Alzheimer’s, and cancer) in the older prison population compared with both the general population and overall prison population.¹⁰¹¹¹² The elderly in prison also demonstrate a greater risk of injury, victimization, ailing health, and death than their younger counterparts.¹³

While incarcerated Americans are the only citizens with a constitutional right to healthcare, they often do not receive the necessary depth or breadth of care. People in prison are dependent on staff for their medication (staff that typically operate on a limited schedule), are faced with a dearth of dietary choices, and have greater difficulty with self care and disease management practices. Diabetics, for example, are typically prohibited from keeping glucose monitoring devices, insulin, or syringes.

Incarceration not only compounds existing health issues and heightens the risk of further health problems, but—most alarmingly—has a deteriorating effect on the bodies of incarcerated people, causing them to physically age at a much faster rate than the public at large.^{14 15} This phenomenon of accelerated aging, which can be attributed to the prevalence of environmental stressors coupled with a lack of access to holistic healthcare, means that the body of an incarcerated 50-year-old has a “physiological age” that is 10 to 15 years older.^{16 17}

Mental health issues are an equally serious concern among this population.¹⁸ One study found that 40 percent of older prisoners had a diagnosis of cognitive impairment, a prevalence rate that far exceeds their peers in the community.¹⁹ Higher rates of depression, anxiety, trauma, and stress have also been found among older incarcerated adults.^{20 21} Furthermore, the poor physical and mental health of aging prisoners places them at greater risk for dementia and other severely debilitating forms of cognitive impairment.

Unfortunately, mental health diagnoses among aging prisoners remain both underreported and undertreated.^{22 23} Data from the Bureau of Justice Statistics indicate that roughly 40-60 percent of imprisoned individuals aged 50 and older are reported to have mental health problems, yet only one in three have access to treatment.²⁴ Early warning signs for the onset of dementia and other mental health diagnoses can be hidden by the rigid routine of prison life. Existing research

shows that corrections officers have reported cognitive impairment in older prisoners at nearly five times the rate as that reported by prison officials, displaying a critical knowledge disparity between levels of bureaucracy that bears potentially serious consequences for aging prisoners who may not receive the care they need.²⁵ At the same time, cognitive, visual, and aural impairment (for example, failing to hear the orders of a correctional officer) can lead to behaviors mistaken for disobedience or aggression and subject to institutional punishment, further compromising the well-being of those most in need of care.²⁶ Older adults with dementia and other mental health diagnoses are subjected to victimization and bullying from younger prisoners and can be subject to additional disciplinary action if their self-defense mechanisms turn violent.^{27 28} Individuals with profound dementia are sometimes incapable of understanding that they are incarcerated (let alone understanding *why* they are there or whether they are remorseful) and must be reminded of their crime prior to a parole hearing.²⁹ So while prisons in the United States were expressly designed around the concept of penitence—that is, creating conditions for contemplation, remorse, and rehabilitation—the typical environment and policies of contemporary correctional institutions effectively ensure that very few older adults will leave prison in a better mental and physical state than when they entered.

Strain on Correctional Systems

Given the overwhelming prevalence of serious chronic medical problems among the aging prison population, correctional resources will be increasingly strained by the weight of such staggering need. If the current trend in the aging population continues, correctional systems will soon find themselves in unsustainable financial territory, resulting in cost-cutting measures that lead to overcrowding and compromise their ability to provide sufficient health care, as has been well-documented in California's prisons.³⁰ To be clear, the majority of correctional facilities strive to provide humane and appropriate care. That aging prisoners do not always have their needs met may not be borne of malicious intent, but it is nonetheless indicative of the systemic shortcomings woven into the fabric of correctional structures. Prisons were simply not *designed* to be long-term care facilities, as there are architectural limitations that pose significant problems to the aging population: stairs, narrow doorways, wheelchair inaccessibility, and the lack of handrails are just a few ways in which prisons are structurally unequipped to deal with the needs of this population. Cafeterias, medical units, and other necessary facilities may be spread far apart within a prison, making daily life difficult for individuals with mobility impairment. Aging individuals may also require additional time to eat meals or struggle getting to and from their bed, especially on a top bunk. Geriatric incontinence and other physiological difficulties unique to old age can be extremely difficult to handle with dignity in an environment lacking privacy, leading to harassment and feelings of shame, isolation, and depression.³¹ The possibility of adequately retrofitting prisons or constructing new age-appropriate facilities is, once again, restricted by budget limitations. When prisons cannot adequately make concessions to address these needs, it is the aging prisoners themselves who suffer.

Social Costs and Public Safety

While the most palpable consequences of incarceration affect the individual at the psychophysical (body and mind) level, they also ripple outward to affect individuals, families, communities, and social structures in ways that are less immediately tangible. Rampant incarceration gives rise to disrupted, fragmented communities, and the continued imprisonment

of elders (who are often parents or grandparents) bears a significant intergenerational impact on children and families not easily quantifiable. There is also a clear loss of economic productivity and family stability that stems from incarceration: approximately two in three imprisoned men were the main earners for the households prior to their incarceration and are likely to have difficulty securing employment upon release due to their criminal history. Those who *are* able to find work will find their annual earnings reduced by an average of 40 percent as a result of their having served time.³²

The stated objectives of incarceration would suggest that correctional spending should be allocated among demographics in proportion to their public safety risk and potential for behavioral change. The majority of existing research suggests that length of time served has no clear relationship to recidivism rates³³—rather, it is *age* that serves as an accurate predictor of recidivism. Despite the staggering costs of incarcerating the elderly—which far exceed any other correctional population—aging adults in prison have the *lowest* recidivism rate and pose almost no threat to public safety.³⁴ Nationwide, 43.3 percent of all released individuals recidivate within three years, while only 7 percent of those aged 50-64 and 4 percent of those over 65 are returned to prison for new convictions—the lowest rates among all incarcerated demographics.^{35 36} Similarly, arrest rates among older adults decline to a mere 2 percent by age 50 and are close to zero percent by age 65.³⁷

The Roots of the Crisis

Far from an inexplicable anomaly, the soaring aging prison population is the logical consequence of longstanding rigid sentencing laws and release policies. In 1973, New York Governor Nelson Rockefeller proposed strict sentencing guidelines that came to be known as the Rockefeller Drug Laws. This “tough-on-crime” approach became a national movement, and by the 1980s the Federal Government and many states had adopted mandatory minimum sentence policies including so-called three-strikes laws. The ensuing tough-on-crime culture that permeated the 1980s has had disastrous consequences for the social fabric of America. While some aging individuals are so-called “nonviolent drug offenders” sentenced under these harsher laws, many of the elders who have spent decades in prison were incarcerated for violent offenses bearing lengthy sentences. Regardless, the effects of stringent mandatory minimum and three strikes laws on the front end of the criminal justice continuum are further compounded by limited parole opportunities, underuse of compassionate early release, and truth-in-sentencing laws. This overall increase in sentencing length combined with decreasing rates of release on discretionary parole has created a bottleneck in the criminal justice system, leading to a far greater number of people serving longer, less flexible prison sentences, with little national consensus on how best to address overcrowded facilities and accumulating costs.

What we are left with, then, is a system that continues to funnel large numbers of people into a traumatic prison environment against the evidence that alternative sanctions are more successful in reducing crime and recidivism. By locking individuals into lengthy mandatory sentences with limited avenues for earlier release, we all but ensure that they will grow old in prison. As a result, we are forced to spend billions on incarcerating the aging, elderly, incapacitated, immobile, and infirm in spite of their mounting physical, mental, and social needs and minimal risk to public safety.

Our current national trajectory is economically infeasible and morally untenable: we must consider alternatives that will curb exorbitant economic costs, improve healthcare access and quality, mitigate elder trauma and abuse, and reestablish a precedent for a more humane justice, sensitive to the unique needs of aging prisoners. Fortunately, there are a growing number of programs and organizations that seek to 1) improve conditions for older adults inside correctional facilities; 2) advocate for the increased release of suitable low-risk aging individuals; and 3) connect these individuals to quality community programming upon their release. The following section examines these emerging models so as to provide a road map for further successes, beginning with the work being done within prison walls.

From the Inside Out: Meeting the Needs of the Aging within Prisons

As of 2007, less than 5 percent of state correctional institutions in the U.S. provided any form of geriatric-specific services, and there are currently few evidence-based models targeting aging individuals within correctional facilities.³⁸ This dearth of quality programming can be attributed not only to a lack of funding but a lack of institutional understanding of the needs of older adults in prison. Nonetheless, there is valuable work being undertaken throughout the country to address the myriad issues impacting the aging prison population. Selections from the field are summarized below.

- **Ohio's Hocking Correctional Facility**, in collaboration with the Area Agency on Aging 8, has implemented chronic disease self-management and diabetes self-management programs at the facility. Created at Stanford University, these six-week peer-led programs are grounded in empirical research and have had positive outcomes.³⁹ Similar programs have also been implemented in New Jersey and Oklahoma.
- **Nevada's** volunteer-driven **True Grit** program provides a daily structured living program intended to address the physical, mental, spiritual, and emotional needs and well-being of the elderly in prison. Activities and services include physical therapy and recreation, group and individual counseling, therapy dogs, musical groups, choir, theater, a published journal, and craft-making designed to slow the onset of osteoarthritis through fine-touch movements.^{40,41} An evaluation of True Grit shows that the program has decreased the number of doctor visits and medications used by the elderly while also enhancing levels of social support and well-being.⁴²
- **Virginia's Deerfield Correctional Center** provides assisted living services and programming, including peer tutoring, horticulture, and a library that offers assistance for blind and visually impaired individuals.⁴³
- Incarcerated individuals at **California's Men's Colony** can become "Gold Coats", individuals trained by the Alzheimer's Association to care for the daily needs of fellow prisoners living with dementia and to recognize and report on changes in their behavior.⁴⁴
- **Angola State Prison's** hospice program, which trains prison staff and incarcerated volunteers to care for those dying behind prison walls in accordance with national standards for community hospice programs.⁴⁵ The prison's partnership with University Hospital

Community Hospice in New Orleans allows these services to be provided at no additional cost. Similar hospice services are provided in at least 75 other prisons in 40 states.⁴⁶

- New York’s Unit for the Cognitively Impaired, located at **Fishkill Correctional Facility**, utilizes professional caregivers to provide services to incarcerated individuals living with dementia. The average cost per bed in the Regional Medical Unit (RMU) is \$93,000 – more than double the \$41,000 per bed in the general prison population.⁴⁷

While this list is far from exhaustive and some programs do not yet live up to their promise, it represents a variety of engaging services that have considerable potential to meet the unique needs of this population and to improve quality of life for elders behind prison walls. What these programs do not address, however, is the possibility of allowing aging men and women to live the remainder of their lives in the community.

The Question of Parole

Once an individual has received a sentence that will potentially keep him or her incarcerated into old age (or is imposed after someone has reached old age), there are only two possibilities of returning home: parole and compassionate release. Both mechanisms are handled by the same body, the Parole Board, but evaluate different factors. Whereas parole is primarily concerned with the nature of the crime and an individual’s behavior and remorse while incarcerated, compassionate release most typically considers the health needs of the incarcerated in the case of terminal illness or severe medical issues. Compassionate release can also be applied—however rarely—in the event of the death or incapacitation of a caregiver providing for a prisoner’s family member. While compassionate release laws are on the books federally and in 36 states, they are rarely used. The following excerpt sheds light on a real-life scenario in which the release of an elderly individual was ultimately denied:

In 2013, an 86-year-old man, having served 40 years for felonies committed in the 1970s—crimes that were serious but caused no deaths—comes before the parole board. He is mostly confined to a wheelchair, suffers from a serious neuromuscular disorder, asthma, high blood pressure, cancer and other ailments. Prison officials call him a reliable peacemaker and protector of the vulnerable. He has a place to live and people to support him, should he be released.

The decision? Denied. The reason? The supposed “probability” that he would re-offend and the notion that his release would “undermine respect for the law.” Today, he remains behind bars in the medical wing of an upstate prison.⁴⁸

In other cases, the effects of dementia become so pronounced that individuals have difficulty remembering why they are incarcerated to begin with even as they appear before the Parole Board.⁴⁹ Unfortunately, these situations are all too commonplace in today’s criminal justice system. Medical parole requests and compassionate release are seldom granted, though national data on the number of requests and denials is not readily available. This underuse of existing release mechanisms for the aging can be attributed to narrow and exclusionary criteria, political calculation and bureaucratic procedures that stifle wider implementation.⁵⁰⁵¹⁵² Eligibility for compassionate release is often limited to those over a certain age or convicted of certain offenses, leaving vast numbers of individuals in the prison population—including those convicted of a violent crime—completely shut out from the possibility of release regardless of

their health status or achievements during incarceration. Those eligible are likely to encounter bureaucratic procedures that can slow down the process considerably, to the point of rendering release moot altogether. Of the 2,730 requests for compassionate release in New York State filed from 1992 to April 2012, only 381 were granted release; 950 individuals died prior to release while their applications were pending.⁵³ In a recent high profile case, Herman Wallace, one of the ‘Angola Three’ who spent 41 years in solitary confinement following his conviction in the 1972 killing of a prison guard, was released from prison on October 1, 2013 due to his ailing health and advanced liver cancer; he died less than three days later.⁵⁴

Compassionate release notwithstanding, the broader parole apparatus is remarkably nebulous. Members of the Parole Board are not elected but appointed by state governors, and there is no clear system of checks and balances to ensure a fair appraisal of parole applications. Incarcerated individuals may put in tremendous effort to transform their lives by completing programming, earning advanced degrees, and becoming assets to society, only to see their application denied solely on the basis of “the nature of the crime” —the lone factor that can never be changed and speaks only to past circumstances rather than who a person *has become*. Additionally, Parole Boards are understandably sensitive to public perception and acutely aware of the public scrutiny and outrage that can follow the parole of an individual involved in a high profile case. Without transparency and accountability, it becomes much easier to summarily dismiss eligible applicants than to risk the perception of culpability in the event of a new crime post-release. This reluctance, however understandable, ultimately results in the continued incarceration of large numbers of low-risk aging individuals who have transformed their lives, yet remain imprisoned without clear purpose or benefit.

Though these flaws in the parole system can feel insurmountable, efforts are underway to change the parole process, and the charge is being led from the inside out by individuals who have directly experienced and navigated the system. Recognizing that any shift in parole policy is predicated on a deeper cultural change, Mujahid Farid founded the Release of Aging People in Prison (RAPP) campaign in 2011 after serving 33 years in New York State prison. At its core, RAPP aims to mobilize “currently and formerly incarcerated individuals, their families, and other concerned community members in efforts designed to increase parole release rates for aging people in prison who pose no risk to public safety.”⁵⁵ Working in partnership with a diverse network of individuals, advocates, communities, faith-based groups, and nonprofit organizations across New York, RAPP raises public awareness around the aging prison population and encourages the increased use of release mechanisms for low-risk individuals who have already served much of their sentence. By educating policymakers, correctional officials and the broader public through research and advocacy, RAPP aims to generate the momentum necessary to spark humane parole reform through improved accountability, expanded eligibility and increased utilization of existing release mechanisms. Although focused exclusively on policies and practices within New York State, RAPP represents a grassroots strategy of coalition building that can be replicated across the country.

Others use even more direct measures to address the shortcomings of the parole process. Founded in 1989 at Tulane Law School and now operating in five states, the Project for Older Prisoners (POPS) employs a risk assessment approach to help older incarcerated adults obtain paroles, pardons, and other alternatives to incarceration.⁵⁶ Law student volunteers assess recidivism risk among eligible individuals aged 55 or older by conducting interviews to collect

data, and then work with those candidates identified as low risk to prepare them for their parole hearing and may advocate the case before the Parole Board. Beyond RAPP and POPS, other organizations such as Families Against Mandatory Minimums and the Sentencing Project are engaged in similar issues affecting aging people in prison, although their work is not exclusively focused on this population.

Support for releasing aging prisoners does not only come from academics and advocates: in Michigan, a group of 27 former Department of Corrections officials (including directors, parole board chairs, and wardens) have stepped forward to call for statewide parole reform.⁵⁷ Noting how the correctional regard for those serving life sentences has significantly shifted in a way that provides little opportunity for parole-eligible individuals to earn their freedom, the group states that the “current parole process does not encourage the board to get to know individual lifers well” and accordingly calls for a swift, fair and comprehensive evaluation of every parole-eligible individual serving a life sentence. “Taxpayers are paying roughly \$200,000 for every decision to continue a lifer’s incarceration for another five years,” the group’s February 2014 letter reads, “and they are often getting virtually no increased safety for their money.”

The Reentry Experience

The transition from correctional facility to the community affects not only those elders returning home but on public health more broadly, making it all the more necessary to identify and address the particular needs of this population.^{58 59} While the reentry experience for aging individuals poses similar challenges as that of any other person returning home from prison, elders face additional obstacles and heightened complexities including greater rates of homelessness, low employment, increased anxiety, fragmented community and family ties, chronic medical conditions, and increased mortality rates.^{60 61 62 63 64}

Upon release, returning individuals may not know how to reinstate their benefits and often experience a delay lasting months before their coverage is finally renewed.⁶⁵ This can exacerbate existing health conditions and increase the reliance on expensive and inefficient emergency services as a substitute for primary care: a 2008 Urban Institute study found that one-third of returning individuals used emergency services within the first year of release.⁶⁶ Additionally, the limited supply of medication provided upon release by state correctional departments is likely to run out prior to scheduling an initial healthcare visit.⁶⁷ Older adults with cognitive impairment or mental illness, which comprise a large and underreported segment of this population, are likely to experience even greater difficulty transitioning to the community.

The stigma of incarceration coupled with limited work histories can stifle employment prospects for *any* returning individual, let alone the aging population, when the physical and mental health infirmities of old age can turn even the mundane activities of daily life into significant challenges. Furthermore, benefits such as Social Security and Supplemental Security Income are suspended during incarceration and compensation for work in prison is staggeringly low. As a result, opportunities to build a meaningful financial cushion to help prepare for reentry are all but nonexistent. Many who have been in prison since their young adulthood may not have paid into the Social Security system long enough to be eligible for Social Security or Medicare upon

release, and unbelievably, even those who have Medicare are not able to receive care under the program as long as they are under parole supervision.⁶⁸

Social connectedness and community stability pose considerable challenges as well, particularly in terms of securing long-term geriatric-appropriate housing. Aging individuals may no longer have a family or community network to return home to – and even if they do, there is no guarantee that families are equipped or willing to handle the staggering medical expenses and high level of care required for chronic health conditions.⁶⁹ Aging individuals with criminal records are often discriminated against or stigmatized by nursing homes and hospice care, leaving them with few options and woefully unmet needs. These issues are best articulated by an aging prisoner facing the prospect of release:

“[Y]ou have a lot of men over 50 getting ready to go home, with no money. No place to stay. And no one trying to understand this part of the problem. I earn \$15 a month. I go home in 9 months. I have no family to turn to. I don’t want to come back to prison, after doing 7 years. I am trying to stay positive.... But the reality is, when I hit the street I am on my own.”⁷⁰

Such sobering reflection highlights the necessity for meaningful action. But while geriatric models of care within correctional facilities are beginning to garner greater attention, there are few models of care for formerly incarcerated elderly individuals living in the community. Large gaps in knowledge regarding the health and healthcare needs for this population persist,⁷¹ and the existing evidence has not been effectively communicated to community healthcare providers. Although the current landscape of existing community-based models and services is nascent, there are several viable possibilities worthy of consideration:

- Based in San Francisco, the **Senior Ex-Offender Program (SEOP)** is the first reentry program in the U.S. that exclusively focuses on the aging population. SEOP’s wraparound services include transitional housing, case management, pre- and post-release counseling, transitional support groups, health and mental health services, access to a certified addiction specialist, and useful provisions such as clothing and hygiene products.⁷² Participants engage in services for an average of 3 to 12 months.⁷³
- In addition to robust in-prison services for aging people, Ohio’s **Hocking Correctional Facility** has a one-stop pre-release program providing older individuals with age-appropriate information on housing, employment training and job searching skills, self-care, available benefits and educational opportunities. HCF trains staff in managing the unique issues affecting geriatric populations and strives to ensure that returning individuals have the proper supports and resources available for successful reintegration, including placement in nursing homes when necessary.⁷⁴
- At Colorado’s Sterling Correctional Facility, the Long-Term Offender Program (LTOP) was created in 2011 to assist parole-eligible individuals serving long sentences to transition to the community through structured programming grounded in peer support and restorative justice.⁷⁵ While in prison, elders who have demonstrated significant transformation while incarcerated are screened and enrolled in a course designed to acclimate them to the new realities of the outside world, including how to use an ATM, learn computer skills, and find a job.⁷⁶ Successful candidates are then released to a

halfway house, where they are supported by counselors and meet weekly with their peers to support each other in the reentry process. Thus far, all 32 LTOP participants have found work and housing, with only a single minor misdemeanor incident since the program's inception.

- Created in 2009, the **Transitions Clinic** at Montefiore Medical Center in the Bronx provides access to comprehensive primary care, HIV care, mental health treatment, and addiction treatment services for individuals recently released from correctional facilities. The clinic is operated by professional staff who understand the unique circumstances of the reentry process, helping to assuage patient uneasiness and establish a comfortable doctor-patient relationship.
- In Connecticut, some of the aging prison population is transferred to **Rocky Hill Nursing Home**, a privately-run facility. However, the ambiguity of this public-private partnership resulted in lawsuits over whether residents are technically defined as “incarcerated,” a status that makes them ineligible for Medicaid or Medicare under existing laws.⁷⁷ Ultimately, these elders were designated as “residents” rather than “prisoners”, thus transferring the cost of care from corrections to Medicaid.⁷⁸

While State and Federal programming does not expressly target or meet the wide range of needs of this population, many formerly incarcerated aging men and women can benefit from government programs. There are several types of **adult care facilities** in New York State that provide transitional and permanent residential care to adults unable to independently care for themselves due to physical and mental impairment/disability or other age-related limitations.^{79,80} Aging New Yorkers returning from prison may also qualify for temporary cash assistance benefits such as Safety Net Assistance (SNA).⁸¹ Additionally, changes to national healthcare through the Affordable Care Act enable incarcerated people in participating states to reestablish benefits such as Medicaid prior to release to help ensure a more seamless transition home. Furthermore, medical services that cannot be delivered within prisons and require off-site travel are now covered by Medicaid in much of the country.⁸² It will, however, take some time to fully realize how the Affordable Care Act affects the criminal justice system.

The Work To Be Done

The issue of aging people in prison can be interpreted through several distinct lenses, whether as a matter of economic urgency, a public health crisis, a violation of human rights, or a reflection of the critical shortcomings of our criminal justice system. Accordingly, any serious and sustainable attempt to resolve this crisis requires a multifaceted approach and cross-disciplinary discussion among practitioners of gerontology, criminal justice, health, and philanthropy. In order to provide a launching point for further dialogue and action, we have identified the following recommendations:

Within Correctional Facilities

Protocols, Rules & Regulations

- Design and implement geriatric assessment care plans within correctional settings that will evaluate the needs of elders prior to their release and connect them to appropriate community-based service providers

- Define and universalize the age at which an incarcerated person is considered ‘aging’ and encourage correctional systems to recognize this population as a unique sub-group with specialized needs⁸³
- Adapt and enforce the *Standard Minimum Rules for the Treatment of Prisoners*⁸⁴ to preserve the dignity and human rights of incarcerated men and women
- Improve screening protocols for aging prisoners to better understand individual health needs during incarceration
- Develop and integrate models and best practices for aging prisoner care into the National Commission on Correctional Health Care standards⁸⁵

Research & Modification

- Modify structural conditions within correctional institutions through age-appropriate retrofitting⁸⁶ and conduct additional research into architectural modifications that may produce positive outcomes for aging individuals⁸⁷
- Identify activities of daily living that are prison-specific in order to recognize functional impairment among the population⁸⁸
- Research the benefits of segregating versus integrating aging prisoners from the general prison population to help develop effective and appropriate correctional housing models⁸⁹
- Test and measure interventions that decrease medical costs while maintaining healthcare quality, incorporating existing gerontological models⁹⁰

Staff Enhancement

- Train correctional staff in geriatric care techniques and empower them with the knowledge to respond to the physical, mental, and gender-specific needs of the aging population⁹¹
- Incorporate ongoing feedback from correctional officers, medical staff, and other on-site providers⁹²

Program Development

- Introduce support groups and geriatric counseling for stress and trauma⁹³
- Greatly increase the availability of programming tailored to elders
- Continue to explore the feasibility of linking with private sector to provide care and assisted living services

Release Mechanisms

- Implement parole reforms such as the Safe and Fair Evaluation (SAFE) Parole Act proposed in New York to eliminate the continued reliance on the nature of the original crime as a basis for perpetual parole denial upon completion of the minimum sentence
- Improve and enforce accountability and transparency of the Parole Board
- Increase utilization of compassionate release and medical parole policies
- Implement geriatric release policies

Post-Release Services

- Ensure continuity of care through specialized transitional planning and follow up for the aging population, including connection to health insurance and care coordinators⁹⁴

- Conduct further research to identify the needs and concerns of the aging reentry population and the communities to which they will return
- Develop infrastructure within communities to receive and care for returning individuals, including enhancing the capacity of senior centers and elder services to effectively serve formerly incarcerated elders

While no single recommendation will serve as panacea to the challenges facing the aging prison population, a shift to embrace *any* of the above recommendations will help move the needle toward a more compassionate, fair, and humane justice system. And with support from key stakeholders, many of these recommendations can be piloted or even fully implemented within a realistic timeframe. Developing a comprehensive evaluation of elders prior to their release, for example, does not require the creation of new assessment tools. Similar care plans are already used within the geriatric field and need only be *adapted* to a correctional setting. Such an approach is not without precedent: during the AIDS epidemic, corrections effectively responded to the crisis through implementation of the M11q form, which fast-tracked individuals in need of services to community providers upon their release.

Toward a New Paradigm of Punishment

Decades in the making, the aging prison population is the logical conclusion of misinformed and retributive criminal justice policies that have led the United States to incarcerate more people than any country in the world. These well-entrenched policies—the result of a confluence of attitudes, ideas, and events, and grounded in the now-bankrupt “tough on crime” ideology of overly aggressive sentencing—have brought us to the precipice of an unmitigated human-made disaster. The crisis inherent to aging in America’s prisons serves as a microcosm for the broader issues at stake, highlighting the urgency of repealing mandatory minimum, truth-in-sentencing, and habitual offender laws and demonstrating the need to reallocate correctional spending from prolonged and impractical incarceration towards diversion, community-based sanctions and services, and community supervision. These developments afford us an opportunity to reflect on longstanding paradigms of punishment.

The traditional criminal justice framework of the United States holds that punishment serves four distinct functions: retribution, deterrence, rehabilitation, and incapacitation. As reports from the ACLU and Human Rights Watch have made clear, the perpetual incarceration of aging men and women does not justifiably fulfill these purposes. **Retribution**—ensuring that the punishment fits the crime—is glaringly undermined by the fact that many individuals have already served more than their minimum sentences and perhaps more than the sentencing judge would have imposed were it not for stringent mandatory minimum guidelines. The use of long sentences as effective **deterrence** is undermined by research showing that long sentences do little, if anything, to deter crime.⁹⁵ Furthermore, an aging prisoner suffering from dementia and chronic illness who cannot recall his or her crime has little to gain from **rehabilitative programming**. Finally, the physical and mental impairments and deteriorating health that accompany old age (accelerated by the years spent in prison) essentially function as a debilitating force, rendering further **incapacitation** via continued incarceration unnecessary and inhumane.

In grappling with the ideological underpinnings of the criminal justice system, we are forced to ask ourselves: what is the *intention* behind incarceration? If the point of the criminal justice

system is public safety and the point of incarceration is retribution, deterrence, rehabilitation, and incapacitation, we gain little by keeping the elderly and infirm behind bars. There may be situations in which there are no alternatives to incarceration that achieve the public purpose but we must look to prison as a last resort when less expensive and more effective dispositions are not deemed appropriate. By analyzing the aging prisoner dilemma through the traditional criminal justice framework, it becomes clear that keeping aging, low-risk individuals incarcerated neither satisfies any of the aforementioned purposes nor serves the public good. Instead, it results in unsustainable economic, social, ethical, and health costs and causes unnecessary human suffering.

Fortunately, changes may be on the horizon. The Obama administration and Attorney General Eric Holder appear to be quite cognizant of the shortcomings of existing criminal justice policy and have repeatedly argued for significant reform. We have begun to feel the rumblings of change: in August 2013, the Federal Bureau of Prisons considerably revised its position on compassionate release mechanisms in three distinct ways. First, BOP extended the period to seek compassionate release in anticipation of an incarcerated person's death from 12 months to 18 months. They then solidified criteria to allow for the possibility of release in the event of the death or incapacitation of a caregiver responsible for a family member (a policy already in existence but yet to be utilized). And finally—in a wholly unprecedented change—BOP now permits individuals age 65 and over with chronic or serious medical conditions who have served at least half of their sentence to apply for early release. Individuals who meet the age requirement but do not suffer from such medical conditions can also apply, provided they have served at least 10 years or 75 percent of their sentence.⁹⁶ While these policy shifts could signify a truly meaningful step towards substantive reform, the mere existence of improved policies on the books does little good if they are seldom utilized, as has been the case to date. Nonetheless, if such promises of systemic reform are kept—and it is our collective duty to ensure that they will be—we may be entering an era of reform that could both stem the flow of entrants into the U.S. criminal justice system and mitigate the aging prisoner crisis.

The abundance of evidence is clear: aging people in prison experience greater hardships and worse health outcomes while incarcerated, have unique needs that place enormous strain on correctional institutions, and comprise the *most expensive* cohort to incarcerate while posing the *least danger* to public safety. Taken together, these factors have culminated in a financially unsustainable and morally precarious—if not wholly untenable—crisis that can no longer be ignored. While architectural and programmatic modifications within prisons are necessary components to meaningful change, merely making living conditions more amenable to the needs of the infirm and frail does not address the full range of problems affecting those aging in prison. At the same time, releasing people en masse without a comprehensive plan for their reentry will simply create a new humanitarian crisis and will not resolve the underlying issues within the prison system.

The interconnected complexity of the aging prisoner crisis demands a strategic response that is versatile and multifaceted, and that seeks to address the issue at multiple points of intervention with involvement from all stakeholders. The fields of gerontology, philanthropy, health, and corrections are uniquely positioned and qualified collectively to inform and implement both short- and long-term solutions to this issue. Armed with critical interdisciplinary knowledge and backed by investment from the philanthropic community, such a collaborative partnership

possesses unparalleled opportunity to make lasting contributions to the policies and best practices affecting the aging prison population.

This joint stakeholder alliance is particularly well-suited to enrich the reentry process, first by identifying those factors that formerly incarcerated elders need to thrive upon their release to the community and subsequently creating resources and pathways for success. Such an approach would not only yield tremendous cost savings, improved public health outcomes, and economic growth, but would also embody a commitment to human rights—including the freedom for our elders to live the remainder of their lives within their communities and to die with grace in the presence of friends and family.

Ultimately, any systemic and sustained change around this issue is contingent upon our collective willingness to deal with the looming challenge of a graying prison population in rational, direct, and effective ways that reduce costs and improves lives while recognizing the inherent dignity and worth of all people.

About the Osborne Association

The Osborne Association offers opportunities for individuals who have been in conflict with the law to transform their lives through innovative, effective, and replicable programs that serve the community by reducing crime and its human and economic costs. We offer opportunities for reform and rehabilitation through public education, advocacy, and alternatives to incarceration that respect the dignity of people and honor their capacity to change. Osborne serves more than 8,000 currently and formerly incarcerated individuals and their families across several sites throughout the state, including the Bronx, Brooklyn, Poughkeepsie, Rikers Island, and in 20 state correctional facilities.

www.osborneny.org / info@osborneny.org

ENDNOTES

¹ Chettiar, I., Bunting, W. & Schotter, G. (2012). At America's Expense: The Mass Incarceration of the Elderly. *American Civil Liberties Union*. Available at: <http://www.aclu.org/criminal-law-reform/americas-expense-mass-incarceration-elderly>.

² Human Rights Watch. (2012). *Old Behind Bars: The Aging Prison Population in the United States*. Available at: http://www.hrw.org/sites/default/files/reports/usprisons0112webwcover_0_0.pdf

³ American Correctional Association. (2010). *Adult inmate population by gender and age on September 30, 2009*. 2010 Directory of Juvenile and Adult Correctional Departments, Institutions, Agencies and Paroling Authorities. Laurel, MD: American Correctional Association.

⁴ American Correctional Association. (1995). *Prisoner Population Over Age 55 by Jurisdiction, as of June 30, 1990, 1992, and 1994*. 1995 Directory of Juvenile and Adult Correctional Departments, Institutions, Agencies and Paroling Authorities. Laurel, MD: American Correctional Association.

⁵ Maschi, T (2012). *Aging in the Criminal Justice System Webinar: Part I*. National Organization of Forensic Social Work. Retrieved from <http://nofsw.org/wp-content/uploads/2012/09/PDF-FOR-WEB-NOFSW-Aging-CJ-WEBINAR-PART-1-9-24-12-FINAL-5.pdf>

⁶ Chettiar et al., 2012.

⁷ Chettiar et al., 2012.

⁸ Schaenman, P. et al. (2013). Opportunities for Cost Savings in Corrections Without Sacrificing Service Quality: Inmate Health Care. *The Urban Institute*. Available at: <http://www.urban.org/UploadedPDF/412754-Inmate-Health-Care.pdf>

-
- ⁹ Linder, J and Meyers, F. (2009). Palliative and End-of-Life Care in Correctional Settings. *Journal of Social Work in End-of-Life & Palliative Care*, 5, 7-33.
- ¹⁰ Aday R. (2003). *Aging Prisoners: Crisis in American Corrections*. Westport, CT: Praeger Publishers.
- ¹¹ Binswanger, I., Krueger, P. & Steiner, J. (2009). Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of Epidemiology and Community Health*, 63, 912-919.
- ¹² Brown, Michelle. (2012). Empathy and Punishment. *Punishment & Society*, 14(4), 383-401.
- ¹³ Dawes, J. (2009). Ageing prisoners: Issues for social work. *Australian Social Work*, 62, 258 – 271.
- ¹⁴ Chettiar et al., 2012.
- ¹⁵ Aday, 2003.
- ¹⁶ Jaye Anno, B. et al (2004). Correctional Health Care: Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates. *U.S. Department of Justice National Institute of Corrections*. Accessible at <http://static.nicic.gov/Library/018735.pdf>.
- ¹⁷ Reimer, G. (2008). The graying of the U.S. prisoner population. *Journal of Correctional Health Care*, 14, 202–208.
- ¹⁸ Caverly S. (2006). Older mentally ill inmates: A descriptive study. *Journal of Correctional Health Care*, 12, 262–268.
- ¹⁹ Williams, B., Baillargeon, J., Lindquist, K. et al. (2009). Medication prescribing practices for older prisoners in the Texas prison system. *American Journal of Public Health*, 100, 756–761.
- ²⁰ Koenig, H.G., Johnson, S., Bellard, J., Denker, M., & Fenlon, R. (1995). Depression and anxiety disorder among older male inmates at a federal correctional facility. *Psychiatr Services*, 46, 399–401.
- ²¹ Krause, N. (2004). Lifetime trauma, emotional support, and life satisfaction among older adults. *The Gerontologist*, 44, 615–623.
- ²² Loeb, S.J., Abudagga, A. (2006). Health-related research on older inmates: An integrative review. *Research in Nursing & Health*, 29, 556–565.
- ²³ Freudenberg, N. (2001). Jails, prisons, and the health of urban populations: A review of the impact of the correctional system on community health. *Journal of Urban Health*, 78, 214–235.
- ²⁴ James, D. & Glaze, L. (2006). *Mental health problems of prison and jail inmates* (NCJ Publication No. 213600). Rockville, MD: U.S. Department of Justice.
- ²⁵ Williams, B., Baillargeon, J., Lindquist, K. et al., 2009.
- ²⁶ Haney, C. (2001). *The psychological impact of incarceration: implications for post-prison adjustment*. Prepared for the “From Prison to Home” Conference (January 30-31, 2002). Accessible at: http://www.urban.org/UploadedPDF/410624_PsychologicalImpact.pdf.
- ²⁷ Dawes, J., 2009.
- ²⁸ Wilson, J., & Barboza, S. (2010). The looming challenge of dementia in prisons. *Correct Care*, 24(2), 10–13. Accessible at http://www.ncchc.org/filebin/images/Website_PDFs/24-2.pdf.
- ²⁹ Fazel, S., McMillan, J., & O'Donnell, I. (2002). Dementia in prison: Ethical and legal implications. *Journal of Medical Ethics*, 28,156–159.
- ³⁰ See *Brown v. Plata*, United States Supreme Court, 131 S. Ct 1910 (2011).
- ³¹ Williams, B. and Abraldes, R. (2007). Growing Older: Challenges of Prison and Reentry for the Aging Population. In Greifinger, R. (Ed.), *Public Health Behind Bars* (56-72). New York, NY: Springer.
- ³² Pew Charitable Trusts. (2010). *Collateral costs: Incarceration's effect on economic mobility*. Washington, DC: The Pew Charitable Trusts.
- ³³ See footnote 219 in Human Rights Watch, 2012. Refer also to Kuziemko, I. (2007). "Going Off Parole: How the Elimination of Discretionary Prison Release Affects the Social Cost of Crime." National Bureau of Economic Research Working Paper Series. Available at <http://www.nber.org/papers/w13380.pdf>.
- ³⁴ Snyder, C., van Wormer, K., Chada, J., & Jagggers, J. (2009). Older adult inmates: The challenges for social work. *Social Work*, 54, 117–124.
- ³⁵ Pew Center on the States. (2011). *State of Recidivism: The Revolving Door of America's Prisons*. Washington, DC: The Pew Charitable Trusts.
- ³⁶ Chettiar et al., 2012.
- ³⁷ Ibid.
- ³⁸ Thivierge-Rikard, V., & Thompson, M. S. (2007). The association between aging inmate housing management models and non-geriatric health services in state correctional institutions. *Journal of Aging and Social Policy*, 19, 39–56.

-
- ³⁹ AAA8 Partners with Hocking Correctional Facility to Offer Disease Management Programs. (2012, February 7). *Area Agency on Aging* 8. Retrieved July 9, 2013 from <http://www.areaagency8.org/about/news/aaa8-partners-with-hocking-correctional-facility-to-offer-disease-management-programs>.
- ⁴⁰ Harrison, M. (2006). True Grit: An Innovative Program For Elderly Inmates. *Corrections Today*, 68(7), 46-49.
- ⁴¹ Harrison, M. and Benedetti, J. (2009). Comprehensive Geriatric Programs in a Time of Shrinking Resources: “True Grit” Revisited. *Corrections Today*, 71(5), 44-47.
- ⁴² Harrison, 2006.
- ⁴³ McCarthy, K. (2013). State Initiatives to Address Aging Prisoners. *Connecticut General Assembly Office of Legislative Research*, 2013-R-0166. Retrieved July 9, 2013 from www.cga.ct.gov/2013/rpt/2013-R-0166.htm.
- ⁴⁴ Belluck, P. (2012, February 25). Life, With Dementia. *New York Times*. Retrieved July 9, 2013 at <http://www.nytimes.com/2012/02/26/health/dealing-with-dementia-among-aging-criminals.html>.
- ⁴⁵ Chang, C. (2012, May 15). Angola inmates are taught life skills, then spend their lives behind bars. *The Times-Picayune*. Retrieved July 30, 2013 from http://www.nola.com/crime/index.ssf/2012/05/angola_inmates_are_taught_life.html.
- ⁴⁶ McCarthy, 2013.
- ⁴⁷ Ibid.
- ⁴⁸ Release of Aging People in Prison. (n.d.) Threat to Public Safety or Abuse of Human Rights? *Nation Inside*. Retrieved from <http://nationinside.org/campaign/release-of-aging-people-in-prison/facts/>.
- ⁴⁹ Belluck, 2012.
- ⁵⁰ Chiu, T. (2010). It’s About Time: Aging Prisoners, Increasing Costs, and Geriatric Release. *Vera Institute of Justice*. Available at <http://www.vera.org/sites/default/files/resources/downloads/Its-about-time-aging-prisoners-increasing-costs-and-geriatric-release.pdf>.
- ⁵¹ Chettiar et al., 2012.
- ⁵² Maschi, T., Viola, D. & Sun, F. (2012). The High Cost of the International Aging Prisoner Crisis: Well-Being as the Common Denominator for Action. *The Gerontologist*, Oct 4 2012, 1-12.
- ⁵³ Quail, E. (2013, August 6). Prisons Get Grayer, But Efforts to Release the Dying Lag. *City Limits*. Retrieved November 16, 2013 at <http://www.citylimits.org/news/articles/4871/prisons-get-grayer-but-efforts-to-release-the-dying-lag>.
- ⁵⁴ Schwartz, J. (2014, October 4). Herman Wallace, Freed After 41 Years in Solitary, Dies at 71. *New York Times*. Retrieved November 16, 2013 at <http://www.nytimes.com/2013/10/05/us/herman-wallace-held-41-years-in-solitary-dies-at-71.html>.
- ⁵⁵ Release of Aging People in Prison. (n.d.) Who We Are. *Nation Inside*. Retrieved from <http://nationinside.org/campaign/release-of-aging-people-in-prison/facts/>.
- ⁵⁶ Tulane University Law School. (n.d.) In the Public Interest: Pro Bono Programs. Retrieved from <http://www.law.tulane.edu/PublicInterest/index.aspx?id=12416>.
- ⁵⁷ Citizens Alliance on Prisons and Public Spending (2014, February). *Michigan Department of Corrections Professionals Comment on Lifer Paroles*. Retrieved from <http://www.capps-mi.org/wp-content/uploads/2014/02/rev-Michigan-Department-of-Corrections-Professionals-Comment-on-Lifer-Paroles.pdf>
- ⁵⁸ Williams, B., McGuire, J., Lindsay, R. et al. (2010). Coming home: Health status and homelessness risk of older pre-release prisoners. *Journal of General Internal Medicine*, 25, 1038–1044.
- ⁵⁹ Freudenberg, N. (2001) Jails, prisons, and the health of urban populations: A review of the impact of the correctional system on community health. *Journal of Urban Health*, 78, 214–235.
- ⁶⁰ Binswanger, I., Stern, M., Deyo, R. et al. (2007) Release from prison—a high risk of death for former inmates. *New England Journal of Medicine*, 356, 157–165.
- ⁶¹ Williams, B., McGuire, J., Lindsay, R. et al., 2010.
- ⁶² Crawley, E. & Sparks, R. (2006). Is there life after imprisonment? How elderly men talk about imprisonment and release. *Criminology and Criminal Justice*, 6(1), 63-82.
- ⁶³ Stojkovic, S. (2007). Elderly prisoners: A growing and forgotten group within correctional systems vulnerable to elder abuse. *Journal of Elder Abuse and Neglect*, 19, 97–117.
- ⁶⁴ Mesurier, N. (2011). *Supporting older people in prison: Ideas for practice*. United Kingdom: Age UK. Retrieved from http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Government-and-society/Older%20Prisoners%20Guide_pro.pdf?dtrk=true
- ⁶⁵ Wakeman, S.E., McKinney, M.E., & Rich, J.D. (2009). Filling the gap: The importance of Medicaid continuity for former inmates. *Journal of General Internal Medicine*, 24(7), 860-862.

-
- ⁶⁶ Mallik-Kane, K. & Visher, C. (2008). *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration*. Washington: Urban Institute.
- ⁶⁷ Alarid, L.F. (2013). *Community-Based Corrections* (10th ed.). Belmont, CA: Cengage Learning. 251.
- ⁶⁸ Refer to the Electronic Code of Federal Regulations, 42 CFR §411.4(b), “*Special conditions for services furnished to individuals in custody of penal authorities.*”
- ⁶⁹ Human Rights Watch, 2012.
- ⁷⁰ Maschi, T., Morrissey, M.B., Immarigeon, R., & Sutfin, S. (2012). *Aging Prisoners: A Crisis in Need of Intervention*. New York: Fordham University Be the Evidence Project, 13.
- ⁷¹ Ahalt, C., Binswanger, I., Steinman, M. et al. (2012). Confined to ignorance: The absence of prisoner information from nationally representative health data sets. *Journal of General Internal Medicine*, 27, 160–166.
- ⁷² Bayview Hunters Point Multipurpose Senior Services, Inc. (2009). Senior Ex-Offender Program. Retrieved from http://bhpmss.org/senior_ex-offender_program.
- ⁷³ Ellis, L. (2010, October 31). Ex-offender program for seniors provides new lease on life for many. *The Western Edition*. Retrieved from <http://www.thewesternedition.com/?c=117&a=1617>.
- ⁷⁴ Maschi, T., Viola, D. & Sun, F, 2012.
- ⁷⁵ Colorado Department of Corrections (n.d.). Long-Term Offender Program. Retrieved from <http://www.doc.state.co.us/long-term-offender-program>
- ⁷⁶ Sullivan, L. (2014, June 4). Life After 'Life': Aging Inmates Struggle For Redemption. *National Public Radio*. Retrieved from <http://www.npr.org/2014/06/04/317055077/life-after-life-aging-inmates-struggle-for-redemption>
- ⁷⁷ Drury, D. (2013, March 20). Fight Over Rocky Hill Nursing Home Hinging On Definition of 'Prisoner'. *The Courant*. Retrieved from http://articles.courant.com/2013-03-20/community/hc-rocky-hill-nursing-home-letter-20130320-1_1_nursing-home-doyle-and-guerrera-medicaid-services.
- ⁷⁸ Law, V. (2014, January 19). "If the Risk Is Low, Let Them Go": Efforts to Resolve the Growing Numbers of Aging Behind Bars. *Truthout*. Retrieved March 31, 2014 at www.truth-out.org/news/item/21120-if-the-risk-is-low-let-them-go-efforts-to-resolve-the-growing-numbers-of-aging-behind-bars
- ⁷⁹ New York State Office for the Aging. (2012). “Adult Home” in *Livable New York Resource Manual*, sec. III.1.r. Accessible at <http://www.aging.ny.gov/livableny/ResourceManual/Housing/III1r.pdf>.
- ⁸⁰ New York State Department of Health. (2013). Adult Care Facilities. Retrieved from http://www.health.ny.gov/facilities/adult_care/.
- ⁸¹ New York State Office of Temporary and Disability Assistance. (2014). Temporary Assistance. Retrieved from <http://otda.ny.gov/programs/temporary-assistance/>.
- ⁸² Vestal, C. (2013, June 25). Medicaid for prisoners: States missing out on millions. *USA Today*. Retrieved October 28, 2013 at <http://www.usatoday.com/story/news/nation/2013/06/25/stateline-medicaid-prisoners/2455201/>
- ⁸³ Policy Research Associates, 2012; Maschi, T., Viola, D. & Sun, F., 2012.
- ⁸⁴ United Nations. (1977). *Minimum standard rules for treatment of prisoners*. Retrieved February 18, 2014 from <http://www.ohchr.org/Documents/ProfessionalInterest/treatmentprisoners.pdf>. See also Maschi, Viola, & Sun, 2012.
- ⁸⁵ Williams, B. et al., 2012.
- ⁸⁶ Policy Research Associates. (August 2012). *Responding to the Needs of an Aging Prison Population*. Available at <http://gainscenter.samhsa.gov/cms-assets/documents/66624-251634.aging-in-correctional-custodyfinal.pdf>
- ⁸⁷ Williams, B. et al. (2012). Addressing the Aging Crisis in U.S. Criminal Justice Health Care. *American Geriatrics Society*, 60.6, 1150-1156.
- ⁸⁸ Williams, B., Lindquist, K., Sudore, R. et al. (2006). Being old and doing time: Functional impairment and adverse experiences of geriatric female prisoners. *Journal of the American Geriatrics Society*, 54, 702–707.
- ⁸⁹ Thivierge-Rikard, V., & Thompson, M. S. (2007). The association between aging inmate housing management models and non-geriatric health services in state correctional institutions. *Journal of Aging and Social Policy*, 19, 39–56.
- ⁹⁰ Williams, B. et al., 2012.
- ⁹¹ Policy Research Associates, 2012.
- ⁹² Williams, B., Lindquist, K., Hill, T. et al. (2009). Caregiving behind bars: Correctional officer reports of disability in geriatric prisoners. *Journal of the American Geriatrics Society*, 57, 1286–1292.
- ⁹³ Aday, 2003.
- ⁹⁴ See Williams & Abraldes, 2007; Aday, 2003; and Crawley & Sparks, 2006.
- ⁹⁵ See footnote 219 in Human Rights Watch, 2012.

⁹⁶ Federal Bureau of Prisons. (2013, August 12). *Program Statement: Compassionate Release/Reduction in Sentence: Procedures for Implementation of 18 U.S.C. §§ 3582(c)(1)(A) and 4205(g)*. U.S. Department of Justice. Retrieved August 15, 2013 at http://www.bop.gov/policy/progstat/5050_049.pdf