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Editorial

Aging Inmates: Issues Surrounding Health Care, End-of-Life and Dying in Prison

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Much like the US population in general, the prison population is aging rapidly raising concerns about health care, end-of-life planning, and dying in prison. The impact of aging is amplified within the prison system. Typically, the health status of inmates in their 50's is physiologically similar to community-dwelling individuals in their 70's, making 55 old by prison standards.[1] The 55+ age group is the fastest growing segment of the prison population[2] increasing by 18.1% between 2000 and 2010 compared to a 17% increase in the overall prison population.[3] It is estimated that within the next ten years one in 5, or 20%, of inmates will be old.[4]

Reasons for the graying of the prison population include longer sentences related to minimum mandatory sentencing and "*three strikes*" rule, reduced options for early release, revocation of parole policies, recidivism, and inmates living longer.[2,3,5-10] Mathematically, the aging of the Baby Boomer generation has led to more older adults committing crimes. Older inmates are comprised of three groups: those aging within the prison system due to longer sentences, repeat offenders, and those who are first-time offenders in later life.[11]

Premature aging means that older inmates tend to be sicker than the general population with more chronic and life-limiting diseases. This is compounded by lifestyle and environmental conditions such as lower socioeconomic status and less prior access to health care resulting in older inmates having poorer health outcomes such as HIV, hepatitis B and C, tuberculosis, substance abuse, and mental illness.[2,5,12,13] A key concern generated by the growth of the older inmate population is how to provide and pay for appropriate environmental conditions and services for older inmates.[6] As it now stands, it costs substantially more to house and provide care for older, compared to younger, inmates,[4,14] about three times more or $72,000/year compared to $24,000.[3,15]

Although empirical evidence that incarceration accelerates aging is lacking,[16] the nature of institutionalization interferes with self-care. Prison systems generally cope with chronically and terminally-ill older inmates by handling their needs in within-facility units.[17] Centralizing health care services for older inmates within a unit saves money and makes it possible to tailor services more specifically to the needs of this group. These units may be age-segregated, for older inmates only, or age-integrated, part of the general prison environment.

Inmates who are paroled or complete their sentences often leave the prison system with serious health problems[11] and limited access to community resources to address these problems. For example, incarcerated individuals are not eligible for federal programs such as Medicare and Medicaid; once released; health care costs are shifted from the prison system to the public sector.[3]

A variety of early-release policies reflect one method of addressing the challenge of providing appropriate care for older inmates. Although some argue that in practice early release policies simply shift the burden from one branch of the state to another or to the community, others cite the potential to alleviate extreme punishment. These laws/policies essentially fall into four broad categories: medical or compassionate release, medical parole, medical clemency, and geriatric release. The medical or compassionate release allows for terminally-ill, eligible inmates to die outside of prison confines prior to completing their sentences.[18] Medical parole may be granted to inmates who require specialized or extensive treatment but are not necessarily terminally ill.[19] Under the conditions of medical parole, inmates are expected to return to

serve the remainder of their sentences provided that they recover sufficiently. The state of Virginia recognizes medical clemency in which a terminally-ill inmate who is not eligible for parole may petition the governor for release to family or a community member willing to provide care.[20] Eligibility for geriatric release, which may or may not include medical parole or compassionate release, varies widely. Most states that permit early release for aging inmates set conditions such as age 60-plus years, the minimum length of sentence served, the severity of offense, e.g. not being a capital crime, and physical conditions related to age or need for long-term care services.[21] Although release rules vary by jurisdiction,[15] reports show one commonality: programs are mired in bureaucracy and the Bureau of Prisons, which administers the programs, is reluctant to grant early release.[22] Out of the 5,400 applications received between 2013-2017, the Bureau of Prisons approved 6%; 266 applicants died in custody.[23]

Currently, the issue of health and end-of-life care for older inmates is being addressed in an ad hoc manner through a patchwork of rules and policies. Although a variety of programs/models have been promoted and adopted in a limited number of locations, no consensus has been reached on the best mode of caring for aging inmates. Each of the programs/policies has its strengths and weaknesses and no one program can meet the variety of needs of older inmates in diverse settings. Regardless of which program or model is adopted, something must be done to meet the needs of the rapidly growing population of older inmates, if not on compassionate grounds, then certainly because it makes fiscal sense. The most viable option is for prison systems and community-based health care providers to work together to develop guidelines for an evidence-based policy for the best, most cost-efficient health and end-of-life care options for the aging prison population.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

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