The Gerontologist Advance Access published October 4, 2012

Forum

The Gerontologist
Cite journal as: The Gerontologist
doi:10.1093/geront/gns125

The High Cost of the International Aging Prisoner Crisis: Well-Being as the Common Denominator for Action

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Received May 1, 2012; Accepted August 28, 2012
Decision Editor: Rachel Pruchno, PhD

The aging prisoner crisis continues to gain international attention as the high human, social, and economic costs of warehousing older adults with complex physical, mental health, and social care needs in prison continues to rise. According to the United Nations, older adults and the serious and terminally ill are considered special needs populations subject to special international health and social practice and policy considerations. We argue that older adults in prison have unique individual and social developmental needs that result from life course exposure to cumulative risk factors compounded by prison conditions that accelerate their aging. We position these factors in a social context model of human development and well-being and present a review of international human rights guidelines that pertain to promoting health and well-being to those aging in custody. The study concludes with promising practices and recommendations of their potential to reduce the high direct and indirect economic costs associated with mass confinement of older adults, many of whom need specialized long-term care that global correctional systems are inadequately equipped to provide.

Key Words: Prison/prisoner, Long-term care, Well-being, Human rights, Aging prisoners, Elder justice, Advocacy

Background of Problem

The aging prisoner crisis continues to gain international attention as the high human and economic costs of warehousing older adults with complex needs in prison continue to rise at a disproportionate rate compared to the general prison population (Human Rights Watch [HRW], 2012). According to the United Nations Office on Drugs and Crime (UNODC, 2009), between 2000 and 2009, the general prison population in the United Kingdom grew by 51%, compared to those aged 50–59, at 111%, and those aged 60 and older, at 216%. In Japan, between 2000 and 2006, the number of prisoners 65 and older increased by 160%. The United States has the largest number of prisoners aged 50 and older; this population has grown 282% between 1981 and 2011 compared to 42% in the general prison population (HRW,

2012). Canada has the lowest percentage increase, in which prisoners aged 50 and older increased 9% in 1996 to 16% in 2005 (UNODC, 2009).

The UN classifies older prisoners and the serious and terminally ill as special needs populations subject to special international considerations in order to best protect their human rights to health and well-being (UNODC, 2009). We argue that older prisoners have unique social developmental needs and illustrate how life course cumulative determinants affect their health, well-being, and risk of criminal justice involvement. We advance a social context model for human development and well-being for use in interdisciplinary action and then review select international human rights guidelines, current promising practices, and their potential cost savings.

Policy Impact

The growth of the aging prison population has been mostly spearheaded by the United States since the1980s with the introduction of "tough-on-crime" criminal justice policies, which have been adopted by many other countries (Aday, 2003; Maschi, Kwak, Ko, & Morrissey, 2012; Morrissey & Maschi, 2012). For example, in the United States, stricter sentencing laws and longer mandatory prison terms have set in motion an upward trend of mass incarceration of many sentenced offenders who were destined to grow old, and even die, in overcrowded prisons (Kinsella, 2004). Many countries have begun to shift to a more compassionate approach, such as the U.S. compassionate release laws, away from overly punitive policies that affect older adults in prison(Williams, Sudore, Greifinger, & Morrison, 2011). China recently passed the 2010 Criminal Law of China that bans the death penalty for people aged 75 or older, except in the case of extreme homicide (Guo, 2011). Currently, global correctional systems, which were not designed as long-term care facilities, are wrestling with the growing wave of older adults, many of whom are in need of specialized care and reentry programming (Stone et al., 2011).

Prison Age Classification

According to the UN, older prisoners, including those with disabilities and terminal illnesses, are special needs populations and thus subject to special international considerations (UNODC, 2009). The age at which individuals are defined as "older" or "elderly" differs across countries. Many societies view people of aged 65 as older because most individuals of this age are eligible to receive full pension or social security benefits; however, this age designation is not uniform across the world because age has different meanings across cultures (UNODC, 2009). Similarly, the age at which a prisoner is defined as elderly varies across different countries. In Australia, people aged 50 and older are designated as older in prison. Although this designation varies among states, incarcerated persons as low as age 50 in the United States may be classified as older adult or elderly (HRW, 2012). Other countries, such as the United Kingdom, designate people of age 60 to 65 as older. Canada has a two-tiered system in which older in prison is defined as those of age 50–64 years and elderly includes those aged 65 and older (UNODC, 2009).

In general, this lower age classification is utilized as the average prisoner may experience accelerated decrements in their health equivalent to community-dwelling adults who are 15 years older (HRW, 2012). This process of accelerated aging is corroborated by international prison studies showing that older adults in prison have significantly higher rates of decline of cognitive and functional capacities compared to younger prisoners or same-aged community-dwelling older adults (HRW, 2012; Maschi et al., 2012). This rapid decline of older prisoners' health has been attributed largely to their high-risk personal histories, chronic health conditions, poor health practices, such as poor diets and smoking, traumatic brain injury, mental illness (e.g., cognitive and functional decline), alcohol and substance abuse, coupled with the stressful conditions of prison confinement, such as prolonged exposure to overcrowding, social deprivation, and prison violence (Maschi, Dennis, Gibson, MacMillan, Sternberg, & Hom, 2011; Maschi et al., 2012; Morgen & Maschi, unpublished manuscript; Williams, Goodwin, Baillargeion, Ahalt, & Walter, 2012). These combined cumulative individual-level and social determinants significantly increase the likelihood of the early onset of comorbid serious physical and mental illnesses, including progressive cognitive impairment and dementia and racial–ethnic disparities in health and criminal justice involvement (Maschi et al. 2012).

Currently, there is a lack of institutional or community programming that promotes the physical, cognitive, emotional, social, spiritual, participatory, and root (basic needs) well-being of older adults across the international criminal justice system service trajectory. In the United States,

only 4% of state correctional institutions provide any type of geriatric-specific services (Thivierge-Rikard & Thompson, 2007). Moreover, older adults in prison often derive little value from prison programming that was designed to target younger prisoners' needs or rights, such as educational or vocational training and programs aimed at reducing offending behavior (Mesurier, 2011). The need for more palliative care services is also a concern, given that a large number—more than 3,000 (5%) of U.S. prisoners, mostly aged 50 or older—die in prison each year (HRW, 2012; Phillips et al., 2011).

In a global climate sensitized to human rights concerns and budgetary constraints, the continued neglect of older prisoners has high human, social, and economic costs (Wilson & Barboza, 2010). Warehousing older adults in prison is costly because of their chronic and serious physical and mental illnesses (American Civil Liberties Union [ACLU], 2012). In fact, estimates suggest that incarcerated older adults cost up to five times more than their younger counterparts (ACLU, 2012). We argue that more compassionate protection and guardianship care for criminal justice involving older adults and their right for caregiver support when needed is warranted (UN, 2011).

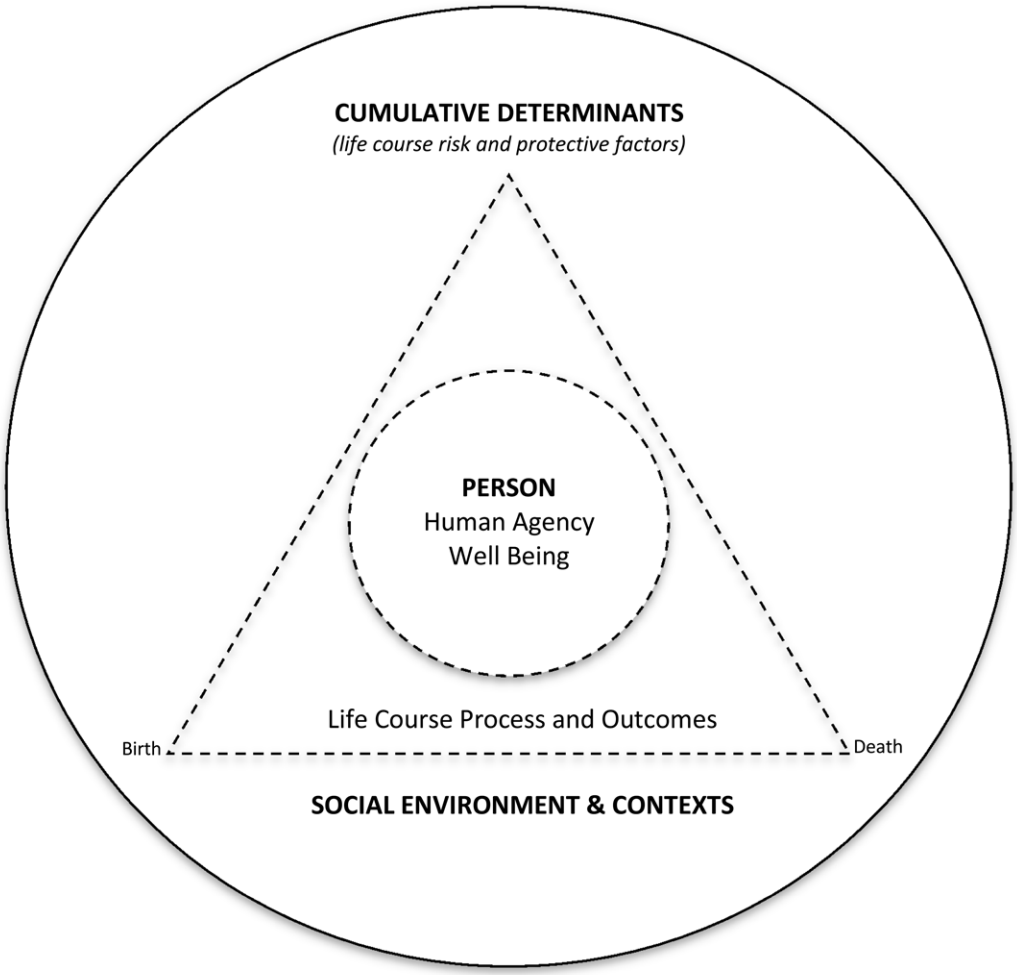
Social Developmental Determinants

As for age group similarities, a large percentage of both the young and the old in prison commonly experienced life course cumulative disadvantage. These social determinants of health and criminal justice involvement include homelessness; poverty and financial problems; low educational attainment; lack of family support and family problems; lack of access to care; and trauma, violence, abuse, and other stressful life events (i.e., being a victim and/or witness to violence and living in poverty-stricken neighborhood) prior to incarceration (Sampson & Lauritsen, 1997; World Health Organization, 2012). As for participatory or political well-being, voting rights may be denied, especially for formerly incarcerated persons with felony convictions (ACLU, 2010). Obtaining access to needed social welfare benefits, including housing and health care, including for veterans, may be difficult (ACLU, 2010, 2012; Mesurier, 2011). Despite these similarities, there are important distinctions that pose a significant challenge for managing older adults across international correctional settings. These more salient differences are (1) age-related physical, mental health, substance abuse issues; (2) prison victimization, mortality, and stress; (3) incarceration and criminal offense patterns; and (4) social security concerns.

Age-Related Physical, Mental Health, and Substance Abuse.—As a natural part of the aging process, older adults in global prisons have higher rates of chronic illnesses or disabilities, such as heart and lung disease and dementia, as compared to younger prisoners (Maschi et al., 2012; Morrissey & Maschi, 2012). Comorbid mental health and substance abuse issues are commonplace in prisoners, especially among older adults (James & Glaze, 2006). Perhaps the most significant issue is the accelerated decline in cognitive and functional capacities (Williams et al., 2012). Poor health behaviors, coupled with the prison context, place older adults at increased risk for age-related mental health problems, especially dementia (Wilson & Barboza, 2010). Access to appropriate medications while in prison also is questionable (Williams et al., 2010).

Prison victimization, mortality, and stress.—Personal safety in prison is another concern. Older adults in prison, especially those with frail health, are at an elevated risk for physical or sexual assault victimization, bullying, and extortion from other prisoners or staff compared to their younger counterparts (Stojkovic, 2007). Older prisoners, compared to younger ones, also are at an elevated risk of physical injury and mortality in prison (Maruschak, 2008). Older prisoners also report higher levels of subjective distress, including the fear of dying in prison and victimization or being diagnosed with a severe physical or mental illness (Maschi et al., 2011; Maschi & Baer, in press). Death anxiety or subjective distress related to dying is more commonly reported among older, compared to younger, prisoners (Aday, 2005; Maschi, Gibson, Zgoba, & Morgen, 2011; Maschi, Morgen, Zgoba, Courtney, & Ristow, 2011). The extent to which geriatric counseling or support groups are used to address trauma, stress, and disenfranchised grief in prison has minimally been explored (Aday, 2003).

Older adults' cognitive and emotional well-being and their adjustment to prison and community reintegration may differ somewhat than their younger counterparts (Dai & Yu, 2011). Older adults in prison, especially in frail health, may be in a state of high alert to victimization, neglect, and/or fear of dying in prison (Aday, 2003). Crawley



Key Terms Used:

- *Person*: The holistic individual as the central focus and their subjective experience of life experiences and events
- *Human Agency*: The creative life force drive to fulfill one's life purpose, potentials, and goals
- *Well-Being*: Holistic state of wellness (e.g., physical, cognitive, emotional, social, spiritual, economic well-being)
- *Life Course Process and Outcomes*: Co-occurring or sequential individual or collective experiences (birth to death)
- *Cumulative Determinants*: Biopsychosocial and structural determinants (i.e., risk or resiliency factors or advantages or disadvantages) that influences life course personal, collective, or generational experiences.
- *Social Environment or Contexts*: Social conditions or external contexts comprised of the following:
    - Values and Ethics: Personal, professional, and societal values, beliefs, perceptions –human rights (dignity and respect of all persons)
    - Power Dynamics: oppression *(internalized, interpersonal, structural, cultural levels):* that influence the level of equality in relationships
    - Historical Time: Personal or collective experiences (event and subjective response), such as multi-level trauma, stress, or loss (may be interpersonal, policy/level, dominant paradigms, generational experiences)
    - Practice/Stakeholder Contexts: Care sectors and intersections (family or peer caregivers or professional services, society)
    - Interdisciplinary Perspectives: Human rights, social justice/capabilities, life course, social ecology, public health
    - Evidence-Based and Evidence-Informed Practices: Person-centered mixed (quantitative & qualitative) methods

Figure 1. A social context model of human development and well-being for multilevel prevention, assessment, and intervention.

and Sparks (2005) document institutional neglect in the treatment of older prisoners by the staff because they are often less of a problem for the latter (HRW, 2012).

Social and cultural well-being is another concern for older adults in prison. Older prisoners from diverse racial or ethnic backgrounds are more likely to have elderly spouses and other aging family members who

can make the prison and reentry experience more complicated (UNODC, 2009). Family members may not be able to provide the caregiving support needed before and after prison release (Mesurier, 2011).

Incarceration and Criminal Offense Patterns.— Based on Goetting's (1984) typology, Maschi et al., (2011) identified three distinct older-adult prison groups based on incarceration patterns: the *life course (prison) older adults*, *acute and chronic recidivists*, and *late-onset offenders*. Life course prison older adults first entered prison as juveniles or younger adults who are serving 20 years or more to life sentences without parole. In countries like the United States, those with longer sentences have committed violent crimes, including sex offenses, and comprise the largest subgroup of the aging prisoner population and lifers who will die in prison (HRW, 2012). The term acute and chronic recidivists refers to older adults in prison who have cycled in and out of prison since they were juveniles or younger adults and have had two or more prison sentences of varying lengths. Late-onset offenders are individuals who were first incarcerated at age 50 and older. Anyone of these subgroups may have varying levels of serious physical and mental illnesses developed during incarceration or prior to the prison term (UNODC, 2009).

In general, recidivism, rearrest, and reconviction rates are much lower for older adults released from prison compared to their younger counterparts (ACLU, 2012). Additionally, when compared with younger adults, older adults are more likely to desist from crime and are found to rarely commit violent crimes later in life (Sampson & Laub, 2003).

Social Security Concerns.— Social security is another significant concern for older adults in prison and post reentry. The term social security refers to the rights of each person to develop and to have the best opportunity for self-development, in terms of cultural, economic, and social well-being (or welfare) in their respective countries (UN, 1948). The cumulative impact of cultural bias and discrimination in prison, especially ageism, racism, or sexism, may significantly disadvantage older racial–ethnic minorities or women in access to employment while in prison or during community integration (UNODC, 2009).

HRW (2012) reported that United States correctional systems bear the health care costs for aging prisoners and are excluded from receiving Medicare and Medicaid funding for prisoners when they are treated in the community. This financial factor may influence aging prisoners' ability to receive appropriate community health care referrals, including access to appropriate medications, when needed (Williams & Abradles, 2010). Additionally, in countries such as the United States, financial benefits, such as Social Security or supplemental income, are suspended for persons serving time in prison (Social Security Administration, 2010). Depending on the correctional facility, older prisoners may or may not receive assistance in applying for or reinstating these benefits before leaving prison (Williams & Abradles, 2010). Additionally, job-related earnings in prison are generally miniscule (e.g., US$1 a day; UNODC, 2009). Therefore, for older adults, especially those who served long prison sentences, the ability to afford basic needs upon prison release, such as food and shelter, is a challenge to their social security rights and well-being.

As shown in Figure 1, we present an integrated interdisciplinary model, entitled a Social Context Model (SCM) of Human Development and Well-Being, and apply it to the process and current outcomes of the aging prisoner crisis for use in clinical- and policy-level assessment, prevention and intervention efforts (see Maschi, Morrissey, Immagieron, & Sutfin, 2012). The SCM model gives central importance to the whole person, or individual, and his or her inner or subjective experiences and meaning-making effort of external life events (e.g., objective event—victim of sexual assault; and subjective response—adaptive or maladaptive response) and subjective well-being, which are the central focus of the model. Human agency is another core component and commonly used in the life course perspective and social justice capabilities theories (Elder, 2003; Nussbaum, 2004). Human agency is conceptualized as a person's creative life force energy and central driver through which the individual pursues his or her life's purpose, passion, and goals in connection to and with others, which in turn fosters an innate and developing sense of well-being and connectedness (Wahl, Iwarsson, & Oswald, 2012).

Well-being is defined consistent with the World Health Organization's (1948) definition of health as a state of multidimensional well-being and not just the absence of disease; specifically, well-being is defined by seven core domains: root (basic needs), physical, cognitive, emotional, social–cultural, spiritual, and participatory (political–legal) well-being. When cumulative determinants or social and environmental conditions are optimal during the life

course, individuals express human agency through concern for self and others and sustain high subjective well-being and meaning-making levels. However, when conditions are suboptimal, such as the experience of personal beliefs or attitudes (e.g., negative world view) or confronted with social environmental barriers (poverty, low educational attainment, adverse neighborhood conditions, long prison sentences), a person's healthy expression of human agency may diminish his or her subjective well-being and negatively manifest as illness (e.g., somatic symptoms) or offending behavior (Maschi & Baer, in press; Maschi et al., 2012). The dynamic social environment also consists of practice and stakeholder contexts that also may influence human agency and well-being. When societal conditions are suboptimal, such as in the case of most international correctional systems, older prisoners' well-being may be compromised (UNODC, 2009). Other social contexts include values and ethics, power dynamics, interdisciplinary perspectives, and evidence-based and evidence-informed practices. Values and ethics can be personal, professional, and societal (UN, 1948). For example, a central value and ethical principle of human rights philosophy is honoring the dignity and worth of all persons and respect for all persons (UN, 1948). In many cases, this principle is not honored for older prisoners.

Power dynamics, balanced (equity) or imbalanced (oppression), comprise another social environment factor. Oppression can occur at the interpersonal (i.e., everyday interactions), structural (e.g., institutional), or cultural levels (e.g., societal attitudes, media), which results in an individual's internalization of negative self-messages and influences behaviors toward others (Maschi et al., 2012; Mullaly, 2010). For example, societies across the globe often have social–structural barriers that enable the dominant group to subjugate oppressed subgroups based on personal characteristics, such as age, gender, race or ethnicity, health status, and class (Mullaly, 2010; Young, 1990). Life course cumulative disadvantage often results in criminalization of oppressed persons as evidenced in the disproportionate stricter sentencing and confinement of minority populations (Sampson & Laub, 1997).

Interdisciplinary perspectives, which are commonly fragmented when addressing aging prisoners, are another social environmental factor (see Figure 1). The SCM model infers that a holistic and integrated theoretical base is essential to adequately address the process and outcomes of the crisis through coordinated interdisciplinary activities, including social work as equal partners in these efforts (Greenfield, 2012; Maschi et al., 2012; Maschi & Killian, 2011, Maschi, Smith-Hatcher, Schwalbe, & Scotto Rosato, 2008). Lastly, incorporation of evidence-based and evidence-informed practices is needed to most adequately capture the process and outcomes of interventions (Glasziou, 2005).

International Human Rights

Human Rights Guidelines

The UN provides guidelines that can be used to forge an international humanitarian and specialized response to aging in the criminal justice system (UN, 1948). Some of the central documents include the Universal Declaration of Human Rights (UN, 1948), the International Covenant on Civil and Political Rights (UN, 1966a), the International Covenant on Economic, Social, and Cultural Rights (UN, 1966b), and the Minimum Standards for the Treatment of Prisoners (UN, 1977). Additionally, federal-, local-, and institutional-level policies, such as compassionate release laws, offer an opportunity to foster well-being, especially among seriously ill older prisoners (HRW, 2012).

Universal Declaration of Human Rights.— Ratified in 1948 as a response to the atrocities of World War II, the UDHR (UN, 1948) provides the philosophical underpinnings and relevant articles to guide this response. The UDHR preamble underscores the norm of "respect for the inherent dignity and equal and inalienable rights" of *all human beings*, which in this case clearly includes older adults and prisoners (UN, 1948). Of the 30 UDHR articles, five are of particular relevance to aging prisoners. Article 25 states that "Everyone has the right to a standard of living adequate for the health and well-being" (UN, 1948, p. 5). These guarantees are relevant to older adults before, during, and after prison term, include housing, medical, mental health, and social services, as well as the right to security in case of unemployment, sickness, disability, or old age (UN, 1948). Article 3, which states "everyone has the right to life, liberty, and the security of person" (UN, 1948, p. 3) and Article 5, which states "no one shall be subjected to torture or to cruel, inhuman, or degrading treatment or punishment" (UN, 1948, p. 3) provide a broad blueprint for designing and implementing international policies and legal standards that

protect older adults, especially from victimization and inadequate health care, while in prison.

Article 22 emphasizes social security in that "everyone has the right to social security" (UN, 1948, p. 5). Social security is consistent with the concept of human agency and right of every person to have the optimal opportunity to achieve cultural, economic, and social well-being in his or her country (UN, 1948). Article 23 emphasizes that "everyone has the right to work and to have just and favorable work conditions, and protection against unemployment" (UN, 1948, p. 5). These two UDHR articles provide a broad guideline for the development and refinement of international policies for financial security, employment, and retirement for older prisoners before and after reentry.

UN Covenants.—The two UN covenants, the ICCPR (UN, 1966a) and the ICESC (UN, 1966b) further explicate the right to services, including older persons' and prisoners' rights. Article 10 in the ICCPR specifies prison rehabilitation as a key component. It states that "the penitentiary system shall comprise treatment of prisoners and the essential aim shall be their reformation and social rehabilitation" (UN, 1966a, p. 3). Article 12 of the ICESC recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (UN, 1966b; p. 4). This includes continual improvement of environmental conditions, the prevention, treatment, and control of the spread of diseases, and adequate medical services (UN, 1966b). Adopting international policies based on these provisions would assist in promoting well-being among prisoners across their life span, especially in older adulthood when they are most vulnerable to age-related health decline.

Standard Minimum Rules for the Treatment of Prisoners.—The Standard Minimum Rules for the Treatment of Prisoners (SMRTP) provides justification for the implementation of geriatric-specific services largely because it recognizes different categories of prisoners (UN, 1977). It states that different types of prisoners "shall be kept in separate institutions or parts of institutions taking into account their sex, age, criminal record, the legal reason for the detention and the necessities of their treatment" (UN, 1977, p. 6). It provides provisions for special accommodations that include housing and medical and psychiatric services. It also specifies the right for prisoners to have family contact at regular intervals (UN, 1977). When these minimum standard rules for prison are adopted internationally, older prisoners could have the potential conditions to fare much better than now.

UN Recommendations for Older Prisoners.—The UN has provided recommendations to its member states in creating a geriatric care response to aging prisoners as a special needs group. These provisions include recommendations for courts to review and revise, if needed, sentencing policies, including minimal use of long-term sentences (unless community safety is a concern) and the development of alternatives to incarceration and diversion programs for older, serious, and terminally ill offenders (UNODC, 2009). For prison management, the recommendations include (1) developing special strategies for older prisoners, (2) obtaining the input of a multidisciplinary team of prison specialists who work in conjunction with community service providers, (3) providing geriatric-specific staff training and encouraging staff to engage with community organizations to best ensure a continuum of care, (4) assisting older prisoners in accessing legal counsel and services to reduce discrimination based on age or disability status, (5) conducting initial and ongoing comprehensive assessments to identify the varied and changing needs of older prisoners, (6) providing appropriate accommodations, including the use of special units, (7) ensuring health care needs such as medical, nutritional, and psychological health; social engagement with interdisciplinary staff; and special programs to address mental health and psychosocial concerns, and (8) placing older prisoners close to home to maintain family and community contacts, including the use of family visit programs (UNODC, 2009).

Other relevant recommendations for terminally ill prisoners include the establishment of palliative and end-of-life care practices and policies with ongoing (1) services of qualified interdisciplinary professionals, (2) medical and psychosocial spiritual assessment and care plans, (3) 24 × 7 staff availability, (4) counseling services by qualified counselors or social workers, and (5) spiritual care provided by a qualified chaplain of the interdisciplinary team (UNODC, 2009). In general, governments and local correctional institutions and advocates can use these UN guidelines as a benchmark for the extent to which current policies and practices meet the special needs of older adults in prison and their rights to well-being.

Promising Compassionate Policies and Laws

UN guidelines that affect aging prisoners can be evidenced in "compassionate" policies and laws in some countries (UNODC, 2009). For example, the United States has 41 state policies, often referred to as discretionary parole, inmate furloughs, or medical or compassionate release policies (Chiu, 2010). Since 2009, United States geriatric release provisions include one or more of the following criteria: minimum age, physical or mental health status, minimum sentence length, and low level criminal risk clauses (Chiu, 2010). However, there have been barriers to their effective implementation, which reduce older prisoners' rights to dignity and respect even when dying (HRW, 2012). These barriers include the poor design of laws (e.g., narrow eligibility criteria), implementation procedures (e.g., bureaucratic red tape), and the reluctance of politicians to remedy the situation due to increased public pressure (ACLU, 2012; Chiu, 2010).

Another useful law is the American with Disabilities Act (ADA). In 1998, the U.S. Supreme Court held in *Pennsylvania Dept. of Corrections v. Yeskey, 524 U.S. 206* (1998) that the ADA applies to persons in prisons and jails. Prison wardens in the United States stated that compliance with the ADA inadvertently improved their services for older prisoners (National Institute of Corrections [NIC], 2010). ADA-compliant standards in prisons have included environmental modifications, such as handrails in inmate cells, showers, hallways, and communal settings (NIC, 2010). Some prisons have created specialized geriatric services to best ensure comprehensive services for older prisoners (Harrison, 2006).

Promising Practice Innovations

Even on a global scale, the well-being of older adults released from prison to their respective communities often cannot be guaranteed. For example, older adults who served long prison sentences may experience institutionalization (e.g., not knowing how to survive outside of prison; Davies, 2011). Community reintegration success for older, formerly incarcerated persons may be compounded by other comorbid health and/or mental health issues; lack of family and peer support; substance use; lack of available community medical, mental health, and substance abuse services; lack of financial resources; and lack of access to social welfare benefits (including retirement), suitable housing options such as assisted living and nursing homes, and available transportation (Williams & Abraldes, 2007).

Some older adults who are released from prison may have limited functional capacities and may need assistance with activities of daily living, such as dressing, walking, and eating (UNODC, 2009). Other seriously or terminally ill older adults may need long-term institutional care, such as placement in a nursing home or hospice (Stone et al., 2011). Barriers to placement in nursing homes and hospices may exist due to stigmatization and discrimination against individuals with criminal offense histories, especially for more serious offenses, such as arson and sex (crimes) offenses (HRW, 2012). For able-bodied, older, formerly incarcerated persons, attainment of employment or job training is another factor for successful community reintegration. Their criminal histories may create barriers to attaining employment, housing, or even long-term care or hospice placement (Mesurier, 2011).

Promising practices often include geriatric case management services for medical and mental health and substance abuse; family and social services; housing, education, or vocational training; victim or victim–offender mediation services; spiritual counseling, exercise, and creative arts programs; employment and/or retirement counseling. Program-specific aspects include one or more of the following: "age-" and "cognitive capacity"-sensitive environmental modifications (including segregated units), interdisciplinary staff and volunteers trained in geriatric-specific correctional care, complimentary medicine, specialized case coordination, the use of family and inmate peer supports and volunteers, mentoring, and self-help advocacy group efforts (Davidson & Rowe, 2010). What follows is a selection of international programs illustrative of how facilities incorporate these key elements in programming for their older prisoners.

Hocking Correctional Facility (United States).—The Hocking Correctional Facility (HCF) in Ohio addresses the prison and community reintegration needs of older prisoners. Offering one-stop wraparound services, it includes a prerelease program that provides inmates with information on social security or welfare benefits, job-seeking skills, housing-placement services, employment training, property maintenance, self-care and gero-informed psychoeducational classes, and general education courses. The facility also provides staff training with knowledge and skills to deal effectively with geriatric populations, including chronic illnesses

and death and dying issues. Community reintegration is an active component of services so that older adults have the necessary resources, including an approved placement in nursing homes if declining health status necessitates this placement (Ohio Department of Corrections, 2011).

Recoop (United Kingdom).—The Resettlement and Care for Older Ex-Offenders (RECOOP) program promotes older adults' health and well-being by providing care, resettlement, and rehabilitation services to older offenders and ex-offenders. It does so through the provision of support services, advocacy, and financial advice, including mentoring on issues such as employment and training. Advice on housing and health is also provided to empower these individuals to take control of their lives, remain free from reoffending, and potentially minimize social isolation (Prison Reform Trust, 2008).

Restore 50 Plus Program (United Kingdom).—The Restore 50 Plus Program is a community-based program that promotes the health and well-being of older adults exiting prison. The program uses older ex-prisoners to provide peer mentoring and social support in coordination with corrections staff. It is a holistic, community-focused program compared to the more commonly prescribed "offender responsibility" model, which is better for older adults reentering the community who are more in need of aging-related supports (Prison Reform Trust, 2008).

RELIEF (Canada).—The Reintegration Effort for Long-term Infirm and Elderly Federal Offenders' (RELIEF) program was established in 1999 to facilitate the transition of elderly and infirm prisoners into the community. The program addresses hospice care needs and was designed with a consideration of human rights and social justice values and dignity of the dying person. It uses former prisoners and caregivers in an attempt to provide compassionate peer support to fellow ex-prisoners (Asian and Pacific Conference of Correctional Administrators, 2000).

Other Global Practice Innovations.—Other countries across the globe are implementing practice innovations designed to respect the dignity and well-being of older prisoners. In Uruguay, there is legislation for the use of house arrest for offenders aged 70 and older, unless they have committed a serious offense, such as rape or homicide. There is also a provision for seriously ill prisoners (UNODC, 2009). In India, an open prison for older prisoners with life sentences was established in order for them to maintain family and community contact. The program allows for older "lifers" to be moved to a minimum security prison, live with their families, and obtain a job of their choice with prescribed limits. Similar to the United States, the Netherlands has a buddy system for prisoners with AIDS. These buddies provide support services in the prison and community (UNODC, 2009).

Economic Cost Considerations

With the global economic decline and budgetary constraints, the human and economic costs of the aging prisoner crisis must be considered. In 2008, the United States spent $75 billion, in large part as a result of the exponential growth in incarceration rates (Schmitt et al., 2010). As of 2009, prisoner population rates per 100,000 were 760 in the United States, 624 for the Russian Federation, 153 in the United Kingdom, 119 in China, and 116 in Canada (Organization for Economic Co-operation and Development [OECD], 2010). The OECD reported that the average was 140 prisoners per 1,000 globally (OECD, 2010). However, the trend toward increased incarcerations is worrisome. In the United Kingdom, the rates almost doubled since the early 1990s. A recent study conducted at Manchester Metropolitan University suggests that "an economically efficient approach to criminal justice policy" is needed to deal with increasing costs in the United Kingdom (Fox & Albertson, 2010).

The High Costs of Aging Prisoners

Health and social care costs associated with incarceration are growing in large part due to the aging inmate population. High medical expenditures for institutional care are common, especially those associated with serious illness, disabilities, or terminal illnesses (UNODC, 2009). In the United States, these costs represent approximately 10% of the total direct prison costs of care for those incarcerated; average cost of care for the average prisoner is approximately $5,500, for prisoners aged 55 to 59, the costs double ($11,000) and are 8 times higher for prisoners aged 80 and older ($40,000; HRW, 2012).

Loss of Wages Estimate

An equally important consideration is the loss of productivity and resulting wage impact on prisoners and their families. In the United States, roughly 66% of male inmates were employed before incarceration and were the main earners for

their households. Incarceration reduces earnings by 40% (Pew Charitable Trusts, 2010). Less known is that incarceration not only affects employment and earning opportunities through the offender's lifetime but through their children's lifetime as well. One in every 28 children in the United States has a parent in jail; the rates are higher among minority groups (Pew Charitable Trusts, 2010). The familial and social costs are practically immeasurable.

Potential Cost Savings Strategies

There have been very few studies that have empirically tested or validated the cost–benefit ratio or cost-effectiveness of prison sentencing, incarceration, and alternative policies and programs. The international community is beginning to recognize its importance. Three potential cost-reducing strategies are suggested from the evidence presented in this study. They include sentencing policy reform, alternatives to incarceration, and innovative policy and program development that address the needs of aging prisoners.

Sentencing Reform.—The first consideration is that the international community make a stronger effort in implementing the UN recommendations for sentencing policy reform. Stricter sentencing policies are the primary driver of rising incarceration rates in many countries, in large part as a result of drug-related offenses. Early prevention, especially reducing social–structural risk factors, is a key goal, which is to prevent young adults from going to prison and to increase their potential to participate as productive community members.

Low-Cost Residential Treatment.—A second consideration is for communities to develop lower cost alternatives such as residential treatment programs that address comorbid health, mental health and substance abuse problems, and housing; these have the potential for lifelong cost savings by reducing the indirect costs associated with improved employment and earning potential as well as improved health over the lifetime of criminal offenders. According to the Matrix Knowledge Group (2007), residential drug treatment programs result in direct cost savings of more than US$300,000 net benefit over prison and surveillance systems, close to US$200,000 per inmate. If the United States were to reduce by half the number of current nonviolent offenders from prison to probation or parole, researchers estimate that the country would save almost $17 billion per year, or roughly 23% of the total corrections budget (Schmitt et al., 2010).

General Investment in Policies and Programs.—A third consideration would be to invest in policies and programs that move aging prisoners with chronic illnesses to community-based care. Family or other informal volunteer peer support models are an important consideration for their cost-saving potential, especially for seriously and terminally ill older adults released on parole or compassionate release. Estimates of unpaid informal family caregiving provided in the community in the United States range from $350 to $450 billion saved that would have been spent annually if the services were provided by professionals (Arno & Viola, 2009; Feinberg et al., 2011). On average, care in the community is more cost effective than care received in prisons, in large part because prisons have not traditionally incorporated disease prevention programs, which reduce the likelihood of comorbidities and chronic conditions such as hypertension and diabetes (Kinsella, 2004). Even for the nonincarcerated aging population, the global emphasis is on providing home- and community-based care over institutional care (e.g., long-term-care facilities) based on cost considerations (Arno & Viola, 2009). For example, if "formal," paid care of aging prisoners in the institutionalized prison systems were replaced by care provided by "informal" caregivers (e.g., family or community volunteers), as commonly occurs in the nonincarcerated, aging population, potential savings would likely be sizable. Although these informal networks presently are not widely embedded in community-based care for the reentry population, the development of such programs should be evaluated from both care and costs perspectives.

Another larger consideration is the potential impact on returning prisoners of renewed international emphasis on the financing and design of long-term care services and supports. In most countries, national health insurance and/or related national long-term care insurance programs provide coverage for adults, although these policies vary among countries. Even in the United States, persons aged 65 or older are entitled to public health insurance as part of Medicare; the younger old generally receive public health insurance through Medicaid given their lower incomes, and both groups may receive assistance from a combination of the two (Viola & Arno, 2013).

Conclusion

In conclusion, there is mounting evidence of the high human, social, and economic costs of the aging prisoner crisis. As a collective, geriatric interdisciplinary professionals are in a unique position to rally behind this issue. This crisis needs a holistic

integrated international human rights-based public health response that targets primary (prevention), secondary (at-risk), and tertiary (targeted population) assessment and intervention (Wronka, 2010). International civil and human rights advocacy organizations and empirical evidence suggest the time for action is now.

Funding

This paper was based on research for a grant by the Hartford Foundation and the Gerontological Society of America, Geriatric Social Work Faculty Scholars Award: Principal Investigator: Tina Maschi, PhD, LCSW, ACSW

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