VERA INSTITUTE OF JUSTICE

# It's About Time

## Aging Prisoners, Increasing Costs, and Geriatric Release

APRIL 2010

CENTER ON SENTENCING AND CORRECTIONS

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# Executive Summary

As harsher policies have led to longer prison sentences, often with a limited possibility of parole, correctional facilities throughout the United States are home to a growing number of elderly adults. Because this population has extensive and costly medical needs, states are confronting the complex, expensive repercussions of their sentencing practices. To reduce the costs of caring for aging inmates—or to avert future costs—legislators and policymakers have been increasingly willing to consider early release for those older prisoners who are seen as posing a relatively low risk to public safety.

This report is based upon a statutory review of geriatric release provisions, including some medical release practices that specifically refer to elderly inmates. The review was supplemented by interviews and examination of data in publicly available documents.

At the end of 2009, 15 states and the District of Columbia had provisions for geriatric release. However, the jurisdictions are rarely using these provisions. Four factors help explain the difference between the stated intent and the actual impact of geriatric release laws: political considerations and public opinion; narrow eligibility criteria; procedures that discourage inmates from applying for release; and complicated and lengthy referral and review processes.

This report offers recommendations for responding to the disparities between geriatric release policies and practice, including the following:

- States that look to geriatric release as a cost-saving measure must examine how they put policy into practice. For instance, they should review the release process to address potential and existing obstacles.
- More analysis is needed to accurately estimate overall cost savings to taxpayers—and not just costs shifted from departments of corrections to other agencies.
- More effective monitoring, reporting, and evaluation mechanisms can improve assessments of the policies' impact.
- Creative strategies allowing older individuals to complete their sentences in the community should be piloted and evaluated.
- Finally, to protect public safety, states should consider developing relevant risk- and needs-assessment instruments, as well as reentry programs and supervision plans, for elderly people who are released from prison.

## FROM THE CENTER DIRECTOR

Throughout the United States, state corrections systems face significant challenges: many prisons are operating over capacity, budgets have been cut, and decisions about who goes to prison and for how long are made by policymakers who often lack good information about the impact of their actions.

State legislatures and corrections departments are tackling these challenges by looking for new ways to reduce their prison populations without jeopardizing public safety. Some states, like Colorado, are considering evidence-based risk-assessment tools to help paroling authorities make better-informed decisions about safe releases, while others, like New York, are using such tools to inform supervision and violation decisions.

This report examines an underused strategy that is increasingly attracting attention as a way to reduce the prison population, save costs, and maintain public safety. Geriatric and medical release policies target inmates whose advanced age or waning health limit the risk they pose to the community. Because the cost of maintaining these individuals in state prisons is significantly higher than that for younger inmates, releasing older inmates has the potential to save corrections departments substantial amounts of money. Nevertheless, many states that have enacted such policies have not realized a decrease in their prison populations or the savings they may have anticipated.

The lessons from this analysis of mostly ineffectual geriatric release provisions can also be applied to other areas of criminal justice policy. Perhaps the most important lesson is that intent is not enough to achieve a legislative or agency policy's desired impact. Policymakers must use available data to understand their corrections population and not be overly restrictive in defining the subset eligible for early release. Instead, they must craft policies and legislation to ensure that exceptions and procedural requirements do not overwhelm a provision's intent. To achieve their maximum impact, policies must be based on evidence and proven outcomes. Finally, legislation and policy change alone are usually not sufficient: attention and resources must also be directed toward careful implementation.

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# Introduction

During the past three decades, the United States' prison population has increased sixfold. Research shows that this growth has been driven not by more crime, but by policies that send more people to prison and keep them there for longer periods of time.[1] One consequence of this trend is a large and increasing number of older inmates.

Geriatric prison populations present a challenge to state officials struggling to control costs in a weakened economy, rendering early release for some prisoners, especially those who did not commit violent offenses, increasingly viable. Because older inmates are typically viewed as less of a threat to public safety than their younger counterparts, many states have implemented policies to release elderly individuals as a potential cost-cutting measure. In 2008 and 2009, for example, several states, including Alabama, North Carolina, and Washington, enacted policy reforms that would allow some older inmates to serve the remainder of their sentences in the community. Yet such policies have not resulted in a sizable release of elderly adults; some of these states have never released a single older prisoner using geriatric-specific provisions.

This report examines some factors that may account for this disparity. First, it provides an overview of older prisoners, including how states define "elderly," a summary of the population's specific needs, and the justification for geriatric release. Next, it provides a snapshot of

release mechanisms in a number of states. Finally, it offers explanations as to why geriatric release policies are not being implemented as intended, along with recommendations to help put these policies into more widespread practice.

# Background

Elderly adults are a rapidly growing cohort of the nation's prison population. According to the U.S. Bureau of Justice Statistics, between 1999 and 2007 the number of people 55 or older in state and federal prisons grew 76.9 percent, from 43,300 to 76,600, and the number of those ages 45 to 54 grew 67.5 percent.[2] (See figures 1 and 2.)

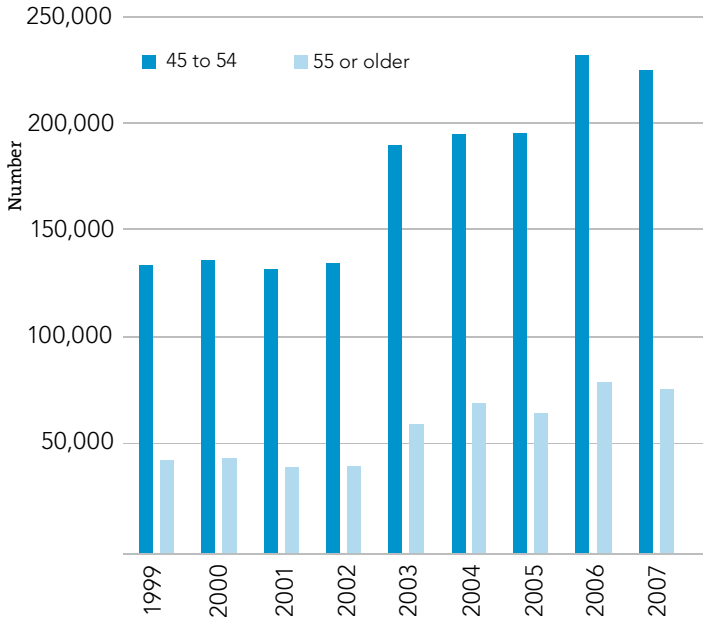
In some states, the increase in the number of older prisoners has been dramatic. In North Carolina, for example, from 2001 through 2005 the elderly inmate population grew faster than any other inmate age group. While the state's general prison population increased by 16 percent, the number of inmates 50 and older grew by 61 percent to 3,490—almost 10 percent of the total.[3] In Virginia, the population over age 50 increased almost sixfold from 1990 to 2008, from 715 to 4,678, or roughly 12 percent of the prison population.[4] In Oklahoma, the number of inmates 50 and older grew from 879 in 1994 to 3,627 in 2008, an increase from 6.4 percent of the prison population to 14.3 percent.[5] State policy choices that result in longer prison terms—such as mandatory minimums, truth-in-sentencing laws, and the abolition of parole—all but guarantee that the number of older prisoners will continue to rise.[6]

## DEFINING WHO IS "OLD"

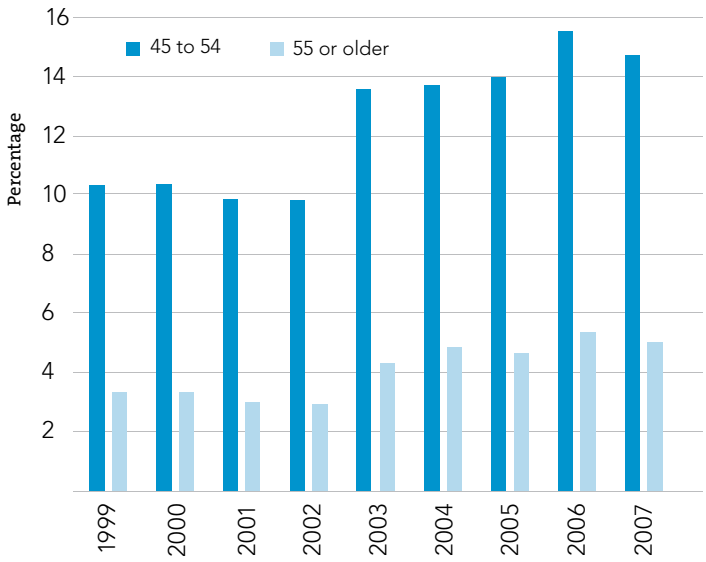
There is no national consensus about the age at which an inmate qualifies as "old" or "elderly." The U.S. Census Bureau defines the general "elderly" population as those 65 and older, but the National Commission on Correctional Health Care uses 55 as its threshold for "elderly" inmates.[7] At least 27 states have a definition for who is an "older prisoner," according to a recent survey: 15 states used 50 years as the cutoff, five states used 55, four states used 60, two states used 65, and one used age 70.[8]

Although most 50-year-olds are not considered elderly, the aging process appears to accelerate for people who

### Figure 1: Prison population ages 45 years and older, 1999 to 2007




### Figure 2: Percentage of total prison population, ages 45 years and over, 1999 to 2007



are incarcerated.[9] Some contributing elements include a person's poor physical or mental health prior to incarceration—often the result of factors such as substance abuse, lack of access to health care or inadequate care, poverty, and lack of education—as well as the physical and psychological stresses associated with prison life itself. Specific stressors include separation from family and friends; the prospect of living a large portion of one's life in confinement; and the threat of victimization, which disproportionately affects older inmates.[10] For these reasons, correctional administrators, health practitioners, and academics agree that an incarcerated person's physiological age may exceed his or her chronological age.[11]

## SOARING HEALTH CARE COSTS

Compared with their younger peers, older inmates have higher rates of both mild and serious health conditions, such as gross functional disabilities and impaired movement, mental illness, increased risk of major diseases, and a heightened need for assistance with daily living activities. Hearing loss, vision problems, arthritis, hypertension, and dementia, for example, are all more common among older inmates, who are also more likely to require frequent dental and periodontal work. According to the *Journal of the American Medical Association*, inmates older than 55 have an average of three chronic conditions and as many as 20 percent have a mental illness.[12] Their need for medical services and devices (such as walkers, wheelchairs, hearing aids, and breathing aids) is consequently greater as well.

As a result of these conditions, elderly individuals use a disproportionate share of prison health-care services. They have five times as many visits to health facilities per year than similarly aged people who are not incarcerated, and any treatment they receive beyond the prison gates carries additional costs in time and travel by correctional staff.[13] To accommodate such prisoners, states may need to refit or build space for treatment and housing, including secure nursing homes. In 2008 at least 13 states had dedicated units for older inmates, six had dedicated prisons, nine had dedicated secure medical facilities, five had dedicated secure nursing-home facilities, and eight had dedicated hospice facilities.[14]

Because of these needs, prisons spend about two to three times more to incarcerate geriatric individuals than younger inmates; according to a 2004 report from the National Institute of Corrections, the annual cost to imprison an older person was an estimated $70,000.[15] In fiscal year 2006-2007 North Carolina spent an average of $5,425 per inmate who was 50 and older to provide them with medication and dental, medical, and mental health care—more than four times what it spent on younger inmates.[16] In Virginia, a study for the Appropriations Committee of the House of Delegates estimated that the Department of Corrections could save up to $6.6 million if 62 individuals—15 percent of the population eligible for geriatric release—were released in 2010.[17]

The growing number of elderly inmates, the rising costs of medical care and incarceration, and the possibility of longer life expectancies resulting from improved prevention and treatment will increase the strain on state correctional budgets, given that prisoners are not eligible for Medicaid or Medicare benefits. Viable alternatives to keeping older adults incarcerated are attractive because of potential cost savings.

## LOWER RECIDIVISM RATES

Such alternatives also make sense from a public safety perspective. Researchers have consistently found that age is one of the most significant predictors of criminality, with criminal or delinquent activity peaking in late adolescence or early adulthood and decreasing as a person ages.[18] Older offenders are less likely to commit additional crimes after their release than younger offenders.[19] Studies on parolee recidivism find the probability of parole violations also decreases with age, with older parolees the least likely group to be re-incarcerated.[20] A 1998 study found that only 3.2 percent of offenders 55 and older returned to prison within a year of release, compared with 45 percent of offenders 18 to 29 years old.[21] Likewise, a 2004 analysis of people sentenced under federal sentencing guidelines found that within two years of release the recidivism rate among offenders older than 50 was only 9.5 percent compared with a rate of 35.5 percent among offenders younger than 21.[22] Given these statistics, releasing some elderly inmates before the end of their sentence poses a relatively low risk to the public.

# State Approaches to Releasing Older Inmates Vary

Fifteen states and the District of Columbia define processes for releasing geriatric inmates. These processes vary from state to state and include discretionary parole, inmate furloughs, and medical—or compassionate—release. Some states have enacted release statutes that specifically target older inmates. Others have added age-specific criteria to parole procedures or medical release statutes. Other states have developed laws that deal with both geriatric and medical release. In defining geriatric release laws, this report includes statutes that focus explicitly on elderly prisoners as well as a subset of medical release statutes that refer specifically to age or age-related medical conditions.[23] (See figure 3.)

To be eligible for geriatric release, inmates must meet a number of requirements, usually related to their age, medical condition, and risk to public safety. The eligibility requirements may also include restrictions that preclude consideration: many states make inmates ineligible for geriatric release due to the severity of their offense of conviction, and in some states older prisoners may not be eligible until they have served a minimum length of their sentence. Some states define eligibility broadly, giving wide discretion to the releasing authority, such as a parole board. Other states define eligibility narrowly and require the releasing authority to make certain findings before releasing an inmate.

Most states that permit the early release of older prisoners have set the age of eligibility at 60 or 65. Louisiana has the lowest age of eligibility, 45. Most eligibility requirements include certain physical conditions, such as a chronic infirmity, illness, or disease related to aging, or that the inmate is physically incapacitated or in need of long-term care.

Maryland, Virginia, and Wisconsin are among the states whose eligibility requirements for geriatric release do not include specific physical or medical conditions. Instead, they set thresholds for age and minimum length of sentence served. In Maryland, eligible prisoners must be 65 and have served at least 15 years of their sentence. In Virginia and Wisconsin, people 65 and older must serve five years and those 60 to 64 must serve 10 years before applying for geriatric release.

Statutes in Connecticut, Missouri, Oregon, Texas, Washington, and Wyoming do not specify an age but refer to age-related physical or mental debilitation as one of the eligibility criteria. Missouri, for instance, requires that inmates be sufficiently "advanced in age" that they are "in need of long-term nursing home care." Wyoming allows medical parole for inmates who are "incapacitated by age to the extent that deteriorating physical or mental health substantially diminishes" their ability to take care of themselves in a prison setting.

Procedures for releasing older prisoners also vary across states. Policies may establish conditions of release, including housing restrictions or periodic medical exams; define revocation procedures, such as automatic revocation if an inmate's medical condition improves; and identify who is authorized to make a release recommendation (for example, department of corrections personnel or medical examiners). (See figure 4.)

# Examining the Gap between Intent and Impact

Given that many state policymakers have expressed an intention to permit the release of elderly inmates who are not a threat to public safety, it is remarkable that geriatric release policies have had little impact. As of early 2009, neither Maryland nor Oklahoma had released an older prisoner under geriatric release provisions. From 2001 to 2008, Colorado released three prisoners under its policy. Oregon has released no more than two prisoners per year. From 2001 to 2007, Virginia released four inmates.[24] From 1999 through 2008, New Mexico released 35 prisoners under its combined medical and geriatric parole program, but how many of these prisoners were elderly is not clear.[25] Missouri appears to have made the greatest use of its provision, which applies to both geriatric and terminally ill individuals, having released 236 inmates

## Figure 3: States with Geriatric-Related Release Policies

| State | Statutory/ Administrative Provision | Minimum Age | Eligible Applicants |
|---|---|---|---|
| AL | Ala. Code §§ 14-14-1 to 14-14-7 | 55 | Must be 55 years or older and suffer from a chronic life-threatening infirmity, life-threatening illness, or chronic debilitating disease related to aging. |
| CO | Colo. Rev. Stat. §§ 17-1-102; 17-22.5-403.5 | 65 | Must be 65, incapacitated, incapable of caring for oneself, not a threat to society, not likely to re-offend, and not convicted of certain felonies. |
| CT | Conn. Gen. Stat. § 54-131k | - | Must be physically or mentally debilitated from age or illness, incapable of being a threat to society, and have served half of their sentence. |
| DC | D.C. Code § 24-465 | 65 | Must be 65 and have a chronic, age-related problem that arose after sentencing. |
| LA | La. Rev. Stat. Ann. § 15:574.4(A)(2) | 45 | Must be 45 and have served 20 years of at least a 30-year sentence. |
| MD | Md. Code Ann., Crim. Law § 14-101(g) | 65 | Must be 65 and have served at least 15 years of a sentence for a crime of violence. |
| MO | Mo. Rev. Stat. § 217.250 | - | Must be advanced in age to the point of needing long-term nursing home care. |
| NC | N.C. Gen. Stat. §§ 15A-1369 to -1369.5 | 65 | Must be 65 years or older and suffer from chronic infirmity, illness, or disease related to aging; and be incapacitated to the extent that they do not pose a public safety risk. |
| NM | N.Mex. Stat. § 31-21-25.1 | 65 | Must be 65, have chronic illness/infirmity/disease related to aging, and must not be a danger to themselves or society. |
| OK | Okla. St. Tit. 57, § 332.7 | 60 | Must have committed their crime before 7/1/1998, be 60 years of age, and have served at least 50% of a sentence imposed under applicable truth-in-sentencing guidelines. |
| OR | Ore. Rev. Stat. § 144.122(1)(c) | - | Must be elderly and permanently incapacitated in such a manner that they are unable to move from place to place without assistance of another person. |
| TX | Tex. Gov't. Code § 508.146 | - | Elderly, physically disabled, mentally ill, terminally ill, or mentally retarded individuals or those who have a condition requiring long-term care, and are not a threat to public safety based on their condition and a medical evaluation. |
| VA | Va. Code Ann. § 53.1-40.01 | 60 or 65 | People age 60 who have served 10 years or those who are age 65 and have served 5 years. |
| WA | Wash. Rev. Code § 9.94A.728 | - | Have a serious medical condition that is expected to require costly care or treatment and are physically incapacitated due to age or medical condition or expected to be so at the time of release. |
| WI | Wis. Stat. § 302.1135 | 60 or 65 | Must be age 60 and have served 10 years or age 65 and have served 5 years; may seek petition for release to extended supervision. |
| WY | Wyo. Stat. Ann. § 7-13-424 | - | Must be incapacitated by age to the extent that deteriorating physical or mental health substantially diminishes their ability to provide self-care within a correctional facility. |

## Figure 4: Elements of Geriatric and Medical Release Policies

The following items may be defined either in a statute or by agency policy and protocol.

Eligibility requirements

- > Minimum age
- > Minimum time served
- > Medical needs

Types of exclusions

- > Conviction offenses
- > Previous criminal history

Application

- > Parties eligible to make application
- > Agency to which application is made

Evaluation

- > Public safety or risk assessments
- > Medical conditions (if applicable)
- > Party responsible for making evaluations
- > Existing parole guidelines
- > Agency responsible for final release decision

Conditions of release

- > Release plan
- > Predetermined release location
- > Program participation
- > Monitoring
- > Reporting requirements
- > Level of supervision (if applicable)
- > Length of supervision (if applicable)

Revocation

- > Reason(s)
- > Responsible agency
- > Procedures

from 1998 through 2008. This figure, however, may reflect a large proportion of people who were terminally ill; at least 64 percent of this group has died since being released.[26]

Several dynamics account for the relatively low impact geriatric release mechanisms have on states' elderly inmate populations. These include components of states' policies that may make the process of releasing older inmates less effective or efficient. For example, the statutes may define the eligible population narrowly, as noted earlier, or procedural issues may cause confusion or delays. Four contributing factors may be restricting the number of older inmates that states release: political considerations and public opinion, eligibility requirements, application procedures, and referral and review processes. These four topics are discussed below.

## POLITICAL CONSIDERATIONS AND PUBLIC OPINION

Politics and public sentiment present obstacles to fully using statutes already on the books. Releasing older inmates can be viewed as politically unwise, fiscally questionable, or philosophically unpalatable.

The decision to grant early release to any prisoner can be politically risky, regardless of potential cost savings. Data or predictions about older inmates' relatively low rates of recidivism may not sway public opinion. A commonly cited reservation is that offenders placed in nursing homes may prey upon an already vulnerable population. A Mansfield University survey of Pennsylvania residents in 2004 found that only 45 percent of respondents favored the early release to parole for chronically or terminally ill inmates, even if they posed no threat to society.[27]

Many opponents of geriatric release question whether cost savings will be realized. Most analyses of the impact of such policies focus on the cost savings to correctional agencies and, therefore, reveal only part of the fiscal picture. Policymakers and taxpayers want to know whether costs are simply being shifted to other state agencies, such as social service or health departments, or to the federal government through Medicare or Medicaid reimbursements after individuals return to the community.

For many other opponents, the desire to keep individu-

als confined may trump any other considerations. As Will Marling, executive director of the National Organization for Victim Assistance, said, "If a person is sentenced to life, we know they are naturally going to get old. A life sentence should mean life."[28]

## ELIGIBILITY REQUIREMENTS

In developing geriatric release statutes and procedures, policymakers often exclude individuals convicted of violent offenses or sex offenses and those sentenced to life imprisonment. For these populations, punishment as a goal of incarceration may outweigh considerations of correctional cost savings or the prospect that age has rendered a person less dangerous. Although this rationale is understandable, the result is that geriatric release policies may apply to only a small subset of older inmates.

In 2008, one in 11 U.S. prisoners—more than 140,000 individuals—were serving a life sentence; 29 percent of them (roughly 41,000 people) have no possibility of parole.[29] In Pennsylvania, a 2003 study of inmates 50 and older found that older prisoners were more likely to have been incarcerated for serious offenses, including rape, murder, robbery, aggravated assault, and burglary; 66 percent were serving maximum sentences of 10 years or more, with 21 percent serving life sentences.[30] A 2006 report on North Carolina prisoners showed that almost 60 percent of inmates ages 50 and older were serving sentences for violent or sex crimes, including sexual assault, habitual felonies, and murder in the first or second degree. Most were serving a sentence of life or of 10 years to life.[31] As larger numbers of people convicted of serious and violent crimes grow old in prison, categorically excluding them from consideration may result in fewer releases and less potential cost savings.

Similarly, states that restrict geriatric release to inmates who have a grave physical condition or terminal illness are likely to discharge only a small number of people. Washington State, for instance, released only 22 prisoners in five years under its original "extraordinary medical placement" statute, which sanctioned such placement only for those inmates who are physically incapacitated due to age or a medical condition.[32] In 2009, the legislature modified the eligibility criteria to include inmates who are not yet infirm but are *expected* to be physically incapacitated at the time of their release. As a result of this change, not only will more prisoners be eligible for placement, but the state Department of Corrections (DOC) could avoid incurring higher medical costs by releasing some individuals before they become gravely ill in prison.[33] The Washington State DOC has projected that it could release as many as 44 offenders older than 55 between 2009 and 2011, for an estimated savings of up to $1.5 million.[34]

## APPLICATION PROCEDURES

Some application procedures may discourage older prisoners from seeking geriatric release. Virginia's geriatric release provision, for example, is limited to offenders who have no convictions for Class 1 felonies and are either at least 60 years old and have served at least 10 years of their sentence, or at least 65 years old and have served at least five years of their sentence. This provision was adopted in 1994 as part of the state's truth-in-sentencing (TIS) reform package. Although this provision was originally applicable only to offenders sentenced under TIS laws, in 2001 lawmakers expanded geriatric release to apply to all state prisoners.

To be considered for geriatric release, inmates must apply to the Virginia Parole Board. Relatively few do this, however. According to the Virginia Criminal Sentencing Commission, only 39 of the 375 eligible inmates—roughly 10 percent—applied in 2004. In 2007, only 52 out 500 eligible individuals applied.[35] These low numbers might reflect a procedural conundrum. Once inmates are eligible for discretionary parole release, they are automatically considered for parole annually. However, those who apply for geriatric release forfeit that year's automatic parole hearing. Because the parole board will not consider cases on both grounds in the same year, parole-eligible individuals have little incentive to apply for geriatric release. On the other hand, people convicted under the state's TIS laws—who are by definition ineligible for discretionary parole release—have only the option of applying for geriatric release. As more of them become eligible for geriatric release, Virginia could make more frequent use of its provision by automatically reviewing their cases, rather than relying on individuals to apply for consideration.[36]

## REFERRAL AND REVIEW PROCESSES

The process of referral and review is often complex and lengthy. It takes time to follow geriatric or medical release procedures, such as identifying potentially eligible inmates, compiling relevant information for review by the parole board or another releasing authority, developing release plans, and securing housing and medical care in the community. Delays are not uncommon, especially when staffing is inadequate or processing is inefficient.

Alabama attempted to expedite release proceedings by specifying a time frame for the Board of Pardons and Paroles to decide whether qualified inmates would be granted medical or geriatric parole, in part because some inmates had died while waiting for their parole applications to be reviewed.[37] After several failed attempts to change the paroling process, in 2008 the legislature created a discretionary medical furlough program, administered by the Department of Corrections. Geriatric inmates—persons 55 years of age or older who suffer from a chronic life-threatening infirmity or illness or a chronic debilitating disease related to aging and who pose a low risk to public safety—are now eligible for medical furlough, unless they were convicted of capital murder or a sexual offense. Still, even under the medical furlough program, releases can be time-consuming: as of August 2009, only three inmates had been released under the statute.[38]

In Texas, a review of staffing and the referral process resulted in expanded use of geriatric or medical release and more efficient procedures. In 1991, the Texas legislature created the Medically Recommended Intensive Supervision (MRIS) program to allow for the early release of nonviolent offenders who are deemed not to be a risk to society because of their medical conditions. Under the program, the Texas Correctional Office for Offenders with Mental or Medical Impairments (TCOOMMI) identifies inmates who are "elderly, physically disabled, mentally ill, terminally ill, or mentally retarded" and recommends their cases to the Board of Pardons and Paroles (BPP). Violent offenders and those who used a weapon as part of their offense are not eligible.

In the years following its creation, few elderly inmates were released through MRIS. Overall BPP approval rates for MRIS had been declining through fiscal year 2002, and out of 352 individuals released through special needs parole during fiscal years 1996 through 1999, only 16 were elderly.[39] A management audit in 2002 found delays or problems in the utilization of MRIS for all eligible prisoners. One factor identified as contributing to the delays was staff resources, which were insufficient to process referrals, complete interviews, compile relevant medical information, and coordinate case presentations to the parole board.

In response to this problem, TCOOMMI contracted the Department of Aging and Disability Services (DADS) for case management services. The DADS staff conduct all pre-release interviews, handle federal entitlement applications, and coordinate post-release services, including placement in nursing homes, hospices, or at other facilities.[40] To ensure that staff make timely referrals for offenders with terminal illnesses or long-term care needs, TCOOMMI also made unit physicians responsible for initiating referrals. (Previously, TCOOMMI would request medical summaries for any referral received from internal or external sources, a process that typically had unit medical staff completing paperwork for offenders whose conditions were not deemed clinically appropriate for early release.) The streamlined referral process helps target appropriate inmates for release and reduces paperwork and processing times.[41]

Few states regularly examine their use of parole for elderly offenders and modify procedures based on continual analysis. Those that do—Texas is one example—are in a better position to maximize their use of release mechanisms for older prisoners.

# Recommendations

Early release for older inmates has attracted attention because it promises cost savings at relatively low risk to public safety. However, the practice can be at odds with other criminal justice goals, such as retribution or incapacitation. Because of this conflict, geriatric release policies can be difficult to implement effectively.

1. States that want to reduce corrections spending by releasing elderly inmates should generate

comprehensive estimates of the overall cost savings to taxpayers—not just to corrections agencies. These can address the political and practical concerns that geriatric release merely shifts costs to other state agencies, the federal government, or localities. Such analyses will not only inform discussions about geriatric release policies and practices, but can also result in a more transparent decision-making process. Once geriatric release policies are in place, states should continue to examine them to make sure they are working as intended and as efficiently as possible.

2. Applying the principle that "what gets measured gets done," states should measure and monitor geriatric release mechanisms and require reporting about how they are used. Alabama, New Mexico, and Washington require annual reports to the legislature on applications, grants, denials for release, and returns to custody. States—especially those that employ general medical release policies—should also collect and report data pertaining to the age and medical condition of inmates who are released. Assessing this basic information will help officials see the results of geriatric release over time and gauge whether policies are having the desired impact.

3. States should also be sure to examine the geriatric release process at every stage to identify and address potential and existing obstacles. For example, are eligibility requirements and exclusions too narrow, resulting in too small a pool of inmates who qualify? Are application procedures confusing or burdensome? Are cases reviewed in a timely fashion? Are releases frequently denied at the final stage of the process? In addition to evaluating their own systems on an ongoing basis, states should review the policies and practices of other jurisdictions to help identify factors that can make geriatric release more or less effective.

4. Because public safety is an overriding concern when it comes to releasing elderly prisoners, states should consider developing and validating assessment instruments that can identify people within this population who are at low risk of recidivism. As part of an effective release policy, such instruments would be more reliable than individual judgment at identifying risk levels and the type of supervision an older prisoner would need in the community. Risk and needs assessment instruments would be especially useful in states where eligibility for geriatric release is defined by age rather than by a physical incapacitation that prevents someone from being a threat to society.

5. States that do not restrict geriatric release to people who are terminally ill, severely incapacitated, or bedridden may need to develop creative strategies so that older, but not entirely infirm, individuals can complete their sentences in the community. Testing nontraditional approaches to reducing the geriatric population would be worthwhile; in 2009, for example, the Federal Bureau of Prisons initiated a two-year Elderly Offender Home Detention Pilot Program to allow certain inmates 65 and older to complete their sentences while under confinement and supervision in their own residence. Supportive housing and the medical home model—which refers to an approach to providing comprehensive, coordinated primary care, not placement at a residential facility—may also be promising, but additional housing and health care options are needed.

6. More information is also necessary to develop and implement effective reentry programs and supervision plans for elderly people who are released from prison. One place to start is by adapting existing reentry programs to address the medical, mental health, housing, employment, and social needs of older individuals. Post-release supervision should be modified to address geriatric issues, and parole officers should be trained to understand the needs of older parolees. Since little is known about what older, formerly incarcerated people require to succeed in the community, stakeholders—including correctional

administrators and staff; probation and parole staff; current and former inmates and their families; health care practitioners; service providers; researchers; and policymakers—must collaborate to develop innovative solutions to working with this population.

7. States should consider lowering the age at which inmates are defined as "elderly." Doing so would make more individuals eligible for geriatric release and potentially increase cost savings. This recommendation may be more politically feasible if states combine a lower age threshold with geriatric-specific risk and needs assessments, establish reentry programs and supervision plans (as discussed earlier), or develop pilot programs for releasing inmates who are 55 to 60 years old.

# Conclusion

The need to reduce corrections costs without jeopardizing public safety provides states with an opportunity to introduce or refine geriatric release policies. The challenge is to make existing policies more effective and to identify and assess new approaches to managing an aging population that is expected to grow. States with provisions for geriatric release can lead the way by making greater use of them and evaluating the outcomes. States that have not created such policies can test innovative strategies and help the criminal justice field learn more about what works, particularly with regard to reentry and community supervision for an elderly population that is ill, infirm, or both.

# ENDNOTES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The author thanks Don Stemen at Loyola University Chicago for his examination of this topic while at the Vera Institute, Dr. Brie Williams of the Division of Geriatrics at the University of California, San Francisco, for her expertise and input, and Alison Lawrence of the National Conference of State Legislatures and Roger K. Warren of the National Center on State Courts for sharing their research. The author is grateful to Vera staff members Adrienne Austin and Michael Woodruff for their research assistance and to Jules Verdone, Abbi Leman, and Robin Campbell for editorial assistance. Finally, thanks to Peggy McGarry and Dan Wilhelm of the Vera Institute, and Adam Gelb, Richard Jerome, Brian Elderbroom, and Ryan King of the Pew Center on the States for providing feedback on this publication.

Edited by: Jules Verdone

Photo: istockphoto.com/mrrabbit2502

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**Suggested Citation**

Tina Chiu, *It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release*. New York: Vera Institute of Justice, 2010.

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This report was funded by the Public Safety Performance Project of the Pew Center on the States.

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