

Managing Increasing Aging Inmate Populations Oklahoma Department of Corrections—October 2008

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Abstract

The inmate population 50 years of age and older in the Oklahoma Department of Corrections has grown from 85 in 1980 to over 3600 in FY 2008. The projected population by FY 2013 is 5,354, a further 48% increase, while the overall inmate population is expected to grow at most 10%. This should concern state correctional officials and government policymakers for the foreseeable future. The growth will require greater attention to training, programs, materials, facilities, and care oriented specifically to this population and to its subgroups, such as female inmates. This in turn will mean greater costs, perhaps 2-3 times those of the general inmate population. Thus, even if general population growth plateaus or decreases in coming years, the costs of the “aging” inmate population could keep necessary overall expenditures at current or higher levels. Correctional officials and government policymakers in Oklahoma need to continue planning for this future with the blueprints laid out by the research and analysis put forward in this paper. Failure to adjust appropriately will likely mean even higher eventual costs.

Inmate Population 50 Years of Age and Older, Oklahoma Department of Corrections, 1980, 1994, 2008

<u>Year</u>	<u>50 and Older</u>	<u>DOC Total Population</u>	<u>% of Total Inmate Population</u>
1980	85	1,746	4.9%
1994	879	13,689	6.4%
2008	3,627	25,306	14.3%

Does not include “outcount” population. Data for 1980 and 1994 from Wheeler et al., 1995. Data for 2008 from Oklahoma Department of Corrections, Offender Management System.

The number of inmates in the Oklahoma Department of Corrections (DOC) 50 years of age and older increased from 1980 to 1994 from 85 to 879 and, fourteen years later to 2008, to 3,627. As a percentage of the total inmate population, those “aging” inmates grew from 4.9% of the total to 6.4%, then to 14.3% in the same time periods. The number of inmates 50 and over multiplied more than 10 times between 1980 and 1994 and 4 times between 1994 and 2008, faster rates than the overall inmate population. This age group is the fastest growing of any inmate age range in DOC and, as will be discussed later, will continue to increase significantly in coming years due both to increased receptions within the age category and to longer time served for offenders, particularly violent offenders. The question for policymakers, given the exponential growth, is: how should this age group be planned for and treated in the future?

Aging Inmates Historically and Nationally

The question is not unique to Oklahoma, now or in the past. *Corrections Today* in August 2008 published a report on a national survey including older prisoner health (Sterns et al., 2008). Among the authors’ findings:

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- *“Older prisoners compound resource challenges for states because this population is more likely to have health problems. In 2006, 41 percent of noninstitutionalized Americans older than the age of 65 reported at least one disability, compared with 67 percent in adult correctional facilities. Inmates are more likely to have health and mental health problems because they often come from poor backgrounds; have less education; have a greater likelihood of drug and alcohol abuse; and have had restricted access to health care, particularly when they were young.”*
- *“. . . of prisoners 50 years of age and older in the survey, nearly 45 percent were reported as having a chronic physical problem. More alarming is that 82 percent of prisoners 65 and older have a chronic physical problem. That is statistically identical to the reported 83 percent of 75 year olds with chronic physical problems in the survey. Women are slightly less dramatic, with an increase in reported chronic problems from 42 percent to 74 percent from age 50 to age 65, respectively.”*
- ***“From this, it can be concluded that not only will the number of older prisoners increase by as much as tenfold, the medical resources to maintain current services will need to increase by double that. Consequentially, a potential twentyfold increase in medical resources will be required within the next 10 years [emphasis added].”***
- Approximately 15% of males 50 and over and one-third of females had mental health problems which will also require attention, according to the authors.
- *“. . . The authors propose targeting training in support of early identification of age-related disease; extensive programming modifications targeted at older prisoners; and eventual moderate facility modifications. . . .”* These included preventative care, web-based training on older prisoner management and programming, program modifications such as older adult activity programs, counseling programs and reentry and early release programs, and special housing units and facilities.

These sorts of findings and recommendations were not new. Thirty-six years ago, Edith Flynn proposed the following:

- 1. Begin systemic development and maintenance of baseline data on the elderly offender to facilitate needs assessment, legal compliance, and planning.*
- 2. Modify existing classification systems to facilitate mainstreaming of the elderly if consistent with their physical and mental health needs, as well as with institutional and inmate safety. Special efforts should be made to assign older inmates to the least restrictive security housing consistent with risk and program safety.*
- 3. Adapt and modify existing institutions to ensure the equitable treatment of the old along with the young. Upgraded faculties should include universal access as required by the Americans with Disabilities Act.*

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4. Adapt and modify existing work and educational programs to include health care education, preventive medicine, and counseling geared toward the special needs of the elderly.

5. Establish special geriatric units for older inmates requiring special care. If the size of the population warrants it, the units should include nonmedical geriatric housing for elderly inmates assigned on a voluntary basis or earned privilege, as well as full-fledged geriatric medical units providing 24-hour nursing and medical care, pharmacy services, special diets, and supportive environments for inmates with severe medical, mental, or special needs problems (Flynn, 1982).

More recent academic research has also echoed Flynn and the *Corrections Today* report (Walsh, 1989; Marquardt et al., 2000; Morton, 2001; Mara, 2002; Aday, 2003; Auerhahn, 2006; Rikard and Rosenberg, 2007). For example, a review of 21 research articles found that

Age 50 and older was used most often. The top three health variables were psychiatric conditions, physical illnesses, and substance abuse. Self-reports of health status varied across studies; however, inmates consistently reported health declines since incarceration. Older inmates' health needs appear often to be unmet. Nursing investigations are needed leading to practice innovations to enhance prisoners' self-management to reduce disease burden and fiscal and societal costs (Loeb et al., 2006).

LaMere et al. (1996) had earlier similarly noted that “*Needs of the aging prison population will challenge traditional prison resources, including correctional nursing staff and mental health and counseling services. Substantive assistance for the inmate who has aged in prison must be accompanied by an awareness of the cumulative effects of living and aging within the unique sociocultural environment of the total institution.*”

A Council of State Governments report (1998) from the same period also stated that

“Correctional services may need to address a number of concerns with regard to the elderly inmates, including health care, depression, work assignments, co-payments, nutritional requirements, victimization by other inmates and appropriate staffing. The greatest challenge facing corrections departments in meeting the needs of elderly prisoners is providing for their medical care and the increased costs of that care. The second is the shortage of available facilities and programs to accommodate this population. In addition, the shortage of adequately trained staff is problematic in caring for elderly inmates.”

More specifically, a Federal Bureau of Prisons study (Falter, 1999) had “*found increased health care utilization due to the presence of hypertension (19.2%), arteriosclerotic heart disease (5.4%), diabetes (3.4%), chronic obstructive pulmonary disease (2.5%), length of sentence, and age.*” A 1992 study of aging inmates in Iowa (Colsher et al., 1992) noted

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that “*Subject's disease history included hypertension (40%), myocardial infarction (19%), and emphysema (18%). Most participants (97%) had missing teeth, 42% had gross physical functional impairments, and 70% smoked cigarettes. These findings have implications for health care provision and release planning.*”

A later 2002 Iowa study (Arndt et al., 2002) also found that “*Seventy-one percent of older inmates reported a substance abuse problem. When compared with younger inmates, older offenders were more likely to abuse alcohol only. Those older inmates with abuse problems had used substances for over 40 years, yet more than one-third had never received treatment. Like younger inmates, most older offenders would benefit from substance abuse treatment. The treatment may need to be tailored to age and lack of previous treatment experience and should be sensitive to this high-risk group's additional medical needs.*” Linder et al. (2002) further added to these special needs of aging inmates attention to provision of hospice care:

Inmates have higher incidence of health complications associated with various circumstances, risk behaviors, and associated medical conditions. These circumstances include prison violence, incarceration-related constraints on exercise, and diet. Inmates are more likely to have a history of alcohol abuse, substance abuse or addiction and sex industry work. Risk-behavior conditions include human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), hepatitis B and C, liver disease, tuberculosis, endocarditis, and cardiomyopathy. Hospice is increasingly the preferred response to the health and care needs of terminally ill inmates. Implementing hospice behind bars has some unique challenges in addition to those inherent in hospice work.

Aday verified this greater concern with inmate adjustment and perception to death behind bars with his study (2005-2006) that found that “*fear of death is slightly higher among older prisoners than for similar age groups in the community. Qualitative information based on personal narratives found that some inmates see death as an escape, while others expressed fears of dying in prison or the stigma associated with imprisonment.*”

Relatedly, researchers have called for more attention to the inmates' own perceptions of their aging while incarcerated. Loeb et al. (2006) found that “*Inmates with greater self-efficacy (i.e., confidence) in their health self-management abilities were significantly more likely to rate their health as better, engage in more health-promoting behaviors, and report more improved health since incarceration. Findings . . . highlight the need to develop educational interventions aimed at enhancing older male inmates' health knowledge and self-efficacy for health management to promote greater participation in health-promoting behaviors and better health outcomes.*” The same set of researchers (2008) further compared inmates and “community-dwelling” men in the “aging” category and discovered that “*Inmates reported significantly less participation in health-promotion behaviors ($p < .01$) and attended fewer programs ($p < .05$). The two groups did not demonstrate significant differences in self-efficacy or health status. The latter finding is important because the community men were on average 15 years older. Finding that prisoners attended significantly fewer programs and engaged less often in*

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health-promoting behaviors may be because of lack of availability or awareness of programs to build self-care skills, perceptions that there is not much they can do about their health, a knowledge deficit in regard to health, or insufficient motivation.”

Additionally, some researchers have insisted on special attention to aging female offenders. Williams (2004) noted the tendency of correctional officials to ignore gender differences, accusing them of “a pattern of benign neglect” of their needs and “the unique living environment, health care and programming needs of aging female inmates.” Likewise, Reviere and Young (2003) discovered that

As the numbers of women in prison have increased, so have the number of older women behind bars. These older women present unique problems for institutions trying to meet their health care needs. We report findings from our national pilot study of federal and state prisons for women. Prisons report basic services for physical and mental health care, and most report having hospice services. However, those that house larger percentages or that expect to house larger percentages of older prisoners do not significantly differ in their approaches to assessing and providing health care from their counterparts. By failing to anticipate the increase in older women, prisons may be failing to provide for many of the health needs of this vulnerable population.

More recently, a study of female inmates in California (Williams et al., 2006) reported

“The number of older prisoners is increasing exponentially. For example, the number of geriatric female prisoners in California has increased 350% in the past decade. Despite an increasing population of geriatric female prisoners, the degree of functional impairment in this population is unknown. . . . Questionnaires were analyzed from 120 geriatric women in California state prisons. Functional impairment was defined as impairment in activities of daily living (ADLs) or in prison ADLs (PADLs), including dropping to the floor for alarms, standing for count, getting to meals, hearing orders, and climbing onto the top bunk. The mean age of participants was 62; 16% were dependent in one ADL, and 69% reported one PADL impairment. Increasing severity of functional impairment was associated with worse health status and more adverse prison experiences. For example, fall rates ranged from 33% in women without impairment to 57% with PADL impairment to 63% with ADL dependence ($P=.02$). Several prison environmental stressors were identified that likely exacerbate functional impairment. For example, 29% of geriatric women were assigned to a top bunk. Geriatric female prisoners report high rates of functional impairment. ADL and PADL impairment were associated with worse health status and adverse prison experiences. Therefore, the evaluation of functional impairment in geriatric female prisoners needs to consider the unique demands of the prison environment.”

It is clear from this literature that the needs of the aging inmate population and its subgroups are substantial and that they are growing in importance for correctional

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programming and policymaking across the nation. We turn now to the specific implications for Oklahoma and its future correctional populations, expenditures, and operations.

The Aging Inmate Population in Oklahoma

Formal analysis of the aging inmate population in Oklahoma extends to the mid-1990s. Wheeler et al. (1995a; see also 1995b) examined inmate data from 1980 to 1994, breaking down increases in the 50 years of age and older population by race, gender, offense type, and percentage of total inmate population. The authors concluded that Oklahoma and its DOC needed to pay greater attention to the growth of that age group, reiterated Edith Flynn's recommendations for policymakers, and added the following:

- *As Oklahoma's older offender population increases, corrections officials should consider dedicating a facility specifically for older inmates. The facility would be equipped to meet the special needs of an aging population. One centrally located facility dedicated to older offenders would reduce the cost created by multiple facilities duplicating services. Additionally, the facility should be centrally located to minimize transfer cost to the state and also minimize the negative impact of distance on older offender's support networks with family and community. Such "special needs" facilities that can show long-term cost savings may also be more politically palatable to legislators and taxpayers as well.*
- *Programs should be created that are directed specifically toward the reintroduction of older offenders into society. The support networks of older offenders, particularly those who age in prison, if they exist at all, are minimal. Without knowledge of community support and social agency programs, it is likely that many older offenders will not be able to function independently within society. The result could be a high rate of recidivism for older offenders.*
- *Programs such as woodworking, basketry, other forms of arts and crafts, and horticulture are examples of recreational and leisure activities that can be profitable and at the same time replace work programs for older inmates. These types of activities could also allow them an opportunity to earn money and "good time" credits.*
- *A comprehensive educational program for all corrections personnel should be required. Training should include the knowledge and skills that are required to meet the specialized needs of older offenders as well as an increased sensitivity to their needs and limitations, and the patience to deal with them. Implementation problems can be enormous without staff "buy-in," and management planning and processes should be carefully directed to this concern.*
- *Some individuals may view many of the issues associated with the elderly, such as chronic illnesses, total dependency, frailty, and death in a negative light. Therefore, consideration should be given to assigning personnel to work with older offenders on a voluntary basis.*
- *In an effort to minimize costs while meeting the special needs of older inmates, consideration should be given to utilizing resources that exist within the community. Hospitals, mental facilities, geriatric, and nursing homes are just a*

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few of the facilities that may exist within the community that older inmates judged to be low security risks might be able to utilize.

Knapp and Elder (1997/1998) surveyed DOC prison personnel at a minimum security facility in Oklahoma regarding their knowledge and perceptions of the aging process and aging offenders. They found that

the age, educational level, and occupational category of the prison personnel impacted their knowledge and perceptions of the aging process. The findings suggested that training programs need to be developed in order to more fully acquaint prison personnel with the realities of the aging process. While all prison personnel could benefit from the training, the results suggested that the training could be especially beneficial to prison personnel who are younger, have less formal education, and, especially, those who have greater contact with the inmates due to their job responsibilities.

More recently, the Oklahoma Criminal Justice Resource Center presented a report (Chown, 2005) on “The Aging of the Oklahoma Prison Population: Implications for Health Care Costs.” That report used 45 as the threshold age for “aging” inmates, making it less comparable to other research on the topic. However, its detail of the increase in the 45 and over population and projections of future growth paralleled that of national and other state research. The report reviewed literature that indicated high continuing rates of increase in health care costs and thus overall correctional budgets due to the aging inmate population. It also detailed statistics showing that “the health care expenses for persons age 55 to 64 are more than twice as much as those for the 19 to 44 age group” in Oklahoma’s DOC. It further demonstrated that the increase in aging inmate population was due both to increased receptions within the age category and to longer time served for offenders, particularly violent offenders. The average age of prison receptions in Oklahoma had increased from 30.0 in 1990 to 32.9 in 2004. Finally, the report projected an increase in the 45+ population from 5,651 in FY 2005 to 9,147 in FY 2015.

A rough projection of the 50+ population can also be done using the average percentage increase in that population group from recent years. For example, the mean annual percentage increase in the 50+ population between FY 2005 and FY 2008 was 8.1%. Assuming the same percentage increase in each of the next five years from FY 2009 through FY 2013, we see the following potential populations:

FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
3,627	3,921	4,238	4,582	4,953	5,354

If the de facto *ceteris paribus* assumptions hold and this increase of 1,727 inmates 50 years of age and older is accurate, this will mean an increase of almost 48% in the time period compared to an overall inmate population increase expected to be at most 10%. Moreover, since this population actually costs a generally accepted 2-3 times the general population, DOC needs to budget for a population greater than that normally expected.

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In fact, this indicates that, even were the general inmate population to decrease in number, the growth of the 50+ population will require as great or greater overall budget growth to meet departmental costs. Failure to meet inmate health care costs could result in forced expenditures through federal court action as is currently occurring in California.

Conclusions

Clearly, the inmate population 50 years of age and older will concern correctional officials and government policymakers for the foreseeable future. This will require greater attention to training, programs, materials, facilities, and care oriented specifically to this population and to its subgroups, such as female inmates. This in turn means greater costs, perhaps 2-3 times those of the general inmate population. Thus, even if general population growth plateaus or decreases in coming years, the costs of the “aging” inmate population will keep necessary overall expenditures at current or higher levels. Oklahoma correctional officials and government policymakers need to continue planning for this future with the blueprints laid out by the research and analysis put forward in this paper. Failure to adjust appropriately will likely mean even higher eventual costs.

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