Challenges Associated with Incarcerating the Elderly: A Look into More Viable Incarceration Options

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Challenges Associated with Incarcerating the Elderly: A Look into More Viable Incarceration Options

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Abstract

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Amanda Mohr

Under the Supervision of Dr. Michael Klemp-North

Statement of the Problem

A major problem currently facing the United States relates to overcrowded prisons and budget deficits. Due to truth in sentencing and three strike laws, prisoners must serve mandatory sentences before being released into the community. Therefore, some offenders are serving life sentences, while others will not be released into the community for several years. Housing elderly inmates continues to be an ongoing challenge that the criminal justice system is faced with. As a result of housing a substantial number of elderly inmates, our society is forced to find ways to handle the overcrowding issues, maintain cost effective budgets, and successfully care for an aging prison population which often requires an increased level of attention and medical care needs.

The purpose of this paper is to address management issues for aging prisoners. According to Aday (1994) the security level of an inmate decreases with age. In order to address these concerns, this paper will explore problems, risks, and needs that aging inmates face while they are incarcerated. First of all, various statistics pertaining to elderly inmate care will be reviewed. Next, this paper will review various prison camps, programs, and alternatives to incarceration that are designed for aging inmates. Furthermore, this paper will provide a recommendation that could benefit the prison system as a whole. Specifically, this paper will
explore alternatives to incarceration that could be utilized by qualifying inmates that would essentially save money while also helping with overcrowding issues.
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I. INTRODUCTION

As a result of truth in sentencing and three strike laws, prisoners must serve mandatory sentences before being released into the community. As a result, some offenders are serving life sentences, while others will not be released into the community for several years. Housing elderly inmates continues to be an ongoing challenge that the criminal justice system is forced to deal with. Since prison systems are now being forced to find ways to handle the overcrowding issues, questions remain as to how we can find ways to maintain a cost effective budget while successfully caring for an ageing prison population who often needs an increased level of care and attention.

A. Increasing Number of Elderly Inmates: A Brief Statistical Overview

Overall, we need to acknowledge the fact there are elderly inmates who are serving lengthy sentences that also require an increased level of care. Most recent statistics show in 2009, state and federal prison authorities had jurisdiction over 1,613,740 inmates. Specifically, there were 1,405,622 offenders under state jurisdiction and 208,118 under federal jurisdiction. Of these incarcerated individuals, 41,800 were between 55-59 years of age, 20,600 were between 60-64 years of age, and 16,700 were 65 or older (Bureau of Justice Statistics, 2011).

As the number of elderly inmates is rising, so are the costs to house and care for them. On average, it costs between $18,000 and $31,000 to house an inmate a year (Blythe, 2007). However, these costs significantly rise when housing an elderly inmate because they require more healthcare and medical attention. In fact, Geranios (2010) suggests on average, it costs about $72,000 per year to house an elderly inmate, compared to $24,000 for an inmate in general population.
The above statistics highlight the number of elderly prisoners, age 55 and older, and the amount of money it costs to house them on a yearly basis. While the number of elderly inmates is increasing, it is clear our system needs to take further steps to provide for the elderly prison population. Although certain programs have already been established to care for this special needs population, there is room for improvement. Therefore, we, as a society, need to invest in programming that is not only cost effective, but can help manage elderly prisoners.

### B. Importance of Elderly Needs

In general, elderly people can require an increased level of care and needs over the general population (Gater, 2010). However, elderly prisoners can require additional help at an earlier age than what society considers elderly because many of them do not receive proper healthcare before they are incarcerated. As a result, many of these inmates appear to be on average 10-11.5 years older than they actually are and require specialized care at an early age (Thivierge-Rikard & Thompson, 2007).

Overall, it is important that our society recognizes the importance of elderly needs early on. For example, on average, statistics have shown it is estimated that an elderly prisoner suffers from at least three chronic illnesses (Aday, 1994). In addition to the illnesses, several elderly inmates require specialized housing units, diets, and round-the-clock nursing care that can tailor to the issues that could arise. In order to address the needs of the elderly, it is important to find ways to handle these illnesses while also providing the best care possible.

### C. Anticipated Outcomes

It is anticipated that research will show and reflect the need for continued care in the prison system for the elderly prison population. A review of various programs will show the
extensive costs and care that go into tending to the needs of an elderly prisoner. Recommendations will show that our prison system could benefit from a specific program designed to care for elderly inmates while also creating jobs for general population inmates who would be able to care for this special needs population at a reduced cost. In addition, it is anticipated that the general population inmates would also benefit once they were released from prison because the job skills they obtained while caring for the elderly prisoners could easily be applied to specific jobs once they were released. Furthermore, it is anticipated that qualifying non-violent elderly offenders could benefit from alternative incarceration options such as electronic monitoring/GPS which could also be more beneficial and cost effective.
II. LITERATURE REVIEW:

A. Elderly Inmate Statistics

Today, the elderly prison population, age 55 and older, is one of the fastest growing incarceration populations throughout the United States (Cox & Lawrence, 2010). According to Thivierge-Rikard & Thompson (2007) inmates who are 50-55 years of age are classified as elderly in the prison system because they often have long histories of alcohol and drug abuse, poor diets and lack of medical care. As a result, these inmates tend to age more quickly and are considered elderly at a much earlier age than the general public. Due to the crime and sentencing trends of the 1980s and the 1990s, the number of federal or state inmates, age 55 and older, continues to rise (Cox & Lawrence, 2010; Aday, 2003). As a result of mandatory sentencing, three strike laws, longer prison terms, and more restrictive release policies, an increasing number of elderly inmates are filling up America’s prisons (Neeley & Addison, 1997). In addition, these new laws have increased the number of inmates admitted into the prison system, and continue to reduce the number that can leave (Aday, 2003).

As seen in Appendix A, the number of elderly prisoners increased substantially between the 1980s and 1990s. From 2000 to 2010, the projected estimates in Appendix A indicate that the number of elderly prisoners will only continue to rise (Yates & Gillespie, 2000). Between 1994 and 1998, prison admissions for offenders age 55 and older increased 55 percent compared with an overall admission increase of only 24 percent (Aday, 2003, p. 14). From 1995 to 2000, statistics show a 38 percent increase in inmates over the age of 50 (Aday, 2003). However, Texas, Louisiana, and Mississippi’s elderly inmate population more than doubled during this time (Aday, 2003). From 2000 to 2005, statistics show that the number of state and federal inmates age 55 and older increased 33 percent, which is faster than the 9 percent overall growth
rate (Blythe, 2007). Most recently, in 2009, state and federal prison authorities had jurisdiction over 1,613,740 inmates. Specifically, there were 1,405,622 offenders under state jurisdiction and 208,118 under federal jurisdiction. Of these incarcerated individuals, 41,800 were between 55-59 years of age, 20,600 were between 60-64 years of age, and 16,700 were 65 or older (Bureau of Justice Statistics, 2011). According to Appendix B, per 100,000 U.S. residents, there were 2,830 inmates age 55-59, 1,686 inmates age 60-64, and 649 inmates age 65 or older that were sentenced prisoners under state or federal jurisdiction in 2009 (Glaze, 2010).

Due to tougher sentencing laws in the southern states, the growth rate has increased by an average of 145% since 1997 (Blythe, 2007). Although there are several variables that can influence why there are many elderly prisoners, researchers have classified these offenders into four different types: new or first time offenders, chronic or career offenders, prison recidivists and inmates who have grown old as inmates (Neeley & Addison, 1997; Aday, 2003). New or first time offenders are those who are incarcerated for the first time in their lives. Research shows that approximately one-half of elderly offenders coming into the prison system are classified as new or first time offenders (Aday, 2003). The chronic career offender or prison recidivist often spends a substantial amount of time revolving in and out of the prison system. These types of offenders continue to commit crimes over the course of their lives, often starting at a young age. Over the course of time, these types of offenders know the prison routine, but still continue to revolve in and out of the prison system. Finally, there are inmates who are considered to have grown old as an inmate. Inmates who are considered to have grown old in prison are inmates who received a life without parole sentence at a young age, and will continue to be incarcerated until their death (Neeley & Addison, 1997; Aday, 2003).
As previously mentioned, approximately one-half of elderly offenders find their way into prison are classified as new offenders. New offenders usually commit crimes of violence, usually against their family members, friends, or acquaintances. For this particular type of offender, the most frequent crimes they commit tend to involve, alcohol, sex offenses, embezzlement, and fraud (Aday, 2003). For chronic or career offenders, their offense conduct varies, but usually involves a lifetime of in and out of prison. Furthermore, their long history of offense conduct had landed them lengthy sentences due to mandatory sentencing laws (Aday, 2003).

According to Aday (2003) the majority of elderly offenders over the age of 50 are non-Hispanic whites. However, it is noted that the elderly prison population does include a disproportionate number of African Americans. Aday (2003) indicates that although the number of incarcerated females is increasing, 95 percent of the elderly inmate population is male. In 2009, the Uniform Crime Report indicates that there were 10,741,157 people arrested. When comparing these statistics to the inmate population as a whole, 1,515,586 of these arrests were on people under the age of 18, and 9,225,571 of these arrests were on people 18 years of age or older. Of the 9,225,571 arrests made on people 18 years of age or older, 895,419 were age 50 and older (U.S. Department of Justice, 2009).

Regardless of which classification an elderly offender falls under or offense they committed, they make up part of a special prison population. Specifically, Aday (2003) indicates the following:

This special population has several special needs that consist of an increased number of health-care costs, medical needs, and problems associated with
individual adjustments to prison life, and issues with family relationships that often pose special challenges to the prison system regarding custody, rehabilitation, and parole. (p. 18)

Overall, it is clear that this special population of people has several needs that need to be addressed. Furthermore, this group of people requires additional care within the institution along with a variety of issues that need to be considered when caring for an elderly prison population. The following section will review the various costs that are involved with caring for an elderly prisoner. Specifically, the financial, emotional, and physical costs with housing and caring for an elderly inmate will be explored.

B. Financial/Emotional/Physical Costs

According to Aday (1994, p. 47) “elderly offenders pose unique and costly problems for correctional systems that are already struggling to cope with overcrowding issues.” In addition, state and federal facilities are forced to find ways to deal with an increasing number of elderly inmates who often need an elevated level of medical care and special housing conditions (Blythe, 2007; Gater, 2010). Although special medical needs can vary from simple things such as hearing aids, eye glasses, and dentures, others can be extremely costly such as prescription medications, prosthetic devices, round-the-clock nursing care, and wheelchairs (Aday, 1994; Yates & Gillespie, 2000). Furthermore, even though medical care can be costly, it is still the state’s responsibility to provide adequate care to all offenders. Specifically, the U.S. Supreme Court’s decision in Estelle v. Gamble., 429 U.S. 97 (1978) requires that prison officials must provide medical care for all inmates; as justified by the Eighth Amendment protecting people against cruel and unusual punishment (Yates & Gillespie, 2000; Chen, 2009).
As of now, inmates are ineligible for Medicare and Medicaid while they are incarcerated. For inmates being housed in a public institution, the department is allowed to suspend eligibility while an individual is incarcerated. Specifically, federal rules and regulations have permitted benefits to be suspended when an individual is incarcerated for less than 12 months, or terminated all together if the incarceration period is longer (Social Security Administration, 2010). As a result, these costs that Medicare or Medicaid previously covered, must now be figured into the correctional budget since each agency is responsible for their inmates’ healthcare costs.

Blythe (2007) found that on average, it costs a state between $18,000 and $31,000 per year to house one inmate. Geranios (2010) suggests on average, it costs about $72,000 per year to house an elderly inmate, compared to $24,000 for an inmate in general population. This increase in cost is significantly higher because elderly inmates require more health and medical attention. This care also means states must include in their budgets additional costs it takes to have proper licensed doctors and additional staff members to care for this special needs population. In fact, research suggests it costs three times more to incarcerate an elderly offender than a non-elderly offender (Yates & Gillespie, 2000; Key, 2005).

Research further suggests that healthcare in prison can cost as much as four times more for an elderly inmate than a younger offender (Johnson, 2011). Overall, each year, there is about $3 billion dollars spent on medical care costs for all inmates across the country. In Wisconsin alone, the Department of Corrections spent $37.2 million and employed 232.5 full time qualified medical professionals and support staff to provide healthcare to approximately 14,900 inmates from 1999-2000 (George, et al., 2001). In addition, the department contracted with 315 vendors and spent $3.9 million on supplemental medical, laboratory, dental, and optical services that the
prison facilities were unable to provide (George, et al., 2001). In 2001, Ohio’s Department of Corrections spent $115 million dollars on prison healthcare. Furthermore, research has shown that there has been a 96.2% increase in costs from 2001 to 2010 in Ohio’s prison system because their healthcare costs have risen to over $225 million (Geisler, 2010). When comparing costs of elderly offenders to the general population, there is a drastic difference. For example, each year, the State of Georgia reports spending about $8,500 solely on medical costs for inmates over 65, compared to about $950 that is spent on younger inmates (Chen, 2009). Texas reports spending over $4,700 in medical costs for inmates over 55 compared to $765 for inmates that are younger (Ramshaw, 2010). As healthcare costs continue to rise, caring for an increasing number of elderly inmates will become more difficult. Overall, it is important to recognize the need for services and the amount of care needed to care for this special needs population. Specifically, if these issues are not recognized, they will continue to dramatically strain health-care services as well as increase prison medical costs (Aday, 2003).

For elderly inmates, when managing chronic diseases and mental health issues, correctional officials have to find a way to balance the need for cost efficiency while also providing adequate medical needs to each inmate (Stojkovic, 2007). According to Aday (2003) correctional officials in several states have reported spending more than 10 percent of their budget on elderly care in a given year. Since the Americans with Disabilities Act was passed and applied to inmates in 1998, states are now forced to provide adequate care to inmates at an extensive cost. Specifically, the American with Disabilities Act was developed to ensure people with disabilities have an equal opportunity to participate or benefit from programs, services, and activities that are accessible to both inmates and their visitors (Krienert, Henderson, & Vandiver, 2003). For example, under this act, state and local agencies must modify their programming and
policies to meet the needs of offenders with disabilities, modify architectural structures to accommodate inmates with disabilities, and make sure that all inmates who have visual, speech or troubles hearing have access to appropriate means for communicating. Specifically, for elderly offenders, this means that structures must be wheelchair accessible and living quarters must be more spacious without bunk beds because many elderly inmates are physically unable to climb to an elevated bed. Additionally, elderly inmates may need to be equipped with special glasses to see, hearing aids, or other prosthetic devices (Aday, 1994). Furthermore, facilities are also forced to deal with the costs associated with specialized housing, recreation, shower and toilet amenities, access to courts, medical services, disciplinary hearings, telephone and commissary privileges, visitation programs, education, vocation and counseling programs, as well as therapy and substance abuse treatment when dealing with this special needs population (Krienert, et al., 2003). Yates and Gillespie (2000) indicate that in order for correctional institutions to keep up with the minimum requirements of the Americans with Disabilities Act, prisons will more than likely begin to experience a rise in costs for facility modifications that will allow for special accommodations for the elderly prison population. Specifically, costs will continue to increase in each institution as the need for various amenities and other specialized housing and living conditions continue to rise.

Research suggests that approximately one-third of elderly inmates will die in prison (Stojkovic, 2007). To manage costs and bring incapacitated inmates home before dying, some institutions suggest medical releases for specific diagnosis. However, a medical release is extremely hard to come by. In Texas alone, of the 4,000 inmates that were recommended for medical release in the past 10 years, the parole board turned down almost 3,000 of them (Ramshaw, 2010). Besides Texas, there are several other states that are struggling to deal with
the increasing health care costs and the concerns regarding a medical release. In an effort to balance these issues, certain facilities have developed hospice services for inmates who are close to death (Stojkovic, 2007; Ramshaw, 2010). Even though a majority of states have established one or two institutions designated for inmates near their death, some are unable to because of the enormous costs and the lack of resources available that would appropriately address the needs of dying prisoners.

Although hospice facilities are expensive, Stojkovic (2007) suggest “these types of centers are practical because they address policies and procedures that tailor to the needs of dying prisoners” (p.107). Research has also suggested that that the care for an elderly inmate over the age of 60 can cost over $69,000 per year which happens to be twice the cost of a nursing home (Sharp, 1999).

Prison officials have routinely recommended medical release for terminally ill inmates who have less than six months to live, but often get denied by the parole board due to safety concerns. As a result, these sick individuals will continue to die in prison at the states expense (Ramshaw, 2010). In 2009 alone, Texas had more than 440 inmates die in prison. In specific cases, 31 were recommended by medical staff for an early release but died while waiting for the parole board to take on their case, 26 died after the parole board rejected their recommendation, and 12 inmates were approved for medical release, but died before they were sent home (Ramshaw, 2010). It is also important to look at the costs of death as well. Research has shown that it is cheaper to have an inmate serve out their entire life without parole sentence than to sentence them to the death penalty. For example, each year it costs California taxpayers $90,000 more to house one prisoner on death row versus having them in the general population. More
specifically, California spends $59 million a year to house general population, but $336 million for inmates on death row (ACLU, 2011).

Besides the monetary costs involved with incarcerating elderly offenders, there are emotional and physical costs that need to be considered as well. Research suggests that several elderly prisoners suffer from anxiety due to the fear of dying in prison (Yates & Gillespie, 2000). In addition, several elderly offenders also experience depression and loneliness while they are institutionalized. Furthermore, elderly offenders can be viewed as vulnerable and are often preyed upon by younger inmates because they are physically unable to complete work assignments and other various tasks that younger inmates can (Yates & Gillespie, 2000).

C. Review of Risks and Needs when Dealing with the Elderly

As aging inmates continue to fill up our prison system, correctional facilities are forced to find ways to care for this special population of people who pose several risks and needs. Since a majority of inmates do not receive proper health care before their incarceration, many of them age faster than their peers who are not incarcerated (Gater, 2010). Although in general there have been several advancements in the medical field, many inmates have extensive histories associated with alcohol and drug abuse, poor diets, and lack of medical care. Additionally, the combination of poor physical and mental health care will on average age inmates 10-11.5 years older physically than they are chronologically. Therefore, inmates who are 50-55 years of age are classified as elderly in the prison system (Thivierge-Rikard & Thompson, 2007).

Research indicates that correctional systems all over the country are faced with finding ways to respond to the special needs of elderly prisoners (Aday, 1994). In addition, several experts will agree that the increase in the elderly prison population is not due to an elderly crime
wave (Aday, 2003). In fact, a majority of these problems have stemmed from the tougher mandatory sentencing laws that passed in the 1980s and 1990s (Blythe, 2007). As a result, it is becoming increasingly common to see elderly inmates in wheelchairs, or using walkers and canes. Some elderly inmates are even too sick to get out of bed at all (Blythe, 2007).

Overall, prisoners are not a healthy population of people. In a place where tuberculosis, psychiatric disturbances, trauma, substance abuse, and sexually transmitted diseases are common, a need for medical care and treatment is essential (Aday, 2003). On average, it is estimated that an elderly prisoner suffers from at least three chronic illnesses (Aday, 1994, p. 49). Many of the chronic illnesses such as arthritis, respiratory, and cardiovascular diseases can affect the mobility of the elderly inmate making it more difficult for them to get around. This is especially true since many of the institution structures are designed for able-bodied inmates who do not have any handicaps or limitations with mobility. In addition, many elderly prisoners require special diets, round-the-clock nursing care, and special institutional activities (Aday, 1994; Aday, 2003).

There are risks concerning the functioning needs of elderly inmates and the risks of housing them that also need to be considered. First of all, leaving elderly prisoners in conventional prisons can lead to inefficient healthcare, victimization, and a system that is not fit to tailor to the needs of a specialized group of people (Aday, 2003). Unlike the general population, this special needs population requires additional attention and services that staff needs to accommodate for (Gater, 2010).

Like an aging population in the community, prison officials are being forced to deal with special requests and specific healthcare needs behind prison walls. For example, several inmates
struggle with mobility issues, arthritis, seizures, respiratory problems, cancer, dementia, diabetes, heart disease, Alzheimer’s disease, mental health issues, schizophrenia, anxiety, and substance abuse (Villa, 2005; Cox & Lawrence, 2010). When an inmate is forced to deal with these issues and illnesses, there can be different risks associated with them as well. For example, suicide risk is extremely high for the elderly population in general. Specifically, in 2003, elderly people residing in the community had a suicide rate of 22.3 suicides per 100,000 males and 5.9 suicides per 100,000 females that were 55-64 years of age. For elderly people residing in the community that were over the age of 65, the suicide rate increased to 29.8 suicides per 100,000 males and 3.8 per 100,000 females. When comparing the number of elderly suicide rates for incarcerated people to the ones residing in the community, there were 58 suicides per 100,000 elderly inmates who were in jail and 13 suicides per 100,000 elderly inmates who resided in a state prison that were 55 years of age and older in 2003 (Cox & Lawrence, 2010).

Besides the suicide risks associated with illnesses and issues of getting old, there is also an increased suicide risk and self-harm for inmates who have an increased stress level, experience a significant loss, or if this is their first time being incarcerated (Kuhlmann & Ruddell, 2005; Cox & Lawrence, 2010). Elderly offenders are also forced to deal with finding ways to cope with loss and the stress that confinement can have on someone. More specifically, elderly inmates have a hard time dealing with coping with a loss, especially if this is their first incarceration (Aday, 2003; Cox & Lawrence, 2010). Several inmates experience bouts of depression and anxiety over the loss of other elderly friends in prison. They often form bonds with each other because of their age, so when one of them dies, it can present traumatic stress for other elderly inmates (Cox & Lawrence, 2010).
It is also important to recognize how common cognitive and emotional disorders are among elderly offenders. Aday (2003) indicates that correctional facilities in the United States house more mentally ill individuals than hospitals and mental institutions do combined. It is estimated that 15 to 25 percent of elderly people living in the community suffer from some sort of psychiatric disorder (Aday, 2003). This number substantially rises for elderly people who are incarcerated. Research has suggested that older inmates tend to have more stressors to deal with than younger inmates because they have not experienced poor health or major changes in strength, vitality, and endurance like elderly offenders have (Aday, 2003). Of the mental health disorders that the elderly prison population suffers from, reports show that depression, Alzheimer’s, alcohol and drug use, anxiety, dementia, and late life schizophrenia are the highest (Aday, 2003; Cox & Lawrence, 2010). For elderly inmates who suffer from dementia, housing them can be challenging because often times they do not even remember their crimes. In addition, an outburst by an inmate with dementia could be a symptom of a troubled mind or issues that are associated with their disease instead of a hostile or intentional act of violence. Therefore, correctional staff must recognize that a majority of the time, you can not constitute these types of inmates has having bad behavior because they have no idea what they are doing to justify their actions (Hill, 2007).

Researchers have shown that the risk level of elderly prisoners to others is relatively low. If anything, the general population tends to pose an increased risk level to the elderly. For example, many elderly offenders tend to be prime suspects for victimization within the prison (Aday, 2003). Specifically, elderly prisoners experience bouts of abuse, harassment, teasing, and other minor incidents from the general population because they are seen as vulnerable and are thus targeted by the younger inmates (Yate & Gillespie, 2000; Aday, 2003).
Although addressing risks and providing care for elderly inmates is mandatory, it also costs taxpayers a substantial amount of money. Blythe (2007) advises that until lawmakers begin to address the issues that are putting the elderly in institutional settings for long periods of time, the number of elderly inmates will only continue to rise, as will the costs. Researchers suggest that correctional professionals need to practice proactive planning strategies that address the rapidly growing elderly prison population (Neeley & Addison, 1997). Research also suggests that since many elderly prisoners have complex medical and psychiatric needs that cannot always be reasonably met, other options need to be considered. For example, many elderly prisoners experience abuse and neglect at the hands of correctional administrators because adequate care is not available (Stojkovic, 2007). As a result, researchers recommend that certain health-related issues pertaining to the management of prisoners with Alzheimer’s disease, prisoners suffering from serious mental health problems, and end-of-life care should be considered for non-custodial sentences (Stojkovic, 2007, p. 105). In addition, for the elderly inmates that do not qualify for non-custodial sentences, the development of future programs and policies that correctional officials can use in order to better respond to the needs of elderly inmates is essential (Aday, 1994).

D. Review of Current Programs and Services

Correctional officials are being forced to deal with an increase in the number of elderly prisoners in the United States. As a result, correctional agencies and other groups are exploring various policy alternatives in order to effectively and efficiently deal with this special population of people (Yates & Gillespie, 2000).
a. Dorm-Like Housing Units

It is becoming more common for states to house elderly inmates apart from the general population. A majority of these units represent dormitory housing units that offer unique programming and services for elderly offenders (Aday, 1994). States such as Alabama, Georgia, Illinois, Kansas, Kentucky, Maryland, Michigan, Minnesota, Mississippi, North Carolina, New Jersey, Ohio, South Carolina, Tennessee, Texas, Virginia, West Virginia, and Wisconsin have all established special dorm-like housing units described to care for aged, geriatric, or disabled offenders (Aday, 1994). Within these dorm-like structures, the department of corrections considers each inmate’s aging needs and concerns on an as needed basis (Gater, 2010). In dorm like settings, preventative care for inmates seems to be the number one goal along with chronic care clinics and more physical examinations for elderly offenders (Aday, 2003). These specialized housing structures have minimal stairs and are designed for inmates who have a difficult time traveling the distances to other facilities in the institution such as the lunchroom, canteen, or to recreation. These facilities also accommodate the education, vocational, recreational, and rehabilitative needs of elderly offenders. Certain facilities even employ psychologists and specialized counselors who can promote social, psychological, and emotional needs of each elderly inmate (Aday, 1994). Dormitory housing units provide care to inmates who need twenty-four hour medical coverage and care. In addition, these types of units provide educational programs that are geared to the specific needs of the residents (Aday, 2004).

b. Long-Term Care Facilities

There are certain states that also have long-term care facilities for elderly inmates. These long-term care facilities are designed to care for aging inmates who need around the clock care
and have severe medical issues. These types of facilities are more spacious, wheelchair accessible, and often have special bathing units that meet the needs of this special population. In addition, these units usually staff a physical therapist to work with the inmates as well (Gater, 2010). Long-term care facilities usually provide hospice care for the sick and dying inmates with cancer. In addition, there are usually special units within these facilities that deal with inmates who have Alzheimer’s, Parkinson’s, or dementia. Some prison systems even offer dialysis units for inmates who are in need. Overall, these long-term care facilities can meet the needs of the prisoners, but at a severe cost to taxpayers (Gater, 2010).

c. The RELIEF Program

The Reintegration Effort for Long-term Infirm and Elderly, Federal Offender (RELIEF) program was implemented in Canada in 1999. This program takes a collaborative effort by having offenders, community volunteers, and correctional staff members work together to meet the needs of incarcerated and conditionally released offenders who are unable to care for themselves (Stewart, 2000). It was designed to address the special needs of elderly offenders by focusing on areas of recreation, exclusion from the workforce, self-care, nutrition, and living in special care settings.

This program is more like an in-home structure versus an institutional one by providing supervision, general care, and access to medical care by using the services of trained offender hospice/care workers, professional staff resources and community medical services to care for the elderly (Stewart, 2000). Additional goals of the program focus on providing a safe reintegration option for elderly inmates by addressing the needs and concerns of a special needs population in a community setting, provide a safe humane care for offenders during a dependent
stage of their life, provide a caregiving program in a correctional setting that will follow the same high standards of care, and to train selected offenders to assist in the care of elderly offenders at the community-based residential facilities (Stewart, 2000).

The RELIEF program has designated four, six bedroom houses for its operation with each house having a different level of care. House A accommodates up to six residents who require around the clock care. Inmates being housed in “A” have severe medical conditions, disabilities, and problems with mobility. Specifically, these types of inmates require wheelchairs or walkers and require help with bathing, dressing themselves, and various other personal care needs (Stewart, 2000). House B can accommodate up to four residents who require 14-16 hours a day of assisted care. Inmates in this setting usually lack physical capabilities that require someone else’s assistance with bathing, personal care, and access assistance (Stewart, 2000). House C accommodates up to four low level residents who require 8-10 hours a day of assisted care. Offenders in this housing unit usually need help with things such as medical conditions, physical disabilities, and post-operative recovery. However, inmates being housed in C are able to do a majority of tasks on their own (Stewart, 2000). House D accommodates the various caregivers’ that are working in House A to ensure respite care. Additionally this specialized house for the caregivers allows for changes in house assignments with minimal impact on the houses themselves (Sewart, 2000). The RELIEF program provides collaborative efforts by ensuring a variety of staff members are available throughout the day to assist offenders with their daily needs. In addition, certain services are available 24 hours a day.

Overall, this program accepts first time elderly offenders and elderly offenders who have grown old within the prison system. These offenders have been labeled as low risk for future criminal activity because of their physical limitations and attitudes towards staff (Stewart, 2000).
A benefit of the RELIEF program is that the offenders are receiving the care they need, and other offenders are helping with the costs because they are being trained to assist with providing care to the sick ones. In addition, although these offenders are potentially in the community, their risk level is low because they are being closely monitored on a day to day basis while also receiving the care they deserve (Stewart, 2000). For the elderly that are participating in the program, the main objective is to move them towards a release into a family setting or appropriate facility care. For the offenders who were trained to care for these elderly inmates, their training has helped them with the reintegration process and could potentially land them employment in other healthcare fields once they are released from prison (Stewart, 2000).

Overall, this program’s purpose is to care for and work with the elderly and other inmate workers while in a community setting that can assist with their reintegration while also providing access to the professional care and needs they require (Stewart, 2000).

d. Project for Older Prisoners Program (POPS)

The Project for Older Prisoners (POPS) program was designed to offer non-custodial alternatives to elderly prisoners who have illnesses that can be better managed in the community (Stojkovic, 2007). This program was designed in 1989 after a 50-year-old prisoner was previously sentenced to thirty years in a maximum prison for stealing $117.00 and a cherry pie from a convenience store. At the time of his release, this individual was a labeled a model prisoner who suffered from several medical related issues (Aday, 2003). This program is based on a voluntary organization that relies on chapters at law schools to provide student volunteers who screen and evaluate appropriate candidates for early release (Yates & Gillespie, 2000).
The POPS program is the first organization to work with the elderly and to influence early release, alternative forms of incarceration, or special release programming. This program was designed for inmates who are at least 55 years old and have already served the average time for their offense. Inmates who have been convicted of first-degree murder or sex offenses are automatically disqualified from participating in the program (Yates & Gillespie, 2000). The project develops ways that states can lower their expenses by acting on common geriatric problems. Even though early release is out of the question for some, many have a very low likelihood of committing new offenses (Aday, 2003). Specifically, some research studies have shown that older inmates are 40 percent less likely to re-offend (Johnson, 2011).

Although some inmate-release programs are controversial, Yates and Gillespie (2000) indicate “programs that are specifically tailored to elderly inmates can give state correctional authorities some relief from prison overcrowding and substantial medical budgets” (p.172). The POPS program focuses on an extensive interviewing process that evaluates prior criminal history, medical history, family background, substance abuse history, and risks for recidivism. Furthermore, interviews with the victims or their families are done to ensure an agreement regarding the offender’s parole. Once the interviews are completed, POPS members will decide whether to recommend release (Yates & Gillespie, 2000).

One benefit of the POPS program is that it enables older prisoners to live in the community while still being effectively supervised (Aday, 2003). For example, many elderly prisoners are put on an electronic monitoring device that monitors their whereabouts 24 hours a day. Additionally, when the prisoner is in the community, they are able to receive state benefits and utilize state hospitals for their care, but federal benefits such as Medicare and Social Security are still off limits (Aday, 2003). In addition, Yates and Gillespie (2000) indicate how the
recidivism rate for prisoners 18-24 years old is approximately 22%, whereas the recidivism rate for people over the age of 45 is only 2%. Since the POPS program was implemented in 1989, over 200 inmates have been released and none of them have returned to prison (Aday, 2003).

Although correctional officials have implemented various programs and policies, there are still several barriers that have prevented states from responding effectively. Despite the costs involved with special programming, there are other things that need to be considered as well (Aday, 1994; Aday, 2003). First of all, there needs to be a systematic way to evaluate these programs. Specifically, the effectiveness of how these programs meet the needs of elderly prisoners should be assessed. An evaluation of these programs needs to further explore how the programs meet the physical, medical, social, and mental health needs of each elderly prisoner (Aday, 2003). Additionally, correctional officials struggle with the research needs associated with the medical costs, general care needs, finding alternatives to incarceration, coping strategies, and determining who gets costly healthcare services and who does not (Aday, 1994).
III. THEORETICAL FRAMEWORK; THE CULTURE OF CONTROL:

Over the past 30 years, there have been dramatic changes in crime control and criminal justice in the United States. Specifically, there have been several changes within our social, cultural, and political forces that have shaped our prison system as it is seen today (Garland, 2001; Owen, 2007). In addition, the growing personal freedoms, affluence, and mobility of the 1960s, along with its belief of rehabilitating criminals, have attributed to today’s cultural beliefs and the “tough on crime” strategies we currently use (Owen, 2007). For example, the United States seems to be accustomed to living in a nation where over two million people are confined each day and roughly two or more offenders are put to death each week (Garland, 2001). Furthermore, Garland (2001) explains how the fastest growing mode of residential living lies within the gated community. Concerns about economic insecurity and personal safety have led us to embrace in habits and policies such as neglecting social bonds and moral values that were unthinkable 30 years ago. Due to these insecurities, we have become a society that allows politicians to lock up an increasing number of offenders each year by imposing harsher laws and stricter, mandatory sentences (Owen, 2007). As a result, this has attributed to the increasing number of elderly prisoners we currently see and are forced to care for in America’s prison system today.

Research has shown that from the 1890s to the 1970s, punishment focused on community based solutions to the crime problems such as rehabilitating offenders, utilizing indeterminate sentencing, and creating solutions that would focus on the personal qualities of the offender. In fact, prisons were considered schools for crime, counterproductive, and usually used as a last resort (Garland, 2001). However, due to societal and economic changes, prior strategies have become extremely dismantled as our society continues to focus on using expressive and
instrumental ways to control offenders. Research suggests that rehabilitative techniques became increasingly less common when high crime rates became normal and the penal welfare complex failed to protect the public from the risks that are associated with crime (Garland, 2001). In addition, the notion that “nothing works” in crime prevention and deterrence came to be known from the 1970s through the 1980s which lead to drastic changes in the criminal justice system. Although rehabilitation and correctionalism tactics did not totally disappear, they drastically depreciated and more control policies, like what are used today, were put in place (Garland, 2001).

As social, economic, and cultural relations continued to change in the 20th century, along with it came insecurities, control problems, and additional risks. Owen (2007) indicates how all three play such a critical role in shaping how our society responds to crime. Furthermore, since we now live in a society where the poor are belittled, incarceration rates are increasing, mandatory sentences are being imposed, and criminals are being executed, there is no longer an open democracy for change (Garland, 2001; Owens, 2007). In addition, Garland (2001) indicates that offenders are no longer seen as individuals in need of care and support and are now viewed as undeserving because there are so many risks that need to be managed. Furthermore, he elaborates by saying that the rehabilitation of criminals is now attributed to risk and private protection, rather than one of public welfare and entitlement (Garland, 2001; Owens, 2007). Overall, Garlands (2001) statements are extremely alarming especially when applied to an elderly prison population. For example, elderly offenders are in need of a lot of care and cannot be viewed as undeserving. This is especially true because they have additional risks and needs that must be managed and met over a prisoner who is solely in general population.
As Garland (2001) has previously indicated, it is the changes within our society that are related to our social, cultural, and political approaches as to how we deal with criminals today. The culture of control and confinement continues to take over America’s prison systems and rehabilitation or re-entry strategies are not strategically explored, especially for elderly offenders. From a society that used to focus on community based solutions to the crime problems such as rehabilitating offenders, utilizing indeterminate sentencing, and creating solutions that would focus on the personal qualities of the offender, it is puzzling why developments in crime control and criminal justice reveal a reversal of the previous historical patterns (Voruz, 2005).

Garland seems to have a specific concern regarding how we have moved away from a criminal justice system where punishment dominated to one where control is central (Voruz, 2005). Research indicates that crime control strategies and criminological ideas are not adopted because they are reputable at solving problems. Rather, the programs and ideas that are selected tend to be ones that fit with the field’s structures and the supported cultures. Additionally, they are the ones that fit with the most powerful institutions, allocate blame in specific ways, and empower groups that need authority, esteem, and resources (Garland, 2001). Garland (2001) has made it apparent that the control policy is beginning to be the problem, not the solution. For example, even though crime rates are decreasing, the number of prisoners is not. Additionally, prison systems are seeing the effects of mass imprisonment and the costs that are associated with it (Garland, 2001). In order to shift society away from the control model, we must invest in research and other resources that can help alleviate the problems associated with control and confinement, and focus on more rehabilitative and re-entry tactics, especially ones that are aimed at benefitting the elderly prison population.
IV. RECOMMENDATIONS

As our prison system continues to face overcrowding issues and increased costs, it is time to look into more viable options that could benefit certain elderly prisoners. The two prior sections discussed the challenges and risk factors associated with the elderly prison population. A review of current programs was investigated. Furthermore, the theoretical aspect regarding the culture of control and how it applies to the increasing number of elderly prisoners was explored. This section will look at addressing the recidivism rates for elderly prisoners and review future research needs that investigate geriatric programming for this special needs population. Specifically, the need for more geriatric programming similar to Canada’s RELIEF program will be recommended, along with exploring a cost-effective environment that is less restrictive for qualifying offenders.

A. Recidivism Rates and the Elderly

It is important to recognize that not every prisoner over the age of 55 should be released from prison. For example, many of these individuals have committed serious crimes and should remain locked up for the rest of their lives. However, there are many offenders who could qualify for special programming designed specifically for elderly offenders such as residing in specialized housing units or being released from prison early. For the prisoners that could be released early, it is still important to review the possibility for recidivism. The National Institute of Justice (2010) defines recidivism as a fundamental concept within the criminal justice system. Furthermore, it is viewed that an individual recidivates when they commit a new crime any time during or after they are released from jail or prison (National Institute of Justice, 2010).
Several studies have indicated that age is one of the most reliable predictors of recidivism rates. Specifically, national research has shown that prisoners who are between the ages of 18 and 29 have a recidivism rate of over 50%, while offenders who are age 55 and older only have a recidivism rate of about 2% (Beiser, 2003; Strupp & Willmott, 2009). According to state statistics on recidivism, 45 percent of people between the ages of 18 and 29 returned to prison within the first year of being released from prison while only 3.2 percent of people age 55 and older returned to prison after the first year (Aday, 2003). In an effort to search for more cost-effective and viable incarceration options, the following section will suggest future programming needs by proposing a specific program aimed at caring for elderly offenders while also exploring alternatives in a less restrictive environment, by exploring GPS and electronic monitoring for eligible offenders.

B. Suggested Future Programming for Elderly Offenders; What Could Work

Although recidivism rates have shown to decrease as the offender ages, it is important to explore future research needs that investigate geriatric programming for this special needs population as well. Specifically, the incarceration of older prisoners represents the smallest threat to public safety, but imposes the largest cost to taxpayers. Additionally, our system has shown how our current laws of mandatory incarceration, exemplifies failed public policy that favors imprisonment over more cost-effective options (Gotsch, Mauer, Wood, Gueronniere, and Collier, 2008).

a. Program Proposal; Planning for the Future

In many ways, our prison system is realizing the need for geriatric programming that addresses the needs for this special population, while also being conscious of the costs at the
same time. Additionally, in a time where offenders are faced with increased prison sentences and decreasing resources, it is important for correctional officials to practice proactive planning by implementing specific programs that address the needs of this rapidly growing prison population (Neeley & Addison, 1997). For example, like Canada’s RELIEF program, the United States could benefit from implementing a similar program that not only addresses the needs of elderly offenders, but also benefits certain inmates who live in general population as well.

The proposed program would consist of housing units designed to care for three levels of offenders; low-risk, medium-risk, and high-risk. Each housing unit would have specific wings that would provide the necessary care needed for each level of care. Additionally, inmates could easily transfer from one wing to another provided they show improvements in their daily functioning that would warrant the move to a different wing. If an elderly offender reaches the lowest level of care possible, an assessment would be done to determine if release from prison to an electronic monitoring device is a viable option.

Elderly offenders that live in the high-risk wing will need 24 hour care. These inmates are terminally ill, mentally ill, have severe disabilities, require hospice care, or have difficulties getting around. These offenders also need assistance with normal day to day tasks such as getting dressed, bathing, mobility, and eating. Meals are prepared and served to them three times a day and a day room will provide activities designated for such offenders. Offenders that live in the medium-risk wing will require care 12-16 hours per day. These inmates are not as sick as the ones that require around the clock care, but they need assistance with normal day to day tasks. This particular group of people has difficulties with getting around, bathing, getting dressed, and preparing meals. A majority of these inmates will also have normal medical needs that are associated with elderly people such as mobility issues, high blood pressure, diabetes,
cardiovascular, and arthritis. Meals will be prepared three times a day and a day room will provide age appropriate activities like television, puzzles, reading materials, and arts and crafts. Offenders that live in the low-risk wing often require 10-14 hours of care per day. A majority of these inmates are somewhat independent, but still require medical care, or assistance with daily functioning. Most of these offenders are able to move around, but require basic assistance from time to time. Offenders in this wing are allowed to assist with meal preparation and they have access to a day room that has daily scheduled activities.

Like the RELIEF program, several people would be responsible for the care and reintegitation of each qualifying elderly offender. The entire three-winged unit will be staffed with professionally trained medical professionals. One doctor, four nurses, two case workers, and a psychologist will be contracted and staffed 24 hours a day. In an effort to minimize costs and benefit the general prison population, certain qualified offenders will be able to obtain their certified nursing assistant (CNA) licensures or culinary art certificates to work in this specialized housing unit. Offenders who obtain their CNA licensures will be able to care for the elderly inmates on a day to day basis while also building on their work experience which could potentially help them obtain employment once they are finished serving their sentences. Offenders who obtain their culinary art certificates will also work in the specialized housing unit under a master chef. These offenders will help prepare the meals for the elderly prisoners while gaining familiarity in the culinary industry which could also enhance their chances for employment once they are released from prison. It is anticipated that offenders who are selected for one of the specialized jobs will take pride in their work as it could potentially enhance their chances for better and continued possibilities once they are released from the institution. If an offender does not take their jobs seriously or do not follow through on their job duties, they will
be terminated from the program immediately, as there will be a zero tolerance policy for any misconduct.

Overall, the goal of this program will be to provide care to the various levels of elderly offenders in a cost effective manner. By implementing a program where other general population prisoners can assist with the care and meal preparation, the cost to care for these people would decrease over time as offenders would be caring for other offenders, while also providing the necessary level of care.

b. Least Restrictive Environment-GPS/Electronic Monitoring

If alternative solutions to prison were more widely used, prison systems could potentially save a lot of money each year while also keeping community safety in mind. Beiser (2003) stresses how the financial burden to each state would drastically decrease because the cost of monitoring a prisoner on parole is about a tenth of what it costs to house an inmate in the institution. One way to implement a cost-effective strategy would be to allow certain qualifying offenders to be released on the electronic monitoring bracelet and allow them to serve the remainder of their sentences on home detention. Specifically, states would allow the release for medically supervised, elderly offenders who no longer pose a threat to the community. In order to qualify, inmates must be considered elderly (55 years or older), have a physical disability, be mentally ill, terminally ill, mentally retarded, or have a condition that requires long-term care (Yanez-Correa, n.d). Offenders cannot have any prior felonies or misdemeanors for a crime of violence that includes homicide, forcible rape, robbery, aggravated assault, or child sexual abuse charges. In addition, offenders must have served 75% of their sentence in the institution before being released (Families Against Mandatory Minimums, 2009).
By releasing these qualifying elderly offenders on electronic monitoring, the state can save a substantial amount of money on prison healthcare costs as well as making room for more dangerous offenders in the institution (Yanez-Correa, n.d.). For example, research indicates that electronic monitoring can cost the state anywhere between $5 to $25 per offender, per day, compared to $70 or higher per day, for providing care and housing an inmate in the institution (Yanez-Correa, n.d; Warren, 2003). For the elderly offenders who are released on electronic monitoring, the state would no longer be mandated to provide the expense for healthcare. As a result, each offender would get their healthcare needs from private sources, which would result in a financially positive impact on each state’s budget (Yanez-Correa, n.d.).
V. SUMMARY AND CONCLUSIONS

As long as truth in sentencing and three strike laws remain in effect, there will be an increasing number of elderly inmates that will require specific care in the institution. Although Aday (1994) indicates that the security level of an inmate decreases with age, our prison system is clogged with elderly offenders waiting for their lives, or sentences to expire.

In order to address these concerns pertaining to elderly offenders, this paper explored the various risks, problems, and needs that aging inmates face while they are incarcerated. A review of current programs provided an outlook as to what our system is utilizing today, only to prove how ineffective they really are since our society is still faced with severe overcrowding issues. In an effort to address the current problems that elderly inmates are faced with, this paper provided a recommendation where the prison system as a whole could benefit from. Specifically, there is an increasing need for enhanced elderly care in the prison system or the use of alternative incarceration options for qualifying elderly offenders. In order to manage these issues, this paper provided a program recommendation that would essentially save money while also helping with overcrowding issues as well.

Housing elderly inmates in a cost effective manner continues to be an ongoing challenge. In order to address these problems, future research needs to focus on developing programs that provide an increased level of health and medical care for an elderly prison population while maintaining a cost effective budget. In an effort to do this, future research should focus on developing programs that could benefit not only the elderly prison population, but the general prison population as well. By developing these specific programs, the qualifying general population inmates will provide care to the elderly inmates in a cost effective way to the state
while under the supervision of an accredited medical staff. In return, the inmates who have obtained training and knowledge in the healthcare field while caring for these offenders will be more marketable to employment once they are released into the community. Furthermore, if the elements of a successful program are considered, the prison system and society as a whole will benefit from the results.
VI. REFERENCES


Appendix A

Current and Projected Total Inmates Over 55 Years Old from 1985-2010

Source: (Yates & Gillespie, 2000)
Appendix B

Estimated Number of Sentenced Prisoners Under State or Federal Jurisdiction per 100,000 U.S. Residents, by Sex, Race, Hispanic Origin, and Age, December 31, 2009

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total/a</td>
<td>White/b</td>
</tr>
<tr>
<td>55-59</td>
<td>424</td>
<td>272</td>
</tr>
<tr>
<td>60-64</td>
<td>251</td>
<td>180</td>
</tr>
<tr>
<td>65 or Older</td>
<td>94</td>
<td>69</td>
</tr>
</tbody>
</table>

Source: (Glaze, 2010)

**Note:** Totals based on prisoners with a sentence of more than 1 year. Rates are per 100,000 U.S. residents in each referenced population group on

*a/Includes American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and persons identifying two or more races.*

*b/Excludes persons of Hispanic or Latino origin.*