A STUCK SAFETY VALVE: THE INADEQUACY OF COMPASSIONATE RELEASE FOR ELDERLY INMATES

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I. INTRODUCTION

> *Prisons are facing a silver tsunami. Walk through any prison and you'll see a surprising number of wheelchairs and walkers and portable-oxygen tanks.*
>
> *Prisons were never designed to be geriatric facilities. Yet U.S. Corrections officials now operate old age homes behind bars.*
>
> —Jamie Fellner[1]

Between 2007 and 2010 alone, the number of state and federal prisoners who were sixty-five years or older grew an exorbitant ninety-four times faster than the general prison population.[2] By the year 2030, it is estimated that one-third of all prisoners will be at least fifty years old,[3] and today they already cost three times as much to incarcerate due to increased health care costs.[4] Elderly prisoners have an average of three chronic

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1. Ashby Jones & Joanna Chung, *Care for Aging Inmates Puts Strain on Prisons*, WSJ A2 (Jan. 27, 2012) (available at http://online.wsj.com/article/SB10001424052970203363504577185362318111898.html); Human Rights Watch, *US: Number of Aging Prisoners Soaring*, http://www.hrw.org/news/2012/01/26/us-number-aging-prisoners-soaring (Jan. 27, 2012).

2. Human Rights Watch, *Old Behind Bars: The Aging Prison Population in the United States* 6 (Jan. 2012) (available at http://www.hrw.org/sites/default/files/reports/usprisons0112webwcover_0.pdf).

3. Jones & Chung, *supra* n. 1.

4. *Id.* As compared to a federal inmate under the age of fifty.

illnesses requiring medical attention,[5] and even the healthy ones need assistance with activities of daily living[6] (ADLs) that are often made difficult by the natural process of aging.

Elderly inmates have unique needs that the United States' prison systems are not prepared to deal with, although they are often legally required to do so.[7] As the age of America's prison population increases, so does the need for a practical and affordable plan to accommodate the aging inmates. One potential solution is to allow courts to terminate or reduce sentences for prisoners who meet stringent conditions enumerated in a federal statute commonly referred to as "compassionate release."[8] However, compassionate release is a classic example of a program that looks good on paper but has insufficient practical application. Placing moral and public policy arguments aside,[9] compassionate release should not be relied upon as the saving grace for prisons dealing with the growing surge of elderly inmates. With only a 0.01% release rate for the entire prison population,[10] a compassionate release program simply does not reach enough inmates to make a tangible difference. Therefore, short of a major

5. Timothy Curtin, *The Continuing Problem of America's Aging Prison Population and the Search for a Cost-Effective and Socially Acceptable Means of Addressing It*, 15 Elder L.J. 473, 481 (2007); Carrie Abner, *Graying Prisons: States Face Challenges of an Aging Inmate Population* 10 (Nov./Dec. 2006) (available at http://www.csg.org/knowledgecenter/docs/sn0611GrayingPrisons.pdf); *see also infra* pt. I(E) (discussing illnesses, including hypertension, heart disease, organ failure, cancer, arthritis, dementia, and Alzheimer's disease).

6. ADLs include toileting, walking, eating, etc. U.S. Dep't of Health and Human Servs., *Measuring the Activities of Daily Living: Comparisons Across National Surveys* 1 (1990) (available at http://aspe.hhs.gov/daltcp/reports/meacmpes.pdf); *infra* pt. I(E) (discussing how ADLs are affected by the aging process).

7. *See Estelle v. Gamble*, 429 U.S. 97 (1976) (holding that deliberate indifference for a prisoner's serious illness constitutes cruel and unusual punishment); *infra* pt. II(A) (discussing a prisoner's constitutional right to adequate medical care).

8. 18 U.S.C. § 3582(c)(1)(A) (2012); *see infra* pt. IV(A) (discussing components of the compassionate release statute). It should be noted that this statute is only applicable to federal, not state, prisoners.

9. Moral and public policy arguments for compassionate release include cost reduction because the purpose of punishment is not being served anymore with ill, elderly prisoners. Arguments against compassionate release include that it goes against the purpose of imprisonment for society (i.e. punishment for crime, no matter how ill one becomes in prison), that these people committed heinous crimes and belong behind bars, and that they are always a risk to society. Human Rights Watch, *The Answer is No: Too Little Compassionate Release in US Prisons* 61–62 (Nov. 2012) (available at http://www.hrw.org/sites/default/files/reports/us1112ForUploadSm.pdf).

10. William W. Berry III, *Extraordinary and Compelling: A Re-Examination of the Justifications for Compassionate Release*, 68 Md. L. Rev. 850, 868 (2009).

and unlikely statutory overhaul, low-cost and practical accommodations must be implemented for the vast majority of elderly inmates who are still in prison.

Because the majority of elderly prisoners will remain behind bars for the duration of their lives, this Article will take a practical stance in asserting that time and efforts are better spent implementing programs within the prisons because they affect the most prisoners. First, this Article explains the drastic increase in the number of elderly prisoners in recent years and the types of ailments and issues they have as a population within the prison system.[11] Second, this Article establishes that elderly prisoners are entitled to adequate medical care, safe conditions, and reasonable accommodations for disabilities under the United States Constitution and the Americans with Disabilities Act, respectively.[12] Third, this Article addresses the federal compassionate release statute,[13] including why its procedural and substantive requirements bar so many inmates from being released, and why it is unlikely to be broadened by Congress in the near future. Fourth, this Article presents practical, low-cost remedies that can be established within prisons to manage the growing number of elderly prisoners.[14]

II. CHARACTERIZING THE POPULATION OF ELDERLY INMATES

A. Defining Elderly

The definition of a prisoner who is "elderly" varies from state to state.[15] Most literature that considers offenders' backgrounds when determining the effects of incarceration uses fifty-five as an age-marker,[16] and, unless stated otherwise, fifty-five is the minimum age constituting an elderly prisoner throughout this

11. *Infra* pt. I(E).

12. *Infra* pt. II (discussing that the Constitution guarantees adequate medical care and safe conditions and that the Americans with Disabilities Act requires reasonable accommodations).

13. 18 U.S.C. § 3582(c)(1)(A); *infra* pt. IV(A) (discussing components of the compassionate release statute).

14. *Infra* pt. VI.

15. The age associated with "older" prisoners ranges from age fifty (used by fifteen states) to seventy (used by one state). Human Rights Watch, *supra* n. 2, at 17.

16. Curtin, *supra* n. 5, at 475.

Article. While fifty-five may seem too young to be considered elderly, prisoners simply age faster.[17] Prior to incarceration, they have higher frequencies of drug and alcohol abuse, impoverished backgrounds, poor dietary and exercise habits, and poor healthcare, if any.[18] This is not to say that in general society age fifty or fifty-five would be considered "older," much less "elderly," but inmates often have conditions that make their "real" age ten years older than their biological age.[19]

B. Increase of Elderly Inmates and the Reason for the Rise in Numbers

> *Simple calculation[—]during the last [thirty] years, more people went to prison for longer periods of time . . . those people are getting older now.*
>
> —Martin Horn[20]

Elderly prisoners represent the fastest growing segment of both federal and state prisons,[21] and the number of prisoners over fifty-five is growing at a rate that is six times that of the normal prison population.[22] Between 1995 and 2010, the number of state and federal prisoners who were fifty-five years old and older nearly quadrupled (282% increase), while the overall prison population grew by less than half (42% increase).[23]

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17. *Id.*

18. *Id.*; Abner, *supra* n. 5, at 9.

19. Human Rights Watch, *supra* n. 2, at 17.

20. Jones & Chung, *supra* n. 1 (Martin Horn is a professor at John Jay College of Criminal Justice in New York and former commissioner of New York City's Department of Correction).

21. Abner, *supra* n. 5, at 9–10 (discussing the increase of elderly prisoners in recent years).

22. Scripps Howard News Serv., The Joplin Globe, *Other Views: Elderly Inmates*, http://www.joplinglobe.com/editorial/x290308732/Other-Views-Elderly-inmates (Feb. 13, 2012); *see also* Human Rights Watch, *supra* n. 2, at 24 (explaining that one of the reasons for the increase in older inmates is the "tough on crime" policies in the last three decades).

23. Human Rights Watch, *supra* n. 2, at 6. In 2010, eight percent of all state and federal prisoners were fifty-five or older. *Id.* In 1995, only three percent were. *Id.* This Human Rights Report was released in January 2012 and is the most current research available on elderly prisoners. Researchers visited nine states and twenty prisons in 2011 interviewing prisoners, prison officials of all levels, and medical personnel. *Id.* Numerical data was compiled from the Bureau of Justice Statistics Website. *Id.* at 14.

Only one percent of all prisoners have been imprisoned for more than thirty years already; the majority of them, 68%, have been there for less than five years but have very long sentences to serve.[24] This means that the number of elderly prisoners that our prison system must accommodate is going to continue to increase in the coming years as these inmates wait out their long sentences and continue to "stack" in prisons.[25] In other words, the pileup of elderly inmates originates when prisons take in more long-term inmates than they release. Generally, mandatory minimum sentences are the longest for violent crimes, and violent offenders normally serve a greater portion of their sentences than nonviolent offenders.[26] This is significant because 65.3% of all elderly prisoners are serving sentences for violent crimes.[27]

Most simply, the rise in numbers of the elderly population reflects the general aging of society and an increase in life expectancies.[28] However, the rise also reflects longer sentences, an increase in life sentences, an increase in inmates who are elderly at the time of their offenses, and a decrease in the exercise of early release.[29] These factors can be attributed to tough-on-crime reforms in legislation enacted in the 1980s and 1990s, which are in need of major reform.[30] This legislation included mandatory minimums in sentencing, "three-strikes rules, and truth-in-sentencing laws."[31] Additionally, parole was eliminated

24. Nadine Curran, *Blue Hairs in the Bighouse: The Rise in the Elderly Inmate Population, Its Effect on the Overcrowding Dilemma and Solutions to Correct It*, 26 New Eng. J. on Crim. & Civ. Confinement 225, 240 (Summer 2000).

25. *See* Human Rights Watch, *supra* n. 2, at app. 3 (providing a numerical showing of "stacking" in prisons).

26. Human Rights Watch, *supra* n. 2, at 30.

27. *Id.* To quote a prison official interviewed by Human Rights Watch, "We're stuck with people who aren't going to get out." *Id.* at 33; *see id.* at app. 4 (presenting an expansion on the types of offenses elderly offenders commit and how this affects "stacking").

28. Life expectancy rose from 49.24 years in 1900 to 77.8 years in 2004. Judith F. Cox & James E. Lawrence, *Planning Services for Elderly Inmates with Mental Illness* (June 1, 2010) (available at https://www.aca.org/fileupload/177/ahaidar/1_Cox_Lawrence.pdf). The number of people over sixty-five grew from three to thirty-five million in the 20th century. Abner, *supra* n. 5, at 9.

29. A significant percentage of inmates fifty-five and over are serving long sentences, and the Bureau of Justice Statistics is currently conducting a project to determine just how many. Human Rights Watch, *supra* n. 2, at 25.

30. Abner, *supra* n. 5, at 9; *see also* Human Rights Watch, *supra* n. 2, at 12 (calling officials to review sentencing laws and corrections officials to review confinement conditions).

31. Abner, *supra* n. 5, at 9; St. of Fla. Correctional Med. Auth., *2009-2010 Annual Report and Report on Aging Inmates* 48 (Dec. 2010) (available at http://edocs.dlis.state.fl

for all federal crimes committed after 1987,[32] and harsh parole revocation policies were enacted as well, returning many to prison for technical violations.[33] The use of parole is not likely to increase again, as parole boards are heavily influenced by politics and public opinion, which are wary of relaxing harsh sentences for prisoners.[34] For these reasons, violent offenders are often incarcerated for years past their eligibility date.[35] Lastly, twice as many elderly people are committing offenses in old age and being sent to prison than in 1995.[36] Older offenders commit crimes that are just as serious as the crimes younger offenders commit[37] and often for the same reasons.[38] In addition, elderly offenders are often affected by isolation, loss of a spouse, and economic hardships that contribute to their likelihood to commit a crime in old age.[39]

.us/fldocs/dcor/CMA/annualreport09-10.pdf). Close to twenty years later, the prisoners incarcerated under original three-strike rules when they were middle aged are entering old age. Graeme A. Yorston & Pamela J. Taylor, *Commentary: Older Offenders—No Place to Go?* 34 J. Am. Acad. Psych. L. 333, 334 (2006). For example, in California, the average third striker is sentenced at age thirty-six with a minimum of twenty-five years to serve; this puts the offender into middle to old age before the possibility of release, and even more so, for those who are sentenced past the median age of thirty-six. Human Rights Watch, *supra* n. 2, at 29. Truth-in-sentencing laws require that an offender serve at least eighty-five percent of his or her sentence, and normally send repeat offenders to prison for twenty-five years to life. Curtin, *supra* n. 5, at 478–479.

32. Curtin, *supra* n. 5, at 479.

33. Human Rights Watch, *supra* n. 2, at 24.

34. The elimination of parole as a sentencing option is likely here to stay because it represents a compromise between death penalty advocates and opponents. States without the death penalty use life without parole as the alternative for violent offenders. Curran, *supra* n. 24, at 230–231; Human Rights Watch, *Compassionate Release*, *supra* n. 9, 61–62.

35. *Id.* at 231.

36. Pam Belluck, *Life, with Dementia*, NY Times A1 (Feb. 25, 2012) (available at http://www.nytimes.com/2012/02/26/health/dealing-with-dementia-among-aging-criminals.html?pagewanted=all&_r=0); *see also* Human Rights Watch, *supra* n. 2, at 14 (providing that the prison population of inmates sixty-five or older has risen ninety-four times faster than the overall prison population from 2007 to 2010).

37. Yorston & Taylor, *supra* n. 31, at 335. For example, in Pennsylvania, older inmates were found to be incarcerated for the same top nine offenses as younger inmates. Curtin, *supra* n. 5, at 480.

38. Like younger offenders, they are largely of a lower economic status and often under the influence of drugs or alcohol. Curran, *supra* n. 24, at 240–241.

39. *Id.*

C. Who Are Our Elderly Inmates?

> *[T]he only ones who remember [him] are his victims and legal system officials.*[40]

Most scholars break down elderly offenders into three main categories.[41] The first category of elderly offenders is made up of those who enter prison for the first time in middle or old age.[42] Normally, those who are imprisoned at an old age have committed very serious crimes.[43] The second category of elderly offenders consists of habitual criminals.[44] They are often referred to as prison recidivists and are "career criminals" who lapse back into crime.[45] The least sympathetic group, these offenders will have less trouble adjusting to prison, but are the most likely to have addiction problems.[46] The final category is comprised of offenders that most likely come to mind when someone mentions the term "elderly prisoner"—those who entered prison at a young age and are still serving the same long sentence,[47] growing old while incarcerated.[48] They are arguably the greatest burden on the prison system because they have lost any employable skill that they may have once had, and are likely to be alone, with no family left to take care of them even if they were released.[49]

Elderly inmates are largely white males with low IQs, have high divorce and alcohol abuse rates, and are highly likely to develop mental problems and dementia.[50] While they commit the same types of crimes as younger offenders, once in prison, elderly inmates are far less likely to exhibit violent or predatory behav-

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40. Curtin, *supra* n. 5, at 485.
41. *Id.* at 483–484.
42. *Id.*; *see also* Curran, *supra* n. 24, at 239.
43. Curtin, *supra* n. 5, at 484.
44. *Id.*
45. Curran, *supra* n. 24, at 240.
46. *Id.* at 236.
47. These offenders are often ones who pled guilty under tough-on-crime administrations and got life sentences. Curtin, *supra* n. 5, at 484–485.
48. Curran, *supra* n. 24, at 240.
49. Curtin, *supra* n. 5, at 485.
50. Only about one thousand elderly inmates are women. Jason S. Ornduff, *Releasing the Elderly Inmate: A Solution to Prison Overcrowding*, 4 Elder L.J. 173, 181–182 (1996).

ior.[51] Prison staff indicate that elderly misconduct is generally limited to only minor rule-breaking, such as being disrespectful to staff or being somewhere without authorization.[52]

D. Types and Causes of Ailments Suffered by Elderly Inmates

> *Age by itself is not the same as disability, but the end result of an accumulation of diseases and injuries, causing decreased ability to safely interact with our surroundings.*[53]

Basic activities like washing, walking long distances, climbing out of bed, going to the bathroom, and climbing stairs become difficult for most elderly people as they age. For elderly prisoners, normal ailments of aging hasten and are exacerbated by virtue of incarceration.[54] Mobility impairments are common as a result of diminished motor skills, slower reflexes, and less muscle tone.[55] Elders often become incontinent, become more sensitive to temperature changes, develop dietary intolerances, and experience the effects of lessened senses, including impaired vision and hearing loss.[56] They have less efficient immune systems, and their memory, especially short-term, weakens.[57] All of these things affect their ability to reason and interact with staff, inmates, and their environment in general.

Elderly inmates may be less able to remember or comply with institutional rules and may be punished for things that they do not realize they are doing wrong.[58] For an elderly prisoner, these common ailments of aging are more aggravated than in a non-

51. Human Rights Watch, *supra* n. 2, at 61. Notably, both of these most common misbehaviors can by symptomatic of dementia. *Id.* at 52.

52. *Id.* at 61. The prisons visited in this study did not track system-wide data on the type of rule violations of elderly inmates and the study relied upon the experiences as relayed by the staff. *Id.*

53. *Id.* at 46.

54. Curran, *supra* n. 24, at 239.

55. *Id.*

56. *Id.*; *see also* St. of Fla. Correctional Med. Auth., *supra* n. 31, at 57.

57. Curran, *supra* n. 24, at 239.

58. The ailments discussed in this section may be part of the reason behind the most common prison rule violations discussed *infra*, at Section I.C. As a result, any chances that these elderly prisoners could have for early release through parole or good behavior programs could be compromised because of misbehavior stemming from a medical condition. St. of Fla. Correctional Med. Auth., *supra* n. 31, at 63.

imprisoned elderly person.[59] One senior prison healthcare official noted, "In elders, hearing, vision[,] and balance progressively decrease; foot speed slows; and muscle loss occurs. All of which make climbing up stairs or into upper bunks difficult if not dangerous."[60] Elderly prisoners have difficulties with ADLs at twice the rate of elders in the public.[61]

While chronological age alone does not constitute automatic poor health, the probability of developing a chronic illness does increase with age.[62] In addition to the normal ailments of aging, elderly prisoners are also more likely to suffer from chronic and mental illnesses than their counterparts in society.[63] At least eighty-two percent of elderly inmates who are sixty-five or older have a chronic health problem.[64] Arthritis, hypertension, ulcer disease, prostate problems, diabetes, Hepatitis C, and cancer are among the most common chronic diseases for elderly inmates.[65] Sexually transmitted diseases are also common among elderly prisoners,[66] and many require costly dental work.[67] Most of these chronic health problems require consistent medical treatment and medication, which burden prison systems with high transportation and high treatment costs.

Nearly half of the state and federal prison population in the United States is suffering from a mental disorder.[68] The most common mental disorders plaguing elderly inmates are depression, anxiety, alcohol and drug addiction, Alzheimer's disease, dementia, and late-life schizophrenia.[69] For someone losing both

59. Curran, *supra* n. 24, at 239.

60. Human Rights Watch, *supra* n. 2, at 46. In California, fifty-one percent of elderly female prisoners reported falls in the last year. *Id.*

61. In California, sixty-nine percent of 120 elderly prisoners interviewed reported that at least one activity of daily living was difficult for them to perform, and sixteen percent of these prisoners reported that they could not perform the ADL without assistance. Abner, *supra* n. 5, at 10.

62. Ronald H. Aday, *Aging Prisoners: Crisis in American Corrections* 143 (Praeger 2003).

63. *Id.*

64. Abner, *supra* n. 5, at 10. The Journal of the American Medical Association found that inmates who are fifty-five or older have an average of three chronic conditions, and up to twenty percent suffer from mental illness. Curtin, *supra* n. 5, at 481.

65. Abner, *supra* n. 5, at 10.

66. Yorston & Taylor, *supra* n. 31, at 335.

67. Curtin, *supra* n. 5, at 481.

68. Cox, *supra* n. 28, at 2.

69. *Id.*

physical strength and mental capabilities, prison becomes much harder to endure due to rigid disciplinary procedures and stress.[70] Dementia, in particular, is underreported in prisons but quickly growing.[71] Dementia often goes undetected by general prison physicians who are not familiar with geriatrics or the disease, which is most easily missed in men.[72] Because of strict prison routines, the symptoms of dementia, like forgetfulness, often go unnoticed in the early stages,[73] and the disease may not become apparent until more extreme behaviors surface.[74] Once the dementia reaches later stages, elderly prisoners can become challenging in terms of both behavior and medical costs.[75] They often become confused and paranoid, conditions that are worsened by confinement, and elderly prisoners may confront or attack staff members or other inmates when an elderly patient without dementia might not.[76] This presents quite a conundrum for prison staff who must maintain order and enforce rules. At the same time, it is often pointless to punish an elder prisoner with dementia because they are not aware that the behaviors they are exhibiting are wrong and will forget both the behavior and the punishment by the time they go through the prison's disciplinary process. As one correctional officer stated regarding an elderly prisoner with dementia, "We could write her up for verbal abuse but what's the point[?]"[77]

Alzheimer's disease is also a significant problem within the elderly prison population. "Alzheimer's currently affects 5.4 million Americans, a number expected to double by [the year]

70. Curran, *supra* n. 24, at 246.

71. Belluck, *supra* n. 36. While there have been no studies done specifically on inmates with dementia, experts say that elderly prisoners are more prone to the disease than elderly people in the general population because inmates often have more risk factors, such as limited education, hypertension, diabetes, depression, and substance abuse. *Id.*

72. Yorston & Taylor, *supra* n. 31, at 335. It should be noted that most elderly inmates are male. Ornduff, *supra* n. 50.

73. Belluck, *supra* n. 36.

74. Human Rights Watch, *supra* n. 2, at 52.

75. "Dementia can set in, and an inmate who was formerly easy to manage becomes very difficult to manage." David Crary, *Elderly Inmates: Aging Prison Population Strains Tight Budgets*, http://www.huffingtonpost.com/2012/01/27/elderly-inmates_n_1236028.html (Jan. 27, 2012) (quoting A.T. Wall, director of the Rhode Island Department of Corrections).

76. Inmates often unknowingly start fights by wandering into other prisoners' cells or "space" without knowing that they are doing anything wrong. Belluck, *supra* n. 36.

77. Human Rights Watch, *supra* n. 2, at 52.

2040."[78] This number is likely higher, by percentage, within the prison population and could grow two to three times faster because "protective factors that might have mitigated developing dementia [or Alzheimer's disease] are slim to none in prison—things like complex jobs, rich social environment, and leisure activities."[79] Early detection of mental illnesses, including dementia and Alzheimer's, is instrumental in determining appropriate care and cutting costs; however, major modifications will have to be made given that most prisons only have very basic health screenings upon admission that are not geriatric-specific.[80] Even if prisoners are not suffering from illness, per se, prison becomes more taxing on the elderly as they get older simply because of the general decline in physical and mental abilities that come with age.[81] A combination of victimization and facilities that are difficult to navigate hasten the long-term deterioration of an elderly prisoner's mental functions.[82]

Although not a traditional "ailment" by definition, victimization is something that very much affects the well-being and health of elderly inmates in prison. It ranges from physical harm such as assault, rape, and homicide to harassment in the form of extortion, theft, or humiliation.[83] Younger inmates often prey on those who are weaker, making elderly inmates prime targets because of their frailty.[84] The way that older and younger inmates choose to serve their time is markedly different and may contribute to the victimization of the elderly.[85] Younger inmates tend to

78. Belluck, *supra* n. 36.

79. *Id.*

80. Cox & Lawrence, *supra* n. 28, at 2.

81. Sooner or later, most elderly prisoners will develop "[d]ecreased sensory acuity, muscle mass loss, intolerance of adverse environmental conditions, dietary intolerance[,] and general vulnerability, [which] precipitate collateral emotional and mental health problems." Human Rights Watch, *supra* n. 2, at 45.

82. Curran, *supra* n. 24, at 246.

83. Human Rights Watch, *supra* n. 2, at 57.

84. *Id.* Most prisons do not track assaults by age, so there is very little data available on this topic. *Id.* Only small studies have been done, but various reports from inmates indicate that when they are victimized, they rarely complain to the staff because then they become known as snitches, putting themselves in a more vulnerable position to younger inmates than before. *Id.* at 58–59. There is no consensus among prison officials; some said that younger inmates protect elderly inmates, and others view elderly inmates as very high risk for harm. *Id.* At any rate, the potential for victimization is very real and present, and should be acknowledged as an issue that many elderly inmates are suffering from while in prison.

85. *Id.* at 59–60.

protect themselves in prison by taking extreme and aggressive measures to prove that they are dangerous.[86] Older inmates are the exact opposite and will avoid confrontation at all costs by simply spending more time in their cells and avoiding activities; they tend to serve their sentences as quietly and as easily as possible.[87] Although the victimizing incidents are not always severe in nature, elderly inmates have a strong fear of victimization by younger offenders and often choose to remain in their units or will only travel in pairs for any type of recreational activity in the yard.[88]

Career criminals and chronic offenders set themselves up for poor health and early aging years before they reach old age, and younger inmates have far worse health than their counterparts who are not in prison.[89] There is evidence that this poor health simply deteriorates further with age, and thus, elderly inmates who have lived a life of crime will likely have more health problems than the general elderly population.[90] Poor health of elderly inmates also stems from overcrowding in prisons, which lessens sanitary conditions of living and increases the amount of time it takes for an inmate to receive medical treatment.[91] There is often not enough staff to man an overcrowded prison and accompany inmates to medical appointments in the community.[92] Additionally, nursing services within the prison are understaffed and have lengthy delays.[93] The longer an elderly person goes without diagnosis or treatment, the worse the condition gets, and the cost of medical care increases.

86. *Id.*

87. *Id.* It has been suggested that this may be a method of simply protecting themselves, but the seclusion contributes to the decline of mental capacity. *Id.* In terms of safety and self-protective behaviors, a difference may exist between elderly inmates who grew old in prison and those who began their sentences in old age. *Id.* at 58.

88. Aday, *supra* n. 62, at 145.

89. Yorston & Taylor, *supra* n. 31, at 334.

90. *Id.*

91. Curran, *supra* n. 24, at 235.

92. *Id.* at 235–236; *see also* Ornduff, *supra* n. 50, at 177–178 (discussing the effects that prison overcrowding has on inmate health).

93. Curran, *supra* n. 24, at 235.

E. Financial Burdens of Caring for Elderly Prisoners

Medical expenses for elderly inmates in state prisons range from three to eight times greater than those of younger inmates.[94] Prisoners are generally uninsured, and, under most circumstances, federal health insurance programs like Medicaid do not cover medical care for state prisoners. Thus, the state prison system must shoulder the entire burden and receives no Medicaid credits for prisoners from the federal government.[95] In 1997, the federal government began allowing for reimbursement from Medicaid when an otherwise eligible inmate received treatment from a local hospital for more than twenty-four hours, outside of the prison.[96] However, most state prisoners are not "otherwise eligible" for Medicaid because the majority of states limit Medicaid coverage to low-income juvenile offenders, pregnant women, those with disabilities, and elders with extremely limited income.[97] Significant changes could come for Medicaid in 2014 when it is slated to cover any person with an income below 133% of the poverty line; virtually all state inmates will qualify for coverage for hospital stays at that point.[98] This will greatly reduce the state prison system's burden of medical care, although it will still be responsible for transport fees and the costs of twenty-four hour coverage by guards when inmates receive treatment in the community.[99]

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94. Arielle Levin Becker, *State Seeking Nursing Home to Take Sick, Disabled Prisoners*, The Conn. Mirror (Feb. 27, 2012) (available at http://www.ctmirror.org/story/15565/state-seeking-nursing-home-take-sick-disabled-prisoners). While elderly prisoners only account for eleven percent of the total prison population in Texas, they make up more than one-third of the expenditures for community medical care. Abner, *supra* n. 5, at 10.

95. Human Rights Watch, *supra* n. 2, at 78. It was established in 1965 that Medicaid would not cover anyone incarcerated in a state prison. Christine Vestal, *Medicaid Expansion Seen Covering Nearly All State Prisoners*, http://www.pewstates.org/projects/stateline/headlines/medicaid-expansion-seen-covering-nearly-all-state-prisoners-85899375284 (Oct. 18, 2011).

96. Human Rights Watch, *supra* n. 2, at 78. Those on probation, parole, or under house arrest could also participate in this program. However, this program was not widely used—many states did not know that the law even existed and only a few states signed up for reimbursement. Vestal, *supra* n. 95.

97. Vestal, *supra* n. 95.

98. *Id.* Most inmates would likely be "new" to Medicaid and would be eligible for one hundred percent coverage by the federal government for the first five years. *Id.* After that, states would still be responsible for only ten percent of their coverage. Human Rights Watch, *supra* n. 2, at 79.

99. Human Rights Watch, *supra* n. 2, at 78–79.

Aside from illnesses, once inmates enter old age, they may need devices such as hearing aids, wheelchairs, walkers, glasses, canes, and dentures just to be able to function every day.[100] Prison facilities often have to be updated to accommodate some of these devices, which can also be costly.[101] However, using specialized prison facilities only for the elderly and chronically ill reduces many costs associated with their care because everything that they need is coordinated within one central location designed specifically for the needs of an older inmate, not a younger one.[102] With specialized housing, more targeted services are available, which are easier and cheaper to provide from one location, instead of being spread out among multiple locations with only a few inmates at each.[103]

III. THE INMATE'S LEGALLY BINDING RIGHTS TO MEDICAL CARE AND ACCOMMODATIONS

> *[A] prisoner is not wholly stripped of constitutional protections when he is imprisoned for crime. There is no iron curtain drawn between the Constitution and the prisons of this country.*[104]

A. Eighth Amendment Right to Adequate Medical Care

The Eighth Amendment to the United States Constitution provides in part that no cruel and unusual punishments should be inflicted.[105] This is perhaps the only constitutional right whose meaning actually expands in the prison context.[106] In 1972, the Supreme Court established in *Estelle v. Gamble*[107] that prison officials are obligated under the Eighth Amendment to provide

100. *See* Abner, *supra* n. 5 (discussing the challenges prisons face from the growth of elderly inmates); Curran, *supra* n. 24, at 248.

101. Abner, *supra* n. 5, at 10; Human Rights Watch, *supra* n. 2, at 47.

102. Abner, *supra* n. 5, at 11; *see infra* pt. V(A) (proposing specialized housing for elderly inmates).

103. Abner, *supra* n. 5, at 11; *see infra* pt. V(A) (discussing the cost savings of less correctional officers and less travel expenses due to a centralized treatment facility).

104. *Wolff v. McDonnell*, 418 U.S. 539, 555–556 (1974).

105. U.S. Const. amend. VIII.

106. Curran, *supra* n. 24, at 236.

107. 429 U.S. 97, 103 (1976).

prisoners with adequate medical care.[108] It should be noted that while *Estelle* provides inmates a right to adequate medical care, it does not provide a right to the very best medical care possible.[109] However, despite the overcrowding of prisons and the financial burden of caring for inmates with health problems, the cost involved can never be a justification for a prison to not provide adequate medical care.[110] In order to advance a claim of inadequate medical care, a prisoner must show that he or she was treated with "deliberate indifference to serious medical needs."[111] A prison official exhibits "deliberate indifference" if he or she recklessly disregards a substantial risk of harm to a prisoner.[112] In a subsequent case in 1994, the Supreme Court expressed three requirements[113] that must be met for a finding of "deliberate indifference": (1) the official must have been aware that the inmate faced a substantial risk of serious harm; (2) the official must have actually deduced from the facts that the inmate faced that risk; and (3) the official must have failed to take reasonable steps to prevent such harm from occurring.[114] This definition can be difficult when applied to elderly prisoners because they often have so many chronic health complaints, and it begs the question of what will actually be considered a "serious medical need."[115] The Supreme Court set forth several factors to better define the phrase, including the following factors most applicable to elderly

108. This care may be provided by either government employees within the prison or by the private medical sector. *Id.* at 106.

109. Curran, *supra* n. 24, at 252.

110. *Estelle*, 429 U.S. at 103–104; *see also* Human Rights Watch, *supra* n. 2, at 78 (discussing the steep cost of caring for elderly inmates); ACLU National Prison Project, *Know Your Rights* (Nov. 2005) (available at http://www.aclu.org/images/asset_upload_file690_25743.pdf) (providing a summary of the law pertaining to a prisoner's right to medical care).

111. *Estelle*, 429 U.S. at 104.

112. ACLU, *supra* n. 110.

113. *Farmer v. Brennan*, 511 U.S. 825, 837 (1994). This threshold is higher than negligence and requires that the prison official both knows of and disregards the risk. ACLU, *supra* n. 110.

114. Patricia S. Corwin, *Senioritis: Why Elderly Federal Inmates Are Literally Dying to Get out of Prison*, 17 J. Contemporary Health L. & Policy 687, 693 (Summer 2001). Proof of a prison official's knowledge can be established by both direct (i.e., records of complaints, sick call requests, etc.) and circumstantial evidence (i.e. deterioration of prisoner's health, weight loss, etc.). An official cannot escape liability by showing that he or she knew of the risk, but did not act because he or she thought the complainant was not likely to be affected by it, or because he or she declined to confirm signs of risk that he or she suspected to exist. *Farmers*, 511 U.S. at 832, 843.

115. Curtin, *supra* n. 5, at 487.

inmates: whether the medical condition significantly affects activities of daily living, whether the inmate is suffering from chronic and substantial pain, and whether a reasonable physician or patient would perceive the medical need as important and worthy of treatment.[116] Notably, pain alone can constitute a serious medical need even if the failure to treat it does not necessarily make it worse.[117] For example, if an elderly prisoner who is suffering from arthritis experiences increased pain because of distances he or she is required to walk or cold temperatures inside the prison, he or she may require an accommodation to prison routines, more access to medical facilities, and pain medication. Housing this inmate in a prison with spread out buildings (making routines difficult for those with mobility issues) or in a prison that is unable to provide the medical care necessary for pain management may constitute a deliberate indifference to serious medical needs and unnecessary infliction of pain.[118] The Supreme Court's reasoning behind the *Estelle* decision is that "[i]t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself."[119] "An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met."[120] Because the prisoner has no choice but to rely on prison authorities for care, any "deliberate indifference" to the prisoner's care constitutes "unnecessary and wanton infliction of pain."[121] Many prisons charge inmates for

116. *Estelle*, 429 U.S. at 104. This list of factors also includes whether a condition has been diagnosed by a doctor as mandating treatment or the treatment is so obvious that even a lay person would recognize the necessity of a doctor's attention, and significant, injury, pain, or loss of function, even if not life threatening. *Brock v. Wright*, 315 F.3d 158, 162 (2d Cir. 2003).

117. ACLU, *supra* n. 110.

118. *Estelle*, 429 U.S. at 104; *see also* Curran, *supra* n. 24, at 252 (providing an example of an elderly prisoner having to walk long distances while suffering the effects of rheumatoid arthritis).

119. *Estelle*, 429 U.S. at 104.

120. *Id.* at 103. The Supreme Court stated that denial of medical care may result in pain and suffering, if not worse, which "no one suggests would serve any penological purpose." *Id.*

121. Curtin, *supra* n. 5, at 487 (quoting *Estelle*, 429 U.S. at 102–103). This standard applies whether the failure is the prison doctor's indifference to the prisoner's medical needs, whether guards deny or restrict access to receive those services, or whether a prison official interferes with prescribed treatment, among other things. *Id.* Notably, it does not apply to treatment from private doctors who ultimately misdiagnose a condition or similar situations. ACLU, *supra* n. 110. These types of actions would be brought as civil

medical care in an attempt to cut costs and to discourage those who try to abuse the system; however, the government still has a duty to provide medical care to prisoners, whether the prisoner can afford it or not.[122]

B. Fourteenth Amendment's Right to Safe Conditions

In addition, prisoners are also afforded the right to safe conditions while imprisoned.[123] In *McCray v. Sullivan*,[124] prisoners in Alabama brought a suit alleging that homosexual prisoners were assaulting other inmates and that prison officials condoned the attacks.[125] The Fifth Circuit held that "where prison officials have failed to control or separate prisoners . . . who endanger the physical safety of other prisoners, prison officials may be required to take steps to protect the prison population from those dangerous prisoners."[126] This holding is significant in its application to elderly inmates as it may prevent victimization.[127] By this court's rationale, prison officials have a duty to protect prisoners from other inmates who endanger their safety.[128] From a practical standpoint, "safe conditions" and "adequate" medical care can vary according to the needs and vulnera-

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malpractice claims that have nothing to do with the prison official, as long as the prison authorities did not interfere with the treatment. *Id.*

122. ACLU, *supra* n. 110, at n. 42; *Estelle*, 429 U.S. at 97; *see DeShaney v. Winnebago Co. Dep't of Soc. Servs.*, 489 U.S. 189, 199–200 (1989) (holding that when the state renders an individual unable to care for himself, the state violates the Eighth Amendment and the Due Process Clause by failing to provide for basic human needs). Only one court has found that charging prisoners for healthcare is unconstitutional. *Collins v. Romer*, 962 F.2d 1508, 1514 (10th Cir. 1992). Most courts have found that co-pays and over-the-counter policies are, in fact, constitutional, as long as the prisoner is not denied the medical care and medication that he or she needs solely because he or she cannot pay for it. ACLU, *supra* n. 110, at n. 44. However, if the inmate has the money to pay for medication, but chooses to apply his or her resources elsewhere, a prison official cannot be held in violation of the Eighth Amendment by refusing to supply the medication for free. *Martin v. DeBruyn*, 880 F. Supp. 610, 615 (N.D. Ind. 1995); ACLU, *supra* n. 110, at n. 45. This seems to be consistent with the Supreme Court's argument in *Estelle* that you cannot take away a prisoner's rights and ability to seek his or her own medical care and then not give him or her adequate care; however, when he or she does have the opportunity and the money to provide his or her own care, then he or she should. *Estelle*, 429 U.S. at 97.

123. Curran, *supra* n. 24, at 250–251.

124. 509 F.2d 1332 (5th Cir. 1975).

125. *Id.*

126. *Id.*

127. *See Curran*, *supra* n. 24, at 250 (explaining that security measures must be taken to prevent violence against elderly inmates).

128. *Id.* at 250–251; *see supra* pt. I(D) (discussing victimization).

bilities of each prisoner. For a weaker, elderly inmate, the right to safe conditions may mean that the older inmate should not have to bunk with a younger, stronger inmate prone to violence and extortion.[129] It may mean that an older inmate with limited mobility should not have to walk across the prison complex outside in harsh weather to receive needed medication.[130] Adequate medical care may mean more regular medical evaluations for those with advancing dementia.[131] It may mean extra assistance for those with incontinence issues, because if not addressed, incontinence puts the elderly inmates at risk for isolation, depression, and harassment from other inmates.[132] Of course, prison officials have the responsibility to enforce prison rules as uniformly and fairly as possible, but common sense and decency require treating an infirm eighty-year-old man differently than a healthy twenty-year-old man, prisoner or not.[133] There will always be disagreement over how much the prison system should accommodate inmates for individual needs, if at all. Regardless of whether one agrees with it, all prisoners are afforded these rights by law. Age does not change constitutional rights, but age may very well change what prison officials must do to meet those rights.

C. Protection under the Americans with Disabilities Act and the Rehabilitation Act

Until 1990, when the Americans with Disabilities Act (ADA) was enacted, the only protection prisoners had was constitutional; they had to prove *Estelle*'s deliberate indifference standard for medical violations.[134] Unlike the "deliberate indifference" standard, a showing of intent is not required to establish discrimination under the ADA.[135] The applicable section of the ADA here,

129. Human Rights Watch, *supra* n. 2, at 47.

130. *See id.* at 10 (discussing the accommodations elderly inmates may need to receive).

131. *Id.*

132. *Id.*

133. This puts prison staff in an awkward and difficult position—they have to be sure to not bend the rules too much to avoid encouraging younger inmates who are watching to see how much they can get away with, while trying to balance the needs of elderly inmates at the same time. *Id.* at 62.

134. Curran, *supra* n. 24, at 253; *see Estelle*, 429 U.S. at 103 (providing the deliberate indifference standard).

135. Curran, *supra* n. 24, at 254.

Title II, is farther reaching than *Estelle* and mandates that all employers, governments, private entities, and providers of public accommodations eliminate practices that discriminate against those with disabilities.[136] It provides in relevant part, "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[137]

While the issue of whether the ADA applies to prisoners has been widely debated in recent years, with states arguing against it on the premise of maintaining states' rights, the Supreme Court held in *Pennsylvania Department of Corrections v. Yeskey*[138] that "public entity" in the statute's language clearly includes prisons and that the protection extends to state prisoners.[139] This holding could be a breakthrough for the elderly inmates; the Supreme Court held in *Pennsylvania Department of Corrections* that the term "qualified individual with a disability" includes prisoners.[140] Therefore, elderly inmates' ailments, often age-related, may meet the definition of "disability" and "impairment"; if so, they are entitled to protection under the ADA and reasonable accommodations in prison that are reflective of their disabilities.[141]

Elderly inmates may also qualify for protection under Section 504 of the Rehabilitation Act.[142] The difference between the two acts is simply that Title II of the ADA applies to all (and only)

136. *Id.* The ADA may require these entities to make structural changes to buildings to accommodate the disabled and to provide equal access to programs and services. In the prison context, it would likely include wheelchair ramps, large print books, and TDD text-telephones, among other things. *Id.* at 254.

137. 42 U.S.C. § 12132 (2012).

138. 524 U.S. 206 (1996).

139. *Id.* at 210. The State of Pennsylvania tried to argue that prisons are not named in the ADA and thus, are not covered. *Id.* Pennsylvania also argued that the phrase "benefits of the services, programs or activities of a public entity" does not apply to prisons because prisons are punishment and do not provide prisoners with benefits. *Id.* The Supreme Court refused to construe that term narrowly and said that lots of programs in prisons "benefit" prisoners even though they may not receive federal funding. *Id.*

140. *Id.*

141. Upon Pennsylvania's final argument that because prisons were not expressly included Congress intended to leave them out, the Supreme Court stated that the fact that a statute can be "'applied in situations not expressly anticipated by Congress does not demonstrate ambiguity. It demonstrates breadth.'" *Id.* at 212 (quoting *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 499 (1985)).

142. 29 U.S.C. § 794 (2012).

state and local government entities, while Section 504 of the Rehabilitation Act applies only to programs or activities that receive federal financial assistance.[143] Because nearly every government entity receives at least some federal money, Section 504 of the Rehabilitation Act covers at least as much conduct as Title II of the ADA.[144] The availability of this protection should not be construed to mean that the elderly are disabled simply by virtue of being old; rather, they are far more likely to develop conditions that will qualify as disabilities, making protection under these Acts probable.[145] Elderly inmates often are not able to participate in many work or recreational programs in prisons because the buildings and activities are primarily designed to meet the needs of younger inmates.[146] The protection and accommodations required by these Acts do not require preferential treatment for the elderly inmates, nor should they, but they could be useful in ensuring that elderly inmates are afforded the same rights and programs as younger inmates.

IV. WHY WHAT WE ARE DOING IS NOT WORKING

A. Prisons Are Designed for Young Inmates, Not Old Ones

Most prisons were built during a time when few inmates were elderly; some were built with multiple buildings and long distances in between, and multi-story buildings did not have elevators, among other things.[147] Prisons are currently designed for young, healthy inmates; healthcare is based on a military sick-call system in which there is an inmate-run daily lineup for

143. Samuel R. Bagenstos, *Disability Rights Law* 164 (Foundation Press 2010).

144. *Id.* at 165 (noting that the person bringing the claim has to prove the receipt of federal funds to establish the claim).

145. Curran, *supra* n. 24, at 256.

146. *Id.* at 256–257. Nadine Curran gives the example of an elderly inmate who loses hearing with age. *Id.* at 257. Hearing impairment qualifies as a disability under the ADA. *Id.* Most prisons are not equipped with telephone systems or other equivalent communication devices that enable hearing-impaired inmates to communicate with others. *Id.* This could qualify as discrimination under Title II of the ADA because other nonimpaired inmates have the ability to communicate using normal telephones while hearing-impaired inmates do not, by virtue of their disability. *Id.*

147. Research report from Cynthia Massie Mara, Christopher K. McKenna, & Barbara Sims, to the United States Department of Justice, *Unintended Consequences of Sentencing Policy: Key Issues in Developing Strategies to Address Long-Term Care Needs of Prison Inmates* 146 (Oct. 14, 2002) (copy on file with *Stetson Law Review*).

those who need medical care.[148] This system assumes that a healthy prison population only needs healthcare temporarily and not on a consistent basis.[149] This does not align well with the needs of the elderly, who likely need more routine care and who may have chronic illnesses.[150] Currently, there is no rule of separation within prisons by age alone—only by sickness and health.[151] This means that those who only have normal aging impairments, like limited mobility, without an actual illness are either lumped in with young inmates and likely prone to victimization, or placed in an infirmary (often in seclusion) when they are not actually ill.[152]

B. Insufficient Training of Prison Staff

Prison officials who are trained only to work with younger inmates are often skeptical of the medical complaints of the elderly because many younger inmates often request extra blankets for bartering and make sick calls simply for an excuse to get out of working.[153] Prison guards are used to simply punishing or isolating prisoners for bad behavior; without proper training, it will not cross their minds to consider whether an elderly inmate's failure to show up on time or "mouthy" nature may be a sign of early Alzheimer's disease.[154] Even medical workers within the prisons are trained to be suspicious of inmate requests, making early diagnosis and treatment of a legitimate chronic illness difficult to diagnose and properly treat.[155] Jonathan Turley, the director of the Project for Older Prisoners, believes that prisons do not purposely withhold care the majority of the time, but an inadequate standard of care is often what prisoners receive because prison staff members are not given the training or the resources otherwise.[156] There seems to be a correlation between the amount of money going into the prison hospitals and society's

148. Curtin, *supra* n. 5, at 476.
149. *Id.* at 486; *see* B. Jaye Anno et al., *Correctional Health Care: Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates* 49 (Crim. Just. Inst., Inc. 2004).
150. Curtin, *supra* n. 5, at 476.
151. Ornduff, *supra* n. 50, at 183.
152. *Id.*
153. Curtin, *supra* n. 5, at 486.
154. Belluck, *supra* n. 36.
155. Curtin, *supra* n. 5, at 486–487.
156. *Id.* at 488. For more on training prison staff, see *infra* Part V(C).

valuation of the life and health of prisoners; prison healthcare is significantly below the standard of healthcare in normal society because prisons do not currently have the resources to improve it.[157]

C. Poor Planning

Prison officials admitted to Human Rights Watch researchers that they are "struggling" to stay above water with regard to housing elderly inmates.[158] They are frustrated by a lack of resources, ill-fitted facilities, insufficient political support, and demands of higher priorities.[159] They freely admitted that they do not know how they will meet the needs of numerous elderly inmates in the future without more money, new construction, and better-trained staff.[160] Officials stressed the need to open more assisted living facilities and skilled nursing facilities to respond to the needs of the elderly inmate population.[161] Currently, there is not a single high-level official in any correctional system that has been assigned the responsibility of assessing the conditions of confinement for elderly prisoners and evaluating the changes needed going forward.[162] Prisons are still budgeting, planning, and working as if the waves of incoming inmates will be young and will still be young when they are released.[163] This simply is not the case anymore, and, at the rate that the elderly inmate population is growing, further solidifies the notion that our prison system is vastly underprepared, both now and for what is to come.

V. EARLY RELEASE PROGRAMS DO NOT AFFECT ENOUGH INMATES TO MAKE A DIFFERENCE

In response to the overcrowding of prisons and high cost of healthcare for elderly inmates, some have argued for the early release of inmates who meet certain qualifications. However,

157. Curtin, *supra* n. 5, at 488.
158. Human Rights Watch, *supra* n. 2, at 52.
159. *Id.*
160. *Id.*
161. *Id.*
162. Human Rights Watch, *supra* n. 2, at 71.
163. Ornduff, *supra* n. 50, at 187.

early release programs do not affect enough inmates to truly make a difference.[164] The Bureau of Prisons (BOP) released an average of only twenty-two inmates per year under compassionate release between 2002 and 2008.[165] Out of approximately 218,000 federal inmates,[166] only 0.01% of all inmates received compassionate release.[167] This "safety valve" provision for circumstances that could not be foreseen at the time of long-term sentencing is inherently flawed. The criteria that the BOP uses before making the motion to the court are interpreted very narrowly, while the court relies upon broader guidelines on the back end. This creates a bottlenecking effect that quite literally leaves many elderly and infirm inmates stuck—behind bars.

A. Stringent Procedural Limitations Render Compassionate Release Ineffective

Federal law contains a rarely used provision commonly referred to as "compassionate release" that Congress established in 1984 under 18 U.S.C Section 3582(c). Upon first receiving a motion from the Director of the BOP, a court has the power to reduce or end an inmate's term of imprisonment when the court finds there are "extraordinary and compelling reasons" to give a reduction; when the prisoner is at least seventy years old, when the prisoner has served at least thirty years in prison, or when the court finds that the prisoner is not a danger to others or the community.[168] Additionally, the reduction must also be consistent

164. It has been argued that all compassionate release programs do is essentially shift the tax burden from the shoulders of state taxpayers to federal taxpayers and welfare programs that will likely have to support the inmates and their healthcare needs upon release. Curtin, *supra* n. 5, at 497.

165. Brie A. Williams et al., *Balancing Punishment and Compassion for Seriously Ill Prisoners*, vol. 155(2) Annals Internal Med. 122–123 (July 19, 2011) (combining statistics in the table shown).

166. This is the total number of federal prisoners as of November 14, 2013. Fed. Bureau of Prisons, *Weekly Population Report*, http://www.bop.gov/locations/weekly_report.jsp (accessed Nov. 14, 2013).

167. Berry, *supra* n. 10, at 868. Further, an average of only thirty-one requests per year even reached the final review stage to be reviewed by the Director of the BOP. Williams et al., *supra* n. 165, at 123. There is no data available on the total number of requests made for compassionate release each year because the BOP may never receive any information on that request if the warden denies the request at an early stage. *Id.*

168. 18 U.S.C. § 3582(c); *see also* Families against Mandatory Minimums (FAMM), *Frequently Asked Questions about Compassionate Release* (June 12, 2008) (available at http://www.famm.org/Repository/Files/Compassionate_Release_FAQs_v._06.12.08%5B1

with policy statements issued by the Sentencing Commission.[169] In 2007, the Sentencing Commission set forth the following application notes in order to assist judges in deciding when "extraordinary and compelling" circumstances exist:

> (1) The [inmate] is suffering from a terminal illness[;] or
>
> (2) The [inmate] is suffering from a permanent physical or medical condition[;] or
>
> (3) The [inmate] is experiencing deteriorating physical or mental health because of the aging process and this aging process substantially diminishes the ability of the [inmate] to provide self-care within the environment of a correctional facility and for which conventional treatment promises no substantial improvement[;] or
>
> (4) The death or incapacitation of the [inmate's] only family member capable of caring for the [inmate's] minor child or children[;] or
>
> (5) As determined by the Director of the Bureau of Prisons, there exists in the [inmate's] case an extraordinary and compelling reason other than, or in combination with, the reasons described above.[170]

By virtue of the above conditions, it appears as if several of the descriptions could apply to elderly inmates and perhaps qualify them for release. However, the majority of elderly inmates who apply will never receive compassionate release, either because their requests are denied by the court, or more com-

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%5D.pdf); PR Log, *The Bureau of Prison's Compassionate Release Program—Do You Qualify?* http://www.prlog.org/11075848-the-bureau-of-prisons-compassionate-release-program-do-you-qualify.html 1 (Aug. 7, 2011). The legislative history indicates that the Senate Judiciary Committee clearly envisioned circumstances that would deem a prisoner eligible for "safety valve" release resulting from severe illness, and potentially, even nonmedical circumstances. Berry, *supra* n. 10, at 860–861. Congress additionally mandated the Sentencing Commission to come up with standards to assist judges in determining what those "extraordinary and compelling circumstances" might be. *Id.*

169. PR Log, *supra* n. 168.

170. *Id.* Many proponents of compassionate release have argued that many elderly inmates are being unnecessarily held despite the fact that their imprisonment no longer serves the goals of rehabilitation—or any other purpose of punishment. Human Rights Watch, *supra* n. 2, at 10. Significantly, the Sentencing Commission provided that "rehabilitation of the defendant is not, by itself, an extraordinary and compelling reason" for compassionate release. United States Senten. Comm'n, *Guidelines Manual* 45 (2011) (on file with *Stetson Law Review*).

monly, because their requests never actually make it before a court for review.

While these guidelines from the Sentencing Commission are all items that a judge may take into account once the case comes before the court for consideration, it is important to note that the first hurdle is getting the BOP to even make a motion for the court to hear the case. Further, the first hurdle is actually comprised of several hurdles, and the BOP's criteria for making a motion are much narrower than the criteria set forth by the Sentencing Commission for judges. First, a prisoner must submit a written request for compassionate release that must be approved by the Warden of the inmate's prison.[171] If approved by the Warden, then it passes on for approval by the Regional Director of the BOP.[172] If approved by the Regional Director, then it advances for approval by the General Counsel of the BOP.[173] Finally, only if approved by the General Counsel does it pass on for approval by the Director of the BOP.[174] Then, only if the Director of the BOP approves, does the request ever make it before a judge.[175] The Director of the BOP is the only person who can petition the court for an inmate's release; the inmate cannot do it himself, nor can an inmate's family member.[176] As explained in the next section, the BOP approves very few motions for

171. The inmate's written request must contain the following, at a minimum: "(1) [t]he extraordinary or compelling circumstances that the inmate believes warrant consideration[,]" or "(2) [p]roposed release plans, including where the inmate will reside, how the inmate will support himself/herself, and, if the basis for the request involves the inmate's health, information on where the inmate will receive medical treatment, and how the inmate will pay for such treatment." FAMM, *supra* n. 168, at 2. Note that these requirements clearly indicate that the prisoner may make requests for reasons other than health reasons, but compassionate release has never been granted for anything unrelated to an actual medical condition. Berry, *supra* n. 10, at 863, 867.

172. Berry, *supra* n. 10, at 864.

173. Up until this step, if a prisoner's request is denied, he or she has the ability to appeal through the Administrative Remedy Procedure. *Id.* at 865. Once it reaches the General Counsel, and afterward, the Director of the Bureau of Prisons, a denial is a final administrative decision and is not appealable through the administrative process. *Id.* (discussing 28 C.F.R. § 571.63(b), (d) (2013)). A prisoner may then attempt to appeal through the federal court system, but these attempts to appeal are routinely denied. *Id.* There is currently no published case granting compassionate release apart from the Director of the BOP making one. *Id.* at 866. The courts have held that a district court cannot consider a compassionate release claim absent a motion from the BOP. *Id.* (citing *United States v. Powell*, 69 Fed. Appx. 368, 369 (9th Cir. 2003)).

174. Berry, *supra* n. 10, at 864–866; FAMM, *supra* n. 168, at 5–6.

175. FAMM, *supra* n. 168, at 6.

176. 18 U.S.C. § 3582(c)(1)(A).

compassionate release, largely due to a very narrow interpretation of the statute.[177]

Procedurally, the requirement of a written request by the prisoner himself can be a significant barrier for an elderly inmate. An elderly inmate with a severe cognitive ailment such as dementia or Alzheimer's disease, or even those who may have dwindling capacity due to a particularly debilitating physical illness, may not have the capacity to complete a written petition.[178] The review process can easily extend for months, and often years, which serves little practical purpose when the majority of inmates applying are elderly with terminal illnesses; many do not survive the process.[179] The reliance of the BOP on a medical prognosis and estimated time left to live creates a "Catch 22." If the request is granted too late, then an eligible prisoner will die before the sentence is terminated.[180] If the request is granted too early, the BOP risks releasing a terminally ill and dangerous prisoner that may live longer than expected.[181]

Additionally, there are also certain classes of prisoners who are not eligible for compassionate release under the federal statute: state prisoners (although they may be eligible for similar release under state programs), state prisoners incarcerated at federal prisons, federal prisoners who violated the District of Columbia Code, and "federal prisoners who committed their offenses prior to November 1, 1987, and received non-parolable sentences."[182] Some states have no early release programs that elderly inmates can rely upon at all, and the ones that do have varying degrees of requirements that are often just as strict, if not more so, than compassionate release.[183] The bar against federal prisoners who were sentenced without parole before late-

177. Berry, *supra* n. 10, at 865.

178. Williams et al., *supra* n. 165, at 124. Further, prisoners have very low literacy rates, are often long distances from family and friends who may offer support, and may not even be aware of early-release programs. *Id.* Formal guidance for prisoners, however, has not been successful or organized. *Id.*

179. *Id.* at 123. An average of six inmates per year die before a final decision is made, out of an average of thirty-one requests per year that reach the final review stage. *Id.* at tbl. 1.

180. *Id.*

181. *Id.*

182. FAMM, *supra* n. 168, at 6. Although, as mentioned earlier, many states have their own early release programs with varying terms. *Id.*

183. *Id.*

1987 largely affects the elderly inmate population. For example, a man who was only twenty-five years old when sentenced to life without parole in 1987 would be fifty years old today, quickly approaching what is "old age" in prison. No matter how much his health declines, he does not even have the hope of compassionate release.

B. Narrow Interpretation by the Bureau of Prisons Renders Compassionate Release Ineffective

The BOP's current criteria for making a motion to the court are not the same as the guidelines set forth by the Sentencing Commission to assist judges. The BOP maintains its own regulations for how the Director makes decisions under 18 U.S.C. Section 3582(c).[184] The regulations describe "extraordinary and compelling" circumstances as circumstances that "could not reasonably have been foreseen by the court at the time of sentencing."[185] In practice, the Director of the BOP makes motions for compassionate release quite sparingly and seems to limit the interpretation of this statute as referring to only situations where a prisoner has a terminal illness and death is imminent.[186] Although the BOP recognized in an inter-office memorandum in 1994 that there may be other medical cases that merit consideration for release,[187] historically, motions for compassionate release have been granted only when a prisoner has a terminal illness with a medical prognosis that he or she has one year or less to live.[188] There is no written requirement in the BOP procedures stating that the Director must act on such a limited basis, but the BOP has never wavered from this very limited interpretation of the statute, nor has it been required by any court to do so.[189]

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184. 28 C.F.R. § 571.60 (2010).

185. *Id.*

186. Berry, *supra* n. 10, at 862–863. It has been suggested that the lack of a codified standard may be what makes the Director proceed with caution and refrain from filing numerous motions under this section. *Id.* at 863.

187. Mary Price, *The Other Safety Valve: Sentence Reduction Motions under 18 U.S.C. § 3582(c)(1)(A)*, 13 Fed. Senten. Rep. 188, 189 (Feb. 2001).

188. Berry, *supra* n. 10, at 866.

189. *Id.* at 868. Although there have been multiple challenges, no court has ever held that the Director's discretion in narrowly interpreting compassionate release petitions was not consistent with statutory language or intent. *Id.* The court seems to use *Chevron* Standard, which give deference to federal agencies when acting pursuant to authority given by Congress. *See Chevron, U.S.A., Inc. v. Nat. Resources Def. Council, Inc.*, 467 U.S.

This self-imposed requirement for a specific prognosis and remaining life span (currently, twelve months or less) has particularly harsh effects on elderly inmates. First, it excludes elderly inmates who may have advanced illnesses or mobility impairments but may not be "terminal."[190] For example, this interpretation excludes elderly prisoners with severe, but perhaps not "end-stage," dementia, and those who are in a persistent vegetative state who could be kept alive for an indeterminate amount of time.[191] Those with end-stage organ disease are also not likely to qualify for compassionate release under the BOP's limited interpretation of the statute because these patients can often live for months or years with continual medical treatment, such as dialysis.[192] Second, it is often difficult for even the best physicians to establish a reliable prognosis and life expectancy for inmates with advanced liver, heart, or lung disease, or those with dementia or Alzheimer's disease.[193] These are some of the leading causes of death and disability in elderly prisoners, but the advancement and effects the conditions will have on prisoners are often varying and sporadic.[194] In other words, it is very difficult for a physician to predict a reliable life expectancy that will be sufficient to satisfy the BOP's standard interpretation of the criteria.[195] Although these conditions are expensive to treat and cause a great deal of pain and suffering, they may not reach "end-stage" status until the last six weeks of a prisoner's life.[196] The same is true for most types of cancers, where prognoses vary from prisoner to prisoner and conditions decline quickly.[197] A patient given a sixteen-month life expectancy could very well only live for

837, 863–864 (1984) (describing the level of deference a court must give to an administrative decision). The most recent challenge resulted in the court holding that the BOP's decision to not grant compassionate release to prisoners sentenced to life without parole before November 1, 1987 was consistent with congressional intent and a permissible interpretation of the statutes. *Sims v. Norwood*, 2008 WL 1960127 at *3 (C.D. Cal. 2008). Other challenges include *Williams v. Van Buren*, 117 Fed. Appx. 985 (5th Cir. 2004), *United States v. Dresbach*, 806 F. Supp. 2d 1039 (E.D. Mich. 2011), and *United States v. Maldonado*, 138 F. Supp. 2d 328 (E.D.N.Y. 2001).

190. Williams et al., *supra* n. 164, at 123.

191. *Id.*

192. *Id.*

193. *Id.*

194. *Id.*

195. *Id.*

196. *Id.*

197. *Id.*

six weeks depending on how fast the cancer grows and spreads.[198] Because many ailments suffered by elderly prisoners have no predictable trajectory or severity, there is a very slim chance that prisoners suffering from ailments like these will be granted a motion for compassionate release from the BOP.

C. Why the Compassionate Release Statute Is Unlikely to Be Broadened

First, the current Compassionate Release Statute is not likely to be broadened because the public is generally not accepting of early release programs, and politicians will not back the expansion or advancement of them for fear of losing voters.[199] No matter how ill an elderly prisoner may be, the argument remains that he or she was put in prison for a long period for a reason.[200] For every stand-alone legislator who is willing to argue for the advancement of compassionate release, there are many more who will argue against it for the safety of the public and for arguably the most vulnerable citizens of all—nursing home residents.[201] If an elderly inmate is too ill or incapacitated to be cared for in prison, then he or she is most likely too ill or incapacitated to be cared for in the community by family. Many do not even have family members left who are either willing or able to care for them once they leave prison.[202] The prisoners will need to be admitted to a private nursing home to get the care they need. However, there is strong opposition from the public and Congress against putting prior felons in nursing homes with community residents.[203] Nursing homes often deal with minor physical aggression from residents, but they are not equipped to

198. *Id.*

199. Pennsylvania has done extensive research and the public response was overwhelmingly against the State's early release programs. Curtin, *supra* n. *5*, at 498. Victims of crimes and family members, district attorneys, and social workers, among others, argued that these inmates have nowhere to go and their release is not "compassionate." *Id.*

200. Abner, *supra* n. 5. "[E]arly release must be weighed against public safety risks." *Id.*

201. Amy Neff Roth, *Compassion vs. Safety: Should Aging/Ill Prisoners Be Released?* http://www.uticaod.com/news/x2102585582/Compassion-v-safety-Should-aging-ill-prisoners-be-released?zc_p=0#axzz2WreY0nbj) (last updated June 25, 2012); Curtin, *supra* n. 5, at 477–478.

202. Dan Levine & Mary Slosson, *Softer California Three Strikes Law Would Save on Older Inmates* http://www.reuters.com/article/2012/07/11/us-usa-california-prisons-idUSBRE86A05G20120711 (accessed Sept. 10, 2013).

203. Curtin, *supra* n. 5, at 477–478.

handle physical aggression on a criminal level.[204] Therefore, there is often no environment outside of prison to realistically manage the risky behavior of inmates upon their release.[205] Currently, the interpretation of the compassionate release statute prevents this from happening because only inmates who are literally on death's doorstep are released.

Putting low-risk prisoners into nursing homes can also lead to unintentional problems.[206] Statutes may require nursing homes to make their residents' criminal records public, and the public backlash is foreseeable.[207] It must be kept in mind that not all elderly inmates are ones that committed a crime many years ago and are still serving long sentences—almost half of elderly prisoners serving long sentences were convicted of crimes committed in old age, and thus, may not be fully rehabilitated no matter how ill or incapacitated they may become.[208] The Compassionate Release Statute and its interpretation are unlikely to be broadened because both legislators and the general public fear the risk to private citizens and nursing home residents if more inmates were released under less stringent terms.

Further, legislators are hesitant to broaden policies that reduce the burden of punishment placed upon prisoners by lengthy sentences because it may send the wrong message to the rest of society. The concern exists that "letting people walk out of prison simply because they're ill or old strikes many as bad policy

204. Yorston & Taylor, *supra* n. 31, at 336. For example, nursing homes may have to deal with unruly residents who have dementia from time to time, but they are not unruly, aggressive criminals with dementia. It is also important to note that the elderly, because they are weaker, make more frequent use of firearms than younger violent offenders. *Id.* Even a very ill inmate will likely still have the strength to pull a trigger.

205. *Id.*

206. Curtin, *supra* n. 5, at 478.

207. *Id.* at 477–478. Also, nursing homes have their own federal and state laws to follow that prohibit the restriction or restraint of residents' movements and activities. So, putting prisoners in their own wing of a private nursing home and still treating it like a prison will not necessarily work. Further, legislative changes would have to be made for elderly prisoners to be put into a nursing home as private residents and then restrained just by the nature of who they are inside the home, whether or not they pose a threat. *Id.*

208. Curtin, *supra* n. 5, at 478. Wisconsin State Representative Scott Suder once stated, "Putting these criminals in residential nursing homes with an already vulnerable population. . . . I think is just utterly dangerous." *Id.* at 478. Additionally, Senator John Kissel reasoned that if one whole wing of a nursing home was only for prisoners, no family member is going to feel good about putting their grandmother in that home. He stated that if there were twenty-five murderers around the corner, no matter how ill, "I don't care how old they are . . . I would not feel good about it . . . I don't care if they're [eighty] years old . . . they're incarcerated for a reason." Becker, *supra* n. 94, at 3.

. . . [and] 'sends the wrong message to younger offenders.'"[209] The concept of compassionate release flies in the face of the retributive purpose of punishment; the general idea is that these people deserve to be punished and would not have received long, unbending sentences if they had not committed a serious crime (or series of crimes) to begin with.[210]

Lastly, and perhaps most significantly, the compassionate release statute is already broader than the ways in which it is interpreted and implemented. As previously mentioned, the Sentencing Commission came up with additional and more specific guidelines to assist judges struggling with what constituted "extraordinary and compelling circumstances" in 2007, but the average number of inmates released has yet to increase.[211] This is mostly because the criteria under which the BOP chooses to operate are more limited than the Sentencing Commission Guidelines that the court operates under, and the BOP is what controls who comes before the court. While the BOP has the authority to expand its interpretation of criteria for submitting motions to the court, it has chosen not to since 1994.[212] Further, courts have repeatedly upheld the BOP's deference, and although challenged in the past, have upheld the BOP's authority to make the limited decisions and interpretations that it does.[213] Because the BOP is a federal agency with authority granted by Congress, courts are reluctant to overstep that boundary and require the BOP to interpret the criteria in a more expanded manner.[214] The courts have repeatedly deferred to the judgment of the BOP and have refused to find for the compassionate release of an inmate absent a motion from the BOP.[215] Because the BOP has made no significant changes to its interpretation of the criteria for granting a motion of compassionate release in the past decade, and because of the great deference given to the BOP in doing so, the number of inmates who ultimately receive compassionate

209. Jones & Chung, *supra* n. 1 (quoting Michael Rushford, President of Criminal Justice Legal Foundation).

210. Human Rights Watch, *supra* n. 2, at 90.

211. Williams et al., *supra* n. 165, at 123; Human Rights Watch, *Compassionate Release*, *supra* n. 9, at 34–39.

212. The interpretation expansion was very limited; the number of months left to live went from twelve months to six months. Berry, *supra* n. 10, at 866.

213. Berry, *supra* n. 10, at 867–868.

214. *Id.* at 868.

215. *Id.* at 866.

release will remain limited. As it stands, the statute is technically broader than it is interpreted, so Congress will not be inclined to make further upward adjustments. Even if Congress chose to broaden the statute, it likely would not make much of a difference. Despite multiple challenges to the BOP's interpretation of current statutory wording, the courts have continually granted broad deference to the BOP and are unlikely to rescind this deference to the BOP's decision-making in the future.[216] Thus, the Compassionate Release Statute and its interpretation are both unlikely to change in a manner that will allow more elderly inmates to receive compassionate release.

VI. PRACTICAL ACCOMMODATIONS FOR THE ELDERLY REMAINING IN PRISON

Even if efforts are made to expand the BOP's interpretation of the Compassionate Release Statute, the elderly inmates awaiting a decision and those who will never qualify cannot be ignored in prison. Prison-based palliative care and programs that meet the needs of the elderly should be developed as a part of a working model to handle the large number of elderly prisoners.[217] Prisoners who are ill enough to be considered for compassionate release, and even the few who are ultimately released, have an illness or condition so debilitating that they would need specialized medical treatment and care in prison long before the point of release.[218] Further, elderly inmates who suffer from age-related ailments that never reach a debilitating or terminal stage are nonetheless entitled to accommodations and adequate medical treatment for their various conditions while in prison.[219] Because the current compassionate release statute does not practically assist the inmates as intended, and because it is not

216. *Id.*

217. Many states have developed hospice programs that operate within the prison system as humane alternatives for those elderly inmates who need palliative care but will never be eligible for medical parole. Human Rights Watch, *supra* n. 2, at 84. In California, the average stay in a prison hospice program before death is six months. *Id.* California also uses inmate volunteers in its hospice program. *Id.* at 85; *see infra* pt. V(D) (discussing the use of inmate volunteers).

218. Williams et al., *supra* n. 165, at 125. Williams is arguing for the broadening of the statute in addition to in-prison programs, but the Author of this Article takes the position that broadening the statute is not likely or practical.

219. *Supra* pt. II.

realistic for the statute to be broadened to cover a larger class of inmates, cash-strapped prison systems must utilize and develop low-cost alternatives to deal with the influx of elderly prisoners in the meantime.

A. Specialized Housing

Although some argue for the mainstreaming of elderly prisoners in the general prison population to mellow younger, aggressive prisoners, the more likely outcome is that the elderly prisoners will be victimized by them instead.[220] Multiple studies indicate that elderly inmates often feel vulnerable and unsafe around younger inmates, and they generally prefer rooming with people their own age.[221] In a recent study, sixty-five percent of elderly inmates who were currently living in a general prison population stated that if their health declined, they would rather be in a geriatric facility than mixed in among younger inmates.[222] Additionally, seventy-four percent of elderly inmates in separate, geriatric housing felt safe; only fifty-seven percent of elderly inmates in general prison populations claimed the same.[223] As of 2008, only thirteen states had specialized units for geriatric prisoners; six had dedicated prisons, nine had dedicated medical facilities, five had dedicated secure nursing home facilities, and eight had hospice facilities.[224] The National Institute of Corrections recently released a report finding that many problems asso-

220. *See supra* pt. I(D) (discussing victimization). The proponents of specialized housing view elderly inmates as needing protection from younger inmates who often extort and cheat older prisoners, including "wolf-prey" syndrome, which is known in prison as making threats "against older inmates in exchange for favors." Curran, *supra* n. 24, at 245.

221. Aday, *supra* n. 62, at 145.

222. *Id.* at 146.

223. *Id.*

224. Human Rights Watch, *supra* n. 2, at 51. Ohio's Hocking Correctional Facility consists of predominantly older men, with an average age of sixty-six. *Id.* They can stay until they cannot take care of ADLs themselves or need a higher level of medical care. *Id.* Missouri has also now put forth its first enhanced care unit to "keep offenders as functional as possible while providing appropriate health and housing services to accommodate their special needs." *Id.* at 50. These units would have no top bunks, daily rounds by health services, organized activities to keep them busy and oriented, and assistance with meals and other ADLs. *Id.* Texas has special geriatric units located in different state prisons to accommodate those who are over sixty years old and need help with ADLs. *Id.* These prisoners have a longer amount of time to dress, eat, move from place to place, and shower. *Id.* Texas also has a higher-level geriatric facility that is beside a hospital to cut back on transport costs and to ensure the availability of medical staff. *Id.*

ciated with providing specialized services to elderly inmates can be alleviated by having proper staff and resources at one central location; the needs of the elderly inmates are easier to manage and care is more cost-effective when concentrated in only one area.[225] Medical, employment, and transportation costs are reduced because they are confined to one central location, and targeted services to the elderly become easier to provide.[226]

The types of facilities that states have available to elderly prisoners are inconsistent and range from only hospice programs, to assisted-living facilities within the prison, to specialized nursing facilities, to separate facilities entirely.[227] At least sixteen states provide separate housing for elderly prisoners; in seven of those states, the facilities are reserved for those with special medical needs or for those ineligible for hospice care.[228] Thus, despite the variances, housing assignments are normally not solely based on age, and only a few states designate specific housing for elderly offenders regardless of their medical condition.[229] Only if space permits, and only when a person's physical or mental conditions severely limit their activities of daily living will the person be placed in a facility that can meet those needs.[230] This can be a problem because inmates often have to wait until they are very ill or impaired to get the specialized care that they need.[231] For this reason, having large facilities that can accommo-

225. Having centralized geriatric facilities would also make medical care needs and budgeting more predictable. Currently, most states do not record the healthcare costs of any particular group of inmates and only budget for the medical costs of the prison population as a whole. Curtin, *supra* n. 5, at 493.

226. Abner, *supra* n. 5, at 11.

227. *Id.* at 10.

228. *Id.*

229. Human Rights Watch, *supra* n. 2, at 48. For example, in Florida, inmates who are fifty or over can ask to be removed from the general population. Fla. Dep't of Corrects., *Annual Report Fiscal Year 2011-2012*, 34 (available at http://www.dc.state.fl.us/pub/annual/1112/AnnualReport-1112.pdf). Florida also has separate housing, separate from this, for inmates with chronic conditions who need a more intensive level of care. *Id.* In Texas, prisoners who are fifty to fifty-five receive lighter workloads. Aday, *supra* n. 62, at 208. In Mississippi, prisoners over fifty years old are housed automatically in specialized units for the elderly if their security level allows. *Id.* In South Carolina, inmates are able to retire from working in the prison at age of sixty-five. *Id.*

230. Human Rights Watch, *supra* n. 2, at 48.

231. *Id.* at 49. For prisons that do not have facilities at all, or that have limited space, sometimes elderly inmates who have only minor age-related ailments, but who still need assistance, are placed in isolated and secluded infirmaries; keeping them there long term is even more detrimental to their health, especially those suffering from ailments like dementia. *Id.*

date many prisoners from throughout the state is the preferred option and would help to centralize the treatment and expertise needed, reduce costs, and increase predictability with a wider range of services. Of course, budget concerns in developing these facilities will be an issue, but building brand new prisons is not always necessary. For example, Pennsylvania has had a designated geriatric prison since 1996 that houses only elderly inmates who need long-term care or assistance with ADLs.[232] Pennsylvania's facility was purchased from the state and simply converted from a mental hospital into a prison.[233] This is contrasted with New York's costly plunge in 2006 to develop a prison facility specializing in only elderly inmates with dementia; while advanced, this is quite an expensive solution that only serves a very specific group of elderly prisoners.[234] Perhaps if the facility was opened to a broader range of elderly inmates who could benefit from the same services as those with dementia, then New York could achieve a greater overall benefit for the same amount of money spent.

Specialized housing eliminates the stress of striking a balance for correctional officers in "bending" rules for older inmates. Because everyone in the facility would be of a similar condition, rules, routines, and regulations could be customized to the elderly population.[235] Canes and walkers were not allowed in prisons in the past because younger inmates would commonly take them and use them to make weapons, but now, they have to be allowed because of the increase in the number of people who need them.[236] If elderly inmates who need these types of accommodations were centralized to one facility or one area within a prison, then perhaps these fears of well-meaning officials, whose jobs are to maintain order in the prison, could be somewhat alleviated.[237] Specialized housing would allow prisons to keep the uniformity and routines that prison officials find necessary; the routines may be slower and different than a normal prison, but

232. Abner, *supra* n. 5, at 11.
233. *Id.*
234. Belluck, *supra* n. 36. This costs the State of New York about $93,000 per bed as opposed to $41,000 per bed in the general prison population. *Id.*
235. Human Rights Watch, *supra* n. 2, at 62.
236. Curtin, *supra* n. 5, at 483.
237. *Id.* at 493.

everyone would be on the same page.[238] This would allow prison officials to take mobility issues into account and adjust the amount of time allowed for prisoners to assemble when needed.[239] It also gives officials the ability to make more efficient and uniform decisions about bunk assignments, access to healthcare, and temperature control.[240]

Although some states already have some centralized facilities, they are often too small for the number of inmates they need to accommodate.[241] States that do not have facilities should make it a priority to develop them, and states that already have them should consider expanding them (if budget constraints allow) to deal with the daunting increase of elderly inmates in the near future.[242] Some believe that ensuring that elderly inmates are incarcerated in a manner that respects human dignity may actually require transfer to specialized units at some point.[243] The question becomes whether prisons will have the capacity to meet these needs for different types of housing and care.[244] Developing one central geriatric facility where a wide range of needs can be addressed has the most advantages for both prison officials and offenders, and would be the most cost efficient.[245] Retrofitting prisons to meet the needs of the elderly and disabled can be costly for cash-strapped states;[246] retrofitting one facility (as opposed to every single facility in the state) or developing one new facility (as opposed to developing a unit in every single facility in the state)

238. *Id.*
239. *Id.*
240. *Id.*
241. St. of Fla. Correctional Med. Auth., *supra* n. 31, at 54–56.
242. *Id.*
243. Human Rights Watch, *supra* n. 2, at 57.
244. *Id.*
245. This stands in contrast to approaches taken by states to have a unit for the elderly/infirm in every single prison, or New York that is developing a unit that serves *only* those with dementia. Human Rights Watch, *supra* n. 2, at 17.
246. For example, installation of handicap toilets and grab bars. Douglas French, Mises Economic Blog, *Geriatric Prison Nation*, http://blog.mises.org/20771/geriatric-prison-nation/ (Jan. 27, 2012). New ramps for wheelchairs, wider doors that they can fit through, beds with lockable bedrails, and lift-type bathing equipment for those who cannot get in and out of shower facilities are necessary, yet costly to implement in every individual prison. Curran, *supra* n. 24, at 245.

would save the prisons money and cut back on their liability risks in the long run.[247]

Of course, this would require that some prisoners be moved to different facilities, which could be a problem when elderly inmates are spread throughout maximum, middle, and minimum-security prisons. However, unless an inmate is still a direct violent threat, it may not be a hazard to move him or her to a lower security prison even if he or she is required to serve an entire sentence. The flight risk is not nearly as high, if not completely eliminated, for elderly prisoners due to mobility impairments.[248] Reduced numbers of guards, infrequent disciplinary issues, and a lower need for high-tech security measures make minimum-security prisons cheaper to operate.[249] If the practical need for maximum security no longer exists for elderly prisoners, then centralizing them to one location should not pose a security threat, and it frees up high-security beds for younger, more violent offenders.[250] The Project for Older Prisoners has long supported specialized housing for elderly inmates as "'more than [fifty] percent of the costs of maintaining prisoners are attributed to the salaries . . . of correctional officers'"[251] because these prisoners do not pose as much of a safety or escape risk, and "administrators could rely on fewer guards."[252] Specialized housing, in this regard, results in better healthcare and services for elderly inmates and cheaper operations for budget-conscious states and prison officials.[253]

247. *See* Aday, *supra* n. 62, at 144–148 (discussing housing costs and specialized and mainstream housing for elderly prisoners).

248. *Id.* at 209.

249. *Id.*; *see also* Yorston & Taylor, *supra* n. 31, at 335–336 (finding that placement in secure hospitals may be more cost effective but difficult).

250. Joann Brown Morton, *Implications for Corrections of an Aging Prison Population*, 5 Corrects. Mgt. Q. 78, 83 (2001).

251. Curtin, *supra* n. 5, at 496 (quoting Jonathan Turley, *An 'Old' Prison Solution*, L.A. Times B17, http://articles.latimes.com/2006/oct/07/opinion/oe-turley7 (Oct. 7, 2006)).

252. *Id.*

253. This Article acknowledges the fact that healthcare costs will remain high for elderly inmates by nature; their constitutional right to adequate medical care and the specialized treatment they often need ensures that. However, these healthcare costs can be reduced by centralizing their needs to one location instead of providing them across many different facilities in many different locations.

B. Telemedicine

Telemedicine is a fairly new and technologically advanced method of healthcare that can increase prisoners' access to healthcare because there is no transportation required and overall costs to prisons are reduced.[254] Telemedicine allows clinicians to provide care or support from a distance through the use of electronic technologies.[255]

A major cost of prison-based healthcare is transportation: gas for prison vans is expensive for high-mileage transports, and some treatments require overnight stays for the inmate, and therefore, guards.[256] Many elderly inmates have conditions that often require overnight treatment, but this can have a detrimental effect for them within the prison.[257] When they return from an overnight stay, there is no guarantee that they will be assigned to the same cell due to the constantly fluctuating prison population.[258] Frequent trips for medical services can terminate a good relationship with a cellmate, cause an assignment to a lower bunk, or a cell assignment on a ground floor, among other negative consequences.[259] These outcomes may be mere inconveniences for younger inmates, but for elderly prisoners who may be frail or have mobility impairments, it can mean they are at risk for victimization with a new, younger cellmate, or they may no longer have the ability to move around outside of their cells.[260] Telemedicine alleviates these problems for many types of ailments because elderly inmates would never have to leave the prison for treatment. Physicians are able to receive medical information and diagnose prisoners from miles away.[261] Telemedicine may be less practical for complex specialties (such as cardiology) that require equipment to treat and diagnose; however, it

254. Curtin, *supra* n. 5, at 490.
255. *Id.*
256. *Id.* at 490–491.
257. *Id.* at 491.
258. *Id.*
259. *Id.*
260. *Id.*; *see supra* pt. I(D) (discussing victimization).
261. Curtin, *supra* n. 5, at 490. For example, the geriatric ward of J.W. Estelle prison in Texas has four video cameras used for telemedicine; they have regular correspondence available with an ER doctor until very late in the evening every day, and the geriatric population of that facility is very satisfied with the telemedicine system there. *Id.*

works well for simple conditions and psychiatric treatments.[262] However, elderly inmates may be able to receive more specialized treatment because one specialist is able to serve many different locations, and one location has access to many different specialists.[263]

In one study done on psychiatric care, telemedicine allowed better access to medication and regular monitoring for inmates needing psychiatric treatment.[264] It allowed much easier access to physicians in crisis situations and averted many expensive emergency transports of inmates to the psychiatric wards of local hospitals.[265] In addition to emergency transport savings, the study estimated that telemedicine consultations cost $71 rather than $108 for traditional, in-prison consultations.[266] Telemedicine also greatly reduces the amount of waiting time for treatment.[267] This is a great benefit for elderly prisoners because doctors can evaluate and treat patients earlier, which can slow or prevent the advancement of illness. In this particular study, the waiting time for evaluation by a physician dropped from ninety-nine days to twenty-three days.[268]

The only current barrier to telemedicine is that it is still very new technology, so some prisons and doctors are hesitant to make use of it.[269] This issue will resolve itself as technology advances and telemedicine becomes more commonplace; for now, it has been suggested that elderly inmates should be congregated, if possible, where telemedicine is available.[270] Telemedicine would be a useful tool for all prisons and for inmates of any age, but it would be especially useful and economical for those prisons with higher populations of elderly inmates. Elderly inmates tend to

262. For ailments that are not as severe, the doctor could rely on prison nurses to administer treatment, and for psychiatric treatment, video conferencing allows the doctor to evaluate the patient without actually seeming him or her in person. *Id.* at 491.

263. *Id.* at 491.

264. *Id.*

265. *Id.*; *see* Human Rights Watch, *supra* n. 2, at 6–7 (discussing the cost of housing elderly prisoners).

266. Curtin, *supra* n. 5, at 491.

267. *Id.* at 492.

268. *Id.* Moreover, "with greater availability, telemedicine could also give elderly prisoners access" to specialists in gerontology. *Id.*

269. *Id.* Further, some liability issues still need to be worked out between consulting physicians and the ones administering the treatment on site. *Id.*

270. *Id.*

have more medical issues than younger prisoners and require the most consistent and ongoing treatment.[271] Telemedicine would fit hand-in-hand with the progression of centralized, special housing for elderly inmates in prisons across the United States;[272] the installation of basic equipment in one facility where prisoners have the greatest need for medical treatment is less expensive than installing equipment in every facility in the state.

C. Training Prison Staff to Work with Elderly Inmates

> *We are accustomed to managing large numbers of inmates, and it's a challenge to identify particular practices that need to be put into place for a subset. . . . There are no easy solutions.*[273]
>
> —A.T. Wall

It takes "special people" to work with the elderly in nursing homes and assisted living outside of prisons, and working with the elderly inside the prison is no different. Prison administrators, prison medical personnel, and particularly prison staff (who often have the closest contact with inmates on a day-to-day basis) need to have at least a basic understanding of the aging process.[274] Inmates often claim that younger prison officials lack patience when dealing with elderly inmates; one elderly inmate reports that, "'they yell and scream at us. . . . Although we treat them with respect, they have no respect for us.'"[275] This lack of patience is likely the result of unfamiliarity as opposed to malintent because prison staff members may not have had any experience working with elderly friends or family members before starting work at a prison.[276] While the consequences of this unfamiliarity are negative, correcting the problem is fairly straightforward with proper training.

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271. Aday, *supra* n. 62, at 143.

272. *Supra* nn. 241–243 and accompanying text.

273. Crary, *supra* n. 75. A.T. Wall is the Director of Rhode Island Department of Corrections and President of the Association of State Correctional Administrators. *Id.*

274. A 1992 study recommended that correctional staff conduct sensitivity training to understand disabling conditions and recognize the needs that some elderly inmates may have. Cox & Lawrence, *supra* n. 28, at 3.

275. Aday, *supra* n. 62, at 189.

276. *See* Cox & Lawrence, *supra* n. 28, at 3 (highlighting the importance of staff awareness and knowledge about elderly prisoners' issues).

Currently, the United Nations Office on Drugs and Crime has a handbook on prisoners with special needs,[277] with a small portion providing commentary on elderly prisoners in particular.[278] However, the section is vague and overly simplistic, recommending that prison staff working with elderly prisoners "receive training to enable them to work constructively and effectively with this group of prisoners."[279] Without any guidance on what that training should constitute or accomplish, this handbook improves nothing inside the actual prisons. Two criminal justice and corrections groups affiliated with the United Nations later developed a model training manual for Correctional Workers in 2006; in a 622 page document, the word "elderly" is only mentioned two times, both in reference to high-risk relationship issues and suicide.[280]

The United States Department of Justice goes a step further in its guidance for federal prisons by specifying that interdisciplinary training should involve "increased knowledge of the aging process, living with chronic illness, the social and emotional needs of the elderly, dynamics of death and dying, signs of depression, and skills for making referrals to expert care."[281] This is a better outline of what prison goals should be in supervising elderly inmates, but in order to be successful, consistent oversight and practical methods of training are needed. Earlier in this Article, a lack of planning was discussed as a problem for prisons, and specifically, the fact that no prison in the United States has a senior official whose job is to evaluate and plan for issues arising from the rapid increase in elderly inmates.[282] Having a senior official whose sole responsibilities are planning for the rise in elderly inmates, and developing and overseeing instruction for prison officials working with these inmates, is a crucial part of a comprehensive training program. Without a reliable and dedi-

277. U.N. Off. on Drugs and Crime, *Handbook on Prisoners with Special Needs* (2009) (available at http://www.unodc.org/documents/justice-and-prison-reform/Prisoners-with-special-needs.pdf).

278. *Id.* at 123–142.

279. *Id.* at 141.

280. Int'l Sci. & Prof. Advisory Counsel of the U.N. Crime Prevention Program (ISPAC) & Int'l Corrects. & Prisons Ass'n (ICPA), *The Luigi Daga Project Basic Training Manual for Correctional Workers*, Draft, 136, 294 (June 2006) (available at http://icpa.ca/tools/download/388/ISPAC-ICPA_Basic_Training_Manual_for_Correctional_Workers.pdf).

281. Anno et al., *supra* n. 149, at 52 (citing Aday, *supra* n. 62, at 189).

282. *Supra* pt. III(C); Human Rights Watch, *supra* n. 2, at 71.

cated source of guidance for prisons, consistency in the treatment of elderly inmates is nearly impossible. Second, the training that is developed for prison staff and prison medical caregivers must be practical in nature; in the Author's opinion, teaching the aging process and setting general goals do nothing if prison officials are not taught specific ways to combat issues.[283]

Prison staff members need to be trained to notice issues that may be problematic for elderly offenders or symptomatic of larger health problems; these include signs of decreased vision, loss of hearing, confusion, and mobility impairments, among other things.[284] Sensitivity training and instruction in geriatric health issues are also necessary to adequately prepare corrections officials to work with this large sector of the prison population.[285] Prison staff should then be instructed on actions they can take to alleviate these issues, making prison routines run smoothly for everyone. For example, in the case of an inmate who is hard of hearing, a prison staff member might simply follow a procedure to go to the inmate's cell in person to let him know it is time to go to the dining hall (or utilize an inmate assistant to do the same) instead of punishing the inmate for not hearing a call over a loudspeaker.[286] Together, education, hands-on experience, and the assignment of a senior official to regulate the process, have the potential to serve as a strong foundation for an improved and comprehensive training program to assist elderly inmates in prisons.[287]

283. It should be noted that there is very little reliable information available to the public on what specific types of training corrections officers go through for safety purposes; the Author's commentary is derived from the commentary of other legal scholars, as well as interpretation of the guidelines and suggested training methods and goals that are available. *See e.g.* Human Rights Watch, *supra* n. 2, at 63 (noting the lack of training for specific inmate disabilities and impairments of California corrections officers).

284. *Supra* pt. 1(D), n. 53–61.

285. Aday, *supra* n. 62, at 189.

286. Mara, McKenna & Sims, *supra* n. 147, at 148.

287. The Author acknowledges that the cost of training is a concern that cannot be overlooked, but training does not necessarily have to be expensive. There are multiple reliable and credible print resources on elder issues and aging, often free, that are available for use by prisons in training. Many national and local organizations also offer free education on aging related ailments, elder issues, and caregiving. *See* Belluck, *supra* n. 36 (outlining training tools used for Gold Coats).

D. Inmate Assistants

One tactic that a few prisons have pioneered is providing assistants to the elderly inmates who need it; the assistants just happen to also be inmates. Both Louisiana and California began training prisoners to handle the needs of ill elderly inmates and those suffering from dementia.[288] California Men's Colony is the best-known program of this sort and is a solid working example of the benefits inmate assistants have to offer to a prison system.[289] This prison refers to their inmate assistants as "Gold Coats," and they assist elderly prisoners who have dementia with whatever ADLs that they may need help with.[290] There are approximately six Gold Coats for every forty inmates, and a psychologist at the prison has stated that, undoubtedly, without these inmate assistants, the prison would not be able to adequately care for the dementia patients.[291]

Before the Gold Coats program began, prison officials said that dementia patients frequently started fights or disturbed other prisoners unknowingly; Gold Coats are trained to help mitigate these situations on behalf of the elderly person and often keep these incidents from happening.[292] Gold Coats protect other inmates from demented patients, but more importantly, they protect the elderly inmates from other inmates who victimize them simply because they are vulnerable.[293] The inmate assistants also sit with the elderly prisoners they care for in the dining hall at special tables that afford them more time to eat.[294] This is key, because it ensures that the elderly inmates actually receive the nutrients that they need to remain in good health. Most meals in prisons normally last around ten minutes, which is not enough time for a dementia patient or someone who is mobility impaired to eat, especially when the person may forget "basic things like what is a spork for."[295] Gold Coats also conduct exer-

288. Belluck, *supra* n. 36.
289. *Id.*
290. This program began in 2009 and is called "Gold Coats" because of the inmate assistants' special yellow jackets. *Id.*
291. *Id.*
292. *Id.*
293. Younger inmates often pick pockets, steal food, steal blankets, etc. from elderly inmates because they know they cannot, and will not, fight back. *Id.*
294. *Id.*
295. *Id.*

cise classes and run meetings designed to lessen disorientation; in short, they act as the elderly prisoner's intermediary in prison.[296]

Secel Montgomery, Jr., is an inmate serving a life sentence for stabbing a woman to death, among other offenses, but he is now entrusted with caring for elderly inmates who suffer from Alzheimer's disease and dementia.[297] He assists them with showering, shaving, personal hygiene, and toileting or changing diapers.[298] Although often convicted of heinous crimes, inmates must have an exceptional behavior record for at least five to ten years before they are eligible to apply to be Gold Coats.[299] They are paid fifty dollars a month and often have a better knowledge of dementia patients than prison guards.[300] Gold Coats are trained by the Alzheimer's Association and given literature on dementia and Alzheimer's disease; they take their responsibilities very seriously, and, because they have such close contact with the elderly inmates, they often notice changes in elderly prisoners that prison guards do not.[301]

Once a week, Gold Coats report changes in the elderly inmates' conditions or behaviors to treating physicians.[302] The Director of the Gold Coats program stated how surprised she was by how violent felons could provide such sensitive care; she found that the inmate assistants were incredibly proud of their positions and appreciated the confidence placed in them.[303] One said tearfully, "[t]hank you for allowing me to feel human [again]."[304] Many of these inmate assistants once viewed humans as objects or pawns to get what they wanted. They killed, raped, and robbed with no regard for human life; yet prison life has mellowed and rehabilitated them to the point that they can be entrusted with small jobs and interaction with other people again. Under close scrutiny and after extensive training, working with the elderly inmates who need assistance gives them purpose

296. However, there are certain restrictions. For example, Gold Coats can file inmates' fingernails, but not clip them, because clipping is a professional caregiving responsibility. *Id.*

297. *Id.*

298. *Id.*

299. *Id.*

300. *Id.*

301. *Id.*

302. *Id.*

303. *Id.*

304. *Id.*

and teaches them how to empathize and care for someone again. It begins to teach them skills for relating to the public and difficult people in general again. While these inmates might have once reacted with violence, working with an often difficult dementia patient teaches them how to react with patience and how to control their emotions when they become frustrated.[305] One Gold Coat stated, "I didn't have any feelings about other people. I mean, in that way, I was a predator. . . . Now, I'm a protector."[306] These inmate assistants provide a cost-effective service to the prison system, to the elderly inmates, and quite often, to themselves; they learn to be lawful citizens and deal with difficult emotional and relationship issues at the same time. Because of programs like this, the inmate assistants have a better chance of not growing old behind bars themselves.[307]

Inmate assistants save prisons thousands of dollars a year; they provide care that allows the prison system to avoid paying another full-salary employee. California even uses inmate assistants in its prison Hospice program for those nearing death behind bars. The assistants receive at least fifty hours of training to participate, and they help nurses with basic duties and keep dying inmates company so that they are not alone.[308] Families of the elderly inmates receiving assistance are very supportive of the Gold Coats program, and one woman stated that she knew there was no way she could match the care that her uncle was receiving in prison.[309]

While the inmate assistant programs may seem to conflict with specialized housing, both programs may be viable options for prisons, after considering the number of elderly inmates in the individual state and the prison funding available. For states that wish to implement a specialized housing unit for the elderly but need time to raise money to retrofit or build a facility, inmate assistants may provide valuable services at very little cost in the

305. *Id.*

306. *Id.*

307. Human Rights Watch, *supra* n. 2, at 85 (finding that paroled inmates who assisted in hospice programs almost never return to prison).

308. *Id.* Activities that the inmate assistants might help with include reading to the dying inmates, writing letters for them, talking and praying with them, or simply holding their hands. *Id.*

309. Belluck, *supra* n. 36.

meantime. States that have smaller numbers of elderly inmates[310] may find it necessary to mainstream elderly inmates with the general prison population because they cannot justify the cost of creating separate specialized facilities for so few inmates.[311] Inmate assistant programs could serve as a viable alternative for these states, providing services prisons need at a much lower cost. Additionally, some prisons already have halfway houses and supervised release programs for those prisoners with clean records who are eligible for parole; perhaps the inmate assistant program could be further developed to aid the prison system with the growing numbers of elders, while giving the assistants the same practical training, responsibility, and privileges that a halfway house would. Instead of merely acquiring a tangible skill, these inmate assistants would be learning something much more valuable and far-reaching—how to appropriately interact with other people and form relationships, the lack of which is what landed many of them in prison to begin with. In this sense, all parties involved are winners—the inmate assistants receive valuable skills and privileges to reward good behavior, the elderly inmates receive the assistance and care that they are in need of, and the prison system is able to provide a service that they have a duty to provide to ill and elderly inmates.

VII. CONCLUSION

The federal compassionate release program is often thought of as a safety valve that releases the elderly and infirm from prison; however, the federal statute has a marginal effect at best due to its limited interpretation by the BOP and courts. For inmates eligible to apply, this limited interpretation makes the chance of being released slim to none. Further, certain classes of prisoners will never be eligible for compassionate release. Thus, the vast majority of prisoners serving lengthy sentences will grow

310. These states include: Vermont, North Dakota, South Dakota, Hawaii, and Maine. Ronald Aday, *Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates*, 58 Fed. Probation 47, 52–53 (June 1994) (note that the number of elderly inmates in these states has risen since the time Aday's article was written, but the principle still stands that certain states will always have fewer elderly inmates than others). Prisons that house female inmates may also benefit more from inmate assistant programs, as the majority of elderly inmates are male. *Id.* at 53.

311. *Id.*

old, and often ill, behind bars, needing a multitude of medical treatments and accommodations within prisons.

Given ongoing growth of the already record-high levels of elderly inmates, prisons can no longer afford to ignore the issue or depend upon compassionate release. Along with the rise in numbers comes a rise in age-related ailments and the cost of medical treatment. Prisons must be prepared to deal with this, no matter the cost, because elderly inmates (like all prisoners) have a constitutional right to adequate medical care. Additionally, elderly inmates may be afforded protection under the Americans with Disabilities Act. Therefore, practical, low-cost methods such as centralized geriatric housing, telemedicine, specialized training of prison staff, and inmate assistant programs should be implemented to deal with escalated levels of elderly inmates inside prisons. While compassionate release may have been well-intended, it is not well-executed, and the prison system must therefore plan to deal with America's aging inmate population from behind bars.

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