Elderly Jail Inmates: Problems, Prevalence and Public Health

Robynn Kuhlmann and Rick Ruddell

California State University, Chico

Abstract

Increases in the size of the elderly population in jails and prisons have created considerable challenges for health-care practitioners within correctional systems and public health agencies. This study examined the prevalence of elderly inmates in 134 county jails and some of the challenges that these older inmates confront. Our findings indicate that the prevalence of elderly inmates in county jails is higher than reported in recent national studies. Further, these populations were thought to be at high-risk for self-harm, suicide, and victimization by other inmates. Implications for health care within county jails as well as public health approaches to solving challenges associated with elderly jail inmates are addressed.

Keywords: elderly inmates, elderly prisoners, jail incarceration

Introduction

Recently, scholars have turned their attention towards America's aging correctional populations. Generally the research points to the challenges prison systems face in treating, supervising, and paying for elderly inmates – especially their health care needs (Adams, 1995; Aday, 2003; Jones, Connelly, & Wagner, 2001). Other studies have focused on exploring the effects of environmental and interpersonal stressors on the health of older prison inmates (Gallagher, 1990; Vega & Silverman, 1988), the special needs of aging prisoners (Aday, 1994a; Anno et. al., 2004; Falter, 1999; Marquart, Merianos, & Doucet 2000; Walsh, 1992), and challenges of providing health programs within correctional systems (Aday, 1994b; Booth, 1989). Of late there has been increased attention paid to the connections between correctional and community health – and how communicable diseases or the negative effects of incarceration (such as violence) can be transmitted from jails or prisons to community populations (Centers for Disease Control and Prevention [CDC], 2001; Conklin, Lincoln, & Wilson, 2002; Potter & Krane Rapposelli, 2002).

These problems would not be in urgent need of review if the jail and prison population of elderly inmates were not in rapid growth. Overall incarceration rates increased fivefold between 1975 and 2005, and the United States leads the world in the use of incarceration (Walmsley, 2003). Along with this growth has come an increase in the population of elderly jail and prison inmates, where the prison population over the age of 55 has almost doubled in size between 1995 and 2003 (Harrison & Beck, 2004).

Increased populations of the aged create a budget strain on correctional systems due to their health care needs (Adams, 1995). The Texas Department of Criminal Justice, for example, reported a rapid growth in the number of elderly offenders admitted to prison than their younger counterparts (Fabelo, 1999). New prison admissions for offenders aged 55 years and over in Texas increased 48.6 percent between 1994 and 1998 (Fabelo, 1999). As a result of this type of growth, the latest budget analysis from the Legislative Analyst's Office (2003) highlights the economic challenges of providing health care to a large population of aging California prison inmates. Such findings underscore the importance of better understanding the characteristics of this growing population, and the challenges they pose – within correctional facilities and upon their release into the community.

Many of the studies about aging populations in correctional systems are based on prison research, and not much is known about similar populations residing in jails. While state prisons house felons sentenced to terms of incarceration longer than one year, county jails are intended to hold persons for shorter periods – in many cases, for just a day or two. One significant difference between these two correctional systems is that the federal or state governments typically operate prisons, while local governments house jail inmates. Consequently, decisions about the delivery of health care to elderly jail inmates are made by county officials and funded by local taxpayers who would much rather see their tax dollars pay for other types of programs – geared towards more sympathetic recipients such as preschoolers or retirees.

Inmates held in jails are typically awaiting a court appearance, serving terms of incarceration that are less than one year, or are awaiting transfers to state prisons (Harrison & Beck, 2004). Although jails are designed, constructed, and staffed for short-term inmates, some recent evidence suggests that many jail inmates are held for periods longer than one year (James, 2004; Ruddell, 2005a). These long-term inmates, some of whom are elderly, create challenges for local jails. Having larger populations of elderly jail inmates results in a corresponding increase in costs in order to meet their needs for special diets, medications, accessibility, and health care. Adams (1995) estimates that the health care costs for an elderly inmate are three times higher than a younger prisoner. In addition to economic considerations, aged inmates may be more vulnerable to self-harm, suicide, or victimization than their younger counterparts.

Questions regarding the care of elderly jail inmates are an important public health issue as most jail inmates return home within a matter of days. The CDC (2001) observes that:

> "Conventional wisdom holds that prisons and jails are walled off and separate from the community. More and more, however, people are recognizing that this is not true. Many ties connect the community with prisons and jails. For one, inmates are constantly moving back and forth between corrections and the community. Problems or risky behaviors begun in prison or jail return with inmates to the community after release." (p. 2)

In 2003, there were some 13.6 million persons arrested (Federal Bureau of Investigation, 2004, p. 269) and most of them were processed through county or city jails. In most cases, periods of jail incarceration are relatively short – the California Board of Corrections (2005, p.4) reports that the average jail incarceration in California was approximately 20 days in 2004 – and many offenders spend only a day or two in jail prior to their release on bail.

Thus, if an elderly jail inmate is victimized by other inmates, contracts a serious communicable disease (due to overcrowded or otherwise unhealthy jail conditions, illicit drug use or unprotected sex), or receives inadequate medical care in jail that results in a more serious health problem, those difficulties will often be presented to acute care or public health practitioners when the inmate returns to the community. As a result, the issue of elderly jail inmates extends beyond criminal justice systems and becomes a public health matter (Conklin et al., 2002; Potter & Krane Rapposelli, 2002). A necessary first step in fully understanding this challenge is to study the boundaries of this problem. Our study extends the literature about the prevalence of these populations and some of the challenges that elderly inmates create for local jails.

Gray Matters: The Aging Jail Population

The term elderly has been used to describe inmates 40 years and older in correctional research (Morton, 1992). Most correctional agencies use the age of 50 years as a baseline to define older or elderly offenders (see Aday, 2003; Morton, 1992). Other scholars, government researchers, and correctional administrators, by contrast, have defined the older prison population as beginning at the age 55 or 60 years (see Jones et al., 2001). Some scholars suggest that elderly persons who are admitted to jail are likely to have aged less

gracefully than their counterparts in the community (Aday, 2003; Mara, 2002; Marquart et al., 2000; Shimkus, 2004). Long-term alcohol or drug use, the effects of long-term poverty, unprotected sex, homelessness, and in general, unhealthy lifestyles are factors that are associated with all admissions to correctional systems, including the elderly (Aday, 2003). Consequently, the term elderly when associated with jail or prison populations is somewhat younger than Census Bureau definitions for elders in community populations.

Recent studies have revealed an increase in the 55 year and older population in both prisons and jails (Harrison & Beck, 2004; James, 2004). The jail population of elderly inmates, for example, increased from 1.5 percent in 1996 to 2.2 percent in 2002 (James, 2004). Although the increase of elders in jail populations is projected as smaller than in prison populations (Aday, 2003), it should be pointed out that those already residing in prisons are not accurate representations of new offenders. Many prison inmates are serving longer terms and are just plain growing old. Such changes may be the result of lengthy prison sentences due to mandatory-minimum sentences, three-strikes legislation, or truth-in-sentencing schemes that require inmates to serve 85 percent of their sentence before they are eligible for parole (Kempker, 2003).

Changes in the ages of persons admitted to correctional systems could be the end result of a number of factors including contemporary demographic changes. The first wave of baby-boomers born in 1946, are now approaching 60 years of age. Just as this demographic group challenged schools and other public services decades ago, the presence of the baby boomers is felt in jails and prisons today. A number of scholars have also speculated that there has been an increased level of criminality amongst older Americans (see Sapp, 1989; Walsh, 1992). Further, “tough on crime” policies may have ensnared some older Americans in criminal justice systems, often for the first times in their lives (Aday, 2003). It is plausible that some combination of these three factors result in higher populations of elderly inmates in jails or prisons. Whatever the cause, both jails and prisons have had to respond to the challenges that these populations pose, and community health providers often encounter these persons when they are released from custody.

Elderly persons admitted to jails require a different sort of health care than their younger counterparts. Shapiro and Shapiro (1987) conducted a study examining the health care of county jail inmates. Using information collected from health history questionnaires they evaluated the effectiveness of health care interventions. These scholars found that medical screening questions often failed to identify inmates who needed care for common and major disorders, and medical follow-up was often incomplete. Such studies underscore the observation that health care screening and interventions for jail inmates of all ages often have little priority. Many American jails provide only cursory health screening. If an inmate only spends one or two days in jail prior to making bail, this approach may be understood, but some inmates spend years in local jails (James, 2004; Ruddell, 2005a).

Concerns about the health status of older inmates typically address the chronic health issues that everybody undergoes as they age. A comprehensive review of the health status of elderly inmates reveals a range of serious health problems such as; dementia, cancer, stroke, incontinence, arthritis, ulcers, hypertension, chronic respiratory ailments, chronic gastrointestinal problems, prostate problems, heart disease, and deteriorating kidney functions (Aday, 2003; Anno et al., 2004; Booth, 1987; Falter, 1999; Gallahger, 1990; Marquart et al., 2000; Shimkus, 2004). Overall physical disability is expected to increase as this geriatric population continues to age (Guralnik & Simonsick, 1993). It is also likely that offender populations will have more chronic illnesses due to life-style choices such as; smoking, drug and alcohol addictions, poor dietary habits, and risky behaviors (Marquart et al., 2000; Shimkus, 2004). It is also plausible that these conditions are exacerbated by poverty and poor health care.

Furthermore, arrests and admissions to jail are stressful events, especially to those who have had few prior contacts with criminal justice systems (Aday, 1994a; 1994b; Booth, 1988). The exposure to stress -- caused by an unpleasant jail environment combined with the uncertainty of one's legal matters -- can aggravate inmate health problems. Stress contributes to physical and psychological reactions such as anxiety, nervousness, and hypertension. The experience of incarceration can increase levels of stress in these older inmates, especially since most county jails are overcrowded, noisy, and chaotic places. A natural reduction in the mobility of older persons (Guralnik & Simonsick, 1993) can also cause stress as it hinders the ability to undertake basic tasks such as going to the bathroom or showering. Some smaller jails have found it difficult to provide fixtures or facilities that are compliant with requirements of the Americans with Disabilities Act (Ruddell, 2005b) – adding further challenges to these elderly inmates.

Interpersonal violence also causes tension in correctional environments (Vega & Silvermann, 1988). Regardless of the best efforts of jail officers, uncertainty and violence are characteristic of jail environments (Tartaro, 2002). Researchers suggest that even though older inmates often seem serene, such adaptations are made in order to avoid the perception of weakness (Gallagher, 1990; Silverman & Vega, 1990; Vega & Silvermann, 1988). Being victimized is a concern of older prisoners and many believe that their age places them at a higher risk (Aday, 1994a; Marquart et al., 2000).

Thus elderly jail inmates may encounter the typical individual and environmental stressors that all prisoners experience, but also experience additional stress due to the normal aging process, their increased likelihood of victimization, and an inability of some jails to accommodate their special needs. Over-time, these stressors may contribute to decreases in physical functioning resulting in an increased need for health care, and these health care costs are a major concern for correctional administrators (Ruddell, 2005b). In some jurisdictions, for instance, policy analysts have recommended that elderly prison inmates be released prior to their release dates to save money (Legislative Analyst's Office, 2003). Jails, however, are unable to release elderly inmates awaiting their court appearances if they cannot make bail.

The increase in the number of elderly prisoners has led to the introduction of health-promotion programs and other public health interventions within some jail and prison systems. There are some correctional systems that even provide separate housing facilities for older prisoners (Aday, 2003; Anno et al., 2004; Legislative Analyst's Office, 2003). While such approaches are practical in prison systems holding thousands of inmates, they are not feasible in smaller jails that may only hold two or three elderly inmates.

In order to respond to the increasing number of elderly jail inmates, a number of innovative health care and public health programs have been introduced. Some larger jails, for example, have hospital units that are able to provide long-term care for inmates with serious and chronic illnesses (Mays & Ruddell, 2004). Most mid-sized jails have regular health care programs, and long-term inmates are able to see a physician. However, not all jails have such facilities, and some specialists are reluctant to provide in-jail services. Moreover, transporting offenders to physician appointments in the community is expensive and places both the offender and jail officer at some risk. As a result, programs such as "telemedicine" enable physicians and other health care providers to treat jail inmates using videoconferencing (Abt Associates, 1999; Jones et al., 2001). In other jails, health practitioners have counseled elderly inmates about chronic health conditions, such as diabetes and prevention of communicable diseases (National Institute of Corrections, 2003).

Despite the 700,000 persons housed in some 3300 local jails, there is very little empirical research that investigates these operations – or the persons who reside within these facilities. While most of the scholarly attention about

elderly persons in correctional facilities has focused on prisons, jails are a potential fruitful area of investigation – especially since the linkages between jail and community are so permeable and today's jail inmate is often tomorrow's public health client. While there is concern amongst academics and correctional administrators about incarcerated elders and their special needs, not much is known about the prevalence of older jail populations, their characteristics, or the problems these inmates are likely to encounter. The current study responds to this gap in the empirical literature by investigating the prevalence of elderly jail inmates and some of the health-related problems they face.

Data and Methods

In mid-June 2004 a survey was sent to 418 jails from 44 states. The survey solicited responses about a number of special needs jail populations including persons we defined as elderly – inmates 60 years of age or older. There is some debate in the literature about the proper age definitions for elderly inmates, and some scholars have placed the lower limit at 50 years (Aday, 2003; Morton, 1992). We took a more conservative approach and chose a higher age boundary, however, one limitation of this strategy is that the federal government reports percentages of jail and prison inmates 55 years and over (see Harrison & Beck, 2004; James, 2004), and thus it is more difficult to make comparisons with these data.

In addition to examining the characteristics of elderly jail inmates, the survey asked respondents to estimate other jail populations, such as persons with severe mental illnesses, gang members, repeat offenders, long-term inmates, and persons with serious illness. The intent of the study was to obtain a one-day "snapshot" of these jail populations, and the perceptions of these jail professionals about the characteristics of these populations. In some cases, we solicited information about specific interventions or programs intended to reduce the disruption associated with these groups. While one-day population counts are frequently used, some scholars have argued that such methods may undercount the true populations of special needs inmates (see Cox, Banks, & Stone, 2000), a possible limitation of the study.

Surveys were sent to all states that had county-operated jails, and therefore excluded the six states that run integrated jail and prison systems. The random sample was drawn from entries in the American Jail Association's (AJA) *Who's Who in Jail Management* (AJA, 2003) – a publication that lists all U.S. jails. According to Harrison and Karburg (2004) the 50 largest jails or jail systems hold almost 30 percent of the jail inmates for the entire nation. As large jails hold so many inmates, these facilities were over-sampled including all operations with a rated capacity over 1500 beds.

Each jail was called to confirm the jail administrator's name, and in some cases, members of the survey team spoke directly with the respondent, advised them of the study, and solicited their participation. Surveys were either faxed or mailed to each facility. In total, 134 jails (a response rate of 32 percent) returned surveys. Respondents were typically jail administrators, although in some cases mental health specialists or classification officers completed the survey. The 134 respondents represent 39 different states and all regions of the nation (state identification data from two surveys were missing).

There are several limitations with the survey results: For example, jails in the Northeastern states were under-represented in the surveys that were returned, as well as returns from small jails. These results reflect the sampling strategy as the states that have state-operated jail systems (Alaska, Delaware, Hawaii, New Hampshire, Rhode Island, and Vermont) are predominately from the Northeast, and facilities from these states were not surveyed. Moreover, fewer surveys were sent to smaller institutions, and the smallest jail that participated in the survey had 28 beds. As a result, smaller American jails are not well represented in the study. Thus the generalizability of the findings in this study is limited somewhat by the facilities that did not respond to the survey, or were not included in the sample**.**

Table 1
Jail Characteristics

	Number/Mean±SD
Participating Jails (N)	134
States	39
Rated Capacity (beds)	941.8 (sd 1279.4)
Percentage Rated Capacity	93.8 (sd 26.2)
Daily Cost	55.4 (sd 19.1)
Total Rated Capacity	125,259 beds
Region	
Northeast	7
Midwest	36
South	45
West	44

Table 1 reveals the organizational characteristics of the jails that represented in the study. The mean jail size was 941.8 inmates, with an average daily population of 898.7 inmates. The jails represented in the study were busy places – operating at approximately 94 percent of capacity, which is similar to the capacity of all jails nationwide (see Harrison & Karberg, 2004). This finding suggests that our sample is representative of national jail populations. The mean daily cost of housing an inmate was $55.40, although this ranged from a low of $20.00 to a high of $123.00. Altogether, the total rated capacity of these 134 jails was 125,259 inmates, or approximately 19 percent of all jail inmates nationwide.

Results

Table 2 reports estimates of the populations of persons over 60 years of age, and these ranged from a low of zero to a high of 25 percent with a mean estimate of 2.94 percent. The standard deviation was 3.92, which demonstrates substantial variation in the estimates. Respondents from ten facilities, for instance, reported that no elderly inmates were held in their jails. Further analyses revealed that the facilities that had no elders tended to be small, with an average rated capacity of 96 beds (ranging from 28 to 290 beds). Finding no elderly inmates in larger facilities seems unlikely so it is possible that the true population may be undercounted in some jails. McLearen and Ryba (2003) found that smaller jails report having fewer persons with severe mental illness. It is plausible that small jails are more likely to undercount the true rate of other special needs populations as well.

Eight jails, by contrast, reported that ten percent or more of their total population were elderly. These facilities tended to be larger and ranged from 114 to 1354 beds, with a mean size of 489 beds. Obtaining a higher count of special needs inmates might also reflect the ability in many large jails to conduct more accurate data analyses. Moreover, it might be possible that special needs populations cluster in urban areas that operate larger jails. Such questions should be examined in follow-up studies of special needs populations.

Table 2
Characteristics of Elderly Inmates

	Percent
Elderly Inmates (Percentage of all jail inmates)	2.94 % (Range 0 – 25%)
Have Admissions Of Elderly Inmates Changed in the Past 5 Years?	
Admissions have increased.	23.7%
Admissions have decreased	10.7%
Admissions have remained stable	64.9%
Offense Characteristics of Elderly Inmates	
Long-term offenders who have extensive experience with justice systems.	70.5%
Offenders with few contacts with justice systems.	27.9%

In a national study of jail inmates completed in 2002, James (2004, p. 2) reported that 2.2 percent of all inmates were elderly. Thus, our estimate is slightly larger than the national average, and there are a number of plausible reasons for this finding. First, our data is from a mid-year 2004 sample of jails, and both jail (James, 2004) and prison data (Harrison & Beck, 2004) report a rise in elderly populations over time. In the six years from 1996 to 2002, for instance, the number of elderly prison inmates increased by 85 percent, while the number of elderly jail inmates increased by over 50 percent. It is therefore possible our newer data more accurately reflect current jail population characteristics.

Variation in the percentage of elderly populations could also reflect geographic differences in our sample, although examination of jails with high rates of elderly inmates were not significantly associated with the so called "sunbelt" states (e.g., the 13 states that fall beneath the 37th degree latitude that draw higher populations of retirees). We also hypothesized that states with higher rates of persons who were elderly would also be likely to have higher rates of older jail inmates. In order to examine this proposition, we compared state-level data from the Census about the percentage of persons 65 years and older and the percentage of elderly inmates (United States Census Bureau, 2004). Bivariate correlations, however, revealed that there was a *negative* non-significant association between these two variables. Thus, it appears as though there is no geographic predictor of high rates of elderly jail inmates – at least in this sample of jails. Subsequent studies might compare county-level population data with jail populations to determine whether there is a "sunbelt" effect or whether the greater number of elderly jail inmates reflects the baby boomer population spike.

Participants were asked whether jail admissions of elders had increased during the past five years, and almost one quarter of all respondents agreed with this statement, but almost 65 percent reported that populations of 60 year-olds and over had been stable over the previous five years. Slightly more than ten percent of jail administrators reported, by contrast, that prevalence of elderly inmates had actually dropped. These findings are inconsistent with the results of national-level studies that examined changes in the number of elderly inmates from 1996 to 2002 (Harrison & Beck, 2004; James, 2004). It might be possible that the populations of elderly populations in these facilities are so small (typically under five percent) that changes go unnoticed, at least in the short-term.

A number of respondents were able to provide us with additional data about jail population characteristics. For example, in one Florida county, the average age of males admitted to the jail had increased 4.1 years (from 28.6 years to 32.7 years) between the years 1988 and 2000. The average age of females admitted to the same facility was similar, and increased 3.9 years over the same 12-year time period. Several other Missouri and Florida counties also were able to provide admissions data, and in 2004 the

average age of persons admitted ranged from 32 to 33 years in these jurisdictions. This age range is very similar to current national prison admissions (see Harrison & Beck, 2004) and suggests that persons admitted to jails are no longer young adults.

Understanding the offense characteristics of persons in jail is important for a number of reasons. Long-term offenders who have extensive experience with criminal justice systems are more likely to have a host of other chronic health problems such as addictions (Aday, 2003). As a result, these inmates are likely to require more extensive health care treatment while in jail (Shimkus, 2004). Elderly persons who have few (or no previous) contacts with justice systems, on the other hand, are often violent offenders (Aday, 2003). In order to evaluate these differences, respondents were asked about the offense characteristics of these inmates, and overwhelmingly reported that their elderly inmates had long-term experience with criminal justice systems. Aday (2003) reported that elderly persons with extensive criminal justice systems represented about half of all state prison populations, so these distinctions in populations between elderly jail and prison populations may be worthy of additional scholarly attention.

Table 3
Involvement in Problem Behaviors and Likelihood of Victimization

Population	Disruption[1]	Assault Inmates	Assault Staff	Victimization	Suicide or Self Harm
Inmates with Mental Illness	521	78	81	89	215
Gang Members	350	90	65	17	16
Frequent Flyers	225	44	30	8	2
Long-Term Inmates	193	35	21	8	23
Elderly Inmates	50	2	2	69	28

[1] Disruption Index – Sum of the following categories: likelihood of suicide, self-harm, assault (other inmates or staff), disruptive behavior, escapes (or attempts), and other criminal conduct (Highest possible value = 938).

Jails tend to be noisy, chaotic and violent places. While the short-term nature of jail incarceration contributes to these conditions, some special needs populations also play a role in jail disorder. The survey solicited responses about the problem behaviors of special needs populations, including persons with mental illness, gang members, frequent fliers (jail inmates with at least 20 admissions in the past five years), long-term inmates (those who had served at least one year in jail), as well as elderly inmates. A number of problem or criminal behaviors were presented, including the likelihood of suicide, self-harm behaviors, assault (of other inmates or staff), general disruptive behavior, escapes (or attempts) or other criminal conduct. Respondents were asked to select each category that applied to each special needs group. The maximum possible value – if every respondent had selected that persons with a group was involved in every possible disruptive behavior was 938 (see Table 3).

Consistent with expectations, inmates with severe mental illness were perceived to be the most disruptive special needs population, with high rates of participation in illegal or dangerous behaviors, including self-harm or suicide. While elderly inmates were the *least* likely group to be involved in disruptive or illegal behavior, jail administrators believed this group to be at high risk of victimization by other inmates – second only to persons with severe mental illness. In addition, respondents judged elderly inmates to be at relatively high risk of self-harm or suicide, compared with other groups.

The findings of higher risks for elderly inmates were somewhat unexpected, but in retrospect, are entirely consistent with current theoretical work on both suicide and victimization. The risk of suicide in jails is typically higher than prisons, and elderly persons accused of violent offenses (and particularly sexual assaults) may be at even greater risk of self-harm. As a result, one important policy question is whether these older inmates should receive more direct supervision, especially during their first hours of incarceration and immediately after adjudication, times of high suicide risk (Tartaro, 2005).

Violence reduction is a priority for most jail administrators. In order to reduce the possibility of victimization separate units of elderly inmates were established in some state prison systems. The findings reported above suggest that such interventions may be appropriate in jail systems as well. One important barrier to such approaches is the low prevalence of elderly inmates in jails. While establishing a unit for elderly inmates may be a reasonable expectation in a large jail system with several thousand beds, it is not practical in a small jail. Thus, one proactive approach is to educate jail officers about the likelihood of victimization for these populations, and the importance of ensuring the safety of these inmates (see Aday, 1994).

Summary and Conclusions

As jails were historically places of short-term incarceration, they have received comparatively little scholarly attention. Our survey reveals that the population of elderly jail inmates may be larger than previous estimates. Surprisingly, a vast majority of the respondents believed that the percentage of elderly inmates has remained stable over- time, which is inconsistent with national level studies including the present research. This finding may be an artifact of "creeping normalcy" where slow and constant change is hidden within short-term fluctuations (see Diamond, 2005). As the population of elderly inmates on any given day is so small, subtle changes over time may be hidden in the day-to-day ebb and flow of jail admissions and discharges.

While jail administrators may not recognize short-term changes within the population of elderly inmates, they certainly acknowledge increasing health care costs (Fabelo, 1999; Legislative Analyst's Office, 2003; Ruddell, 2005b). Acute and chronic health care for elderly inmates places demands on these organizations that are often difficult to control – especially for smaller jails that draw funding from a small tax base. In reaction to these escalating costs, a number of organizations have developed innovative responses, including "in-house" programs as well as partnerships with public health agencies. Jail is a temporary stop for most offenders, and inmates often cycle between the jail and community. Some individual offenders are admitted to local jails dozens, or even over a hundred times (Chandler Ford, 2004). This creates a flow of persons between jails, county public health services, and the emergency rooms that provide primary health care for many persons who are uninsured. Many of these elderly jail inmates often have a host of other problems, including severe mental illness, addictions, homelessness, chaotic interpersonal relationships, poor lifestyle choices, unemployment, and many also suffer from the long-term effects of poverty. Respondents to this survey estimated that three-quarters of elderly inmates in their facilities had long-term histories within justice systems.

In addition to coming to jail with a set of health problems, the stress of confinement can exacerbate these illnesses – especially for first-time elderly offenders who have little experience with the justice system (Aday, 1994a; 1994b). Respondents in our study estimated that one-quarter of all elderly inmates fall within this classification. Regardless of prior criminal history, elderly inmates were thought to be at higher risk of both violence and suicide (or self harm) than other offenders. As a result, exposure to a period of incarceration may cause problems that extend beyond the actual jail. As the Centers for Disease Control and Prevention (2001) note, the boundaries between community and jail are very permeable.

There is some debate amongst jail administrators about the levels of health care they should

provide. Some critics argue that jails now offer programs that were unknown several decades ago, including public health services. Leach (2004, p. 42) outlines the arguments for acting as a public health agency, including; "most offenders have minimal contacts with health providers, jail offenders are a captive public health population, offenders will eventually be released from the jail back into the community, and; jail populations have a high incidence of contagious disease." Despite these arguments for redefining the role of the jail, Leach (2004) observes that jail budgets have not had a corresponding increase, and that the mission of the jail has far surpassed its original purpose as a place for short-term detention.

It is important that arguments about the role of jails in providing care to different inmate groups are based on what the research demonstrates, apropos the actual populations residing within jails – rather than speculation, anecdotal accounts of individual cases, or problems within a single jurisdiction. This study reveals that in our sample of jails, the population of elderly inmates is somewhat larger than the national average – even when we used the higher age boundary of 60 years. Moreover, these inmates are perceived by jail professionals to be at higher risk than other inmates of victimization and self-harm.

We suggest that the growth in elderly jail inmates has created problems for county jail systems – but they also create an opportunity for public health practitioners to work with this captive group. While there are budgetary barriers for jails to provide public health services, it may be possible for public health practitioners and jail administrators to establish better long-term partnerships (Conklin et al., 2002; Potter & Krane Rapposelli, 2002). A recent study of public health interventions in correctional systems suggests that many of the barriers to these partnerships are based on miscommunication or the perception of differing missions of public health organizations (National Institute of Corrections, 2003). We argue, by contrast, that the mission of criminal justice systems and public health organizations are not only complimentary, but that collaborative efforts between these agencies may produce long-term benefits for jail and prison populations, as well as their associates, families, and neighbors in the community.

References

Abt Associates. (1999). Telemedicine can reduce correctional health care costs. Washington, DC: National Institute of Justice.

Adams, W. E. (1995). The incarceration of older criminals: Balancing safety, cost, and humanitarian concerns. Nova Law Review, 19, 465-486.

Aday, R. H. (1994a). Golden years behind bars: Special programs and facilities for elderly inmates. Federal Probation, 58, 47-55.

Aday, R. H. (1994b). Aging in prison: A case study of new elderly offenders. International Journal of Offender Therapy and Comparative Criminology, 38, 79-91.

Aday, R. H. (2003). Aging prisoners: Crisis in American corrections. Westport CT: Praeger.

American Jail Association. (2003).Who's who in jail management. Hagerstown, MD: American Jail Association.

Anno, B. J., Graham, C., Lawrence, J. E., & Shansky, R. (2004). Correctional health care: Assessing the needs of elderly, chronically ill, and terminally ill inmates. Longmont, CO: National Institute of Corrections.

Booth, D. E. (1989). Health status of the incarcerated elderly: Issues and concerns. Journal of Offender Counseling Services and Rehabilitation, 13, 193-213.

California Board of Corrections. (2005). Jail profile survey: 2004 4th quarter survey results. Sacramento: California Board of Corrections.

Centers for Disease Control and Prevention. (2001). Drug use, HIV, and the criminal justice system. Atlanta: Author.

Chandler Ford, M. (2004, March 15). Frequent fliers: The high demand user in local corrections. Annual Meeting of the Academy of Criminal Justice Sciences, Las Vegas, NV.

Conklin, T., Lincoln, T., Wilson, R., & Gramarossa, G. (2002). A public health manual for correctional health care. Ludlow, MA: Hampden County Sheriff's Department.

Cox, J. F., Banks, S., & Stone, J. L. (2000). Counting the mentally ill in jails and prisons. Psychiatric Services, 51, 533.

Diamond, J. (2005). Collapse: How societies choose to fail or succeed. New York: Viking.

Fabelo, T. (1999). Elderly offenders in Texas prisons. Austin, TX: Criminal Justice Policy Council.

Falter, R. G. (1999). Selected predictors of health services needs of inmates over age 50. Journal of Correctional Health Care, 6, 149-75.

Federal Bureau of Investigation (2004). Crime in the United States. Washington, DC: Author.

Gallagher, E. M. (1990). Emotional, social, and physical health characteristics of older men in prison. International Journal of Aging and Human Development, 31, 251-265.

Guralnik, J. M., & Simonsick, E. M. (1993). Physical disability in older Americans. The Journals of Gerontology, 48, 3-10.

Harrison, P. M., & Beck, A. J. (2004). Prisoners in 2003. Washington, DC: Bureau of Justice Statistics.

Harrison, P. M., & Karberg, J. C. (2004). Prison and jail inmates at midyear 2003. Washington, DC: Bureau of Justice Statistics.

James, D. J. (2004). Profile of jail inmates, 2002. Washington DC: Bureau of Justice Statistics.

Jones, G., Connelly, M., & Wagner, K. (2001). Aging offenders and the criminal justice system. Baltimore, MD: State Commission on Criminal Sentencing Policy, Maryland.

Kempker, E. (2003). Graying of American prisons; Addressing the continued increase in geriatric inmates. Corrections Compendium, 28, 22-26.

Leach, D. (2004). Mission creep and the role of the jail in public health policy. Large Jail Network Exchange, 37-44.

Legislative Analyst's Office. (2003). Analysis of the 2003-04 budget: Judiciary and criminal justice, Sacramento: Legislative Analyst's Office.

Mara, C. M. (2002). Expansion of long-term care in the prison system: An aging inmate population poses policy and programmatic questions. Journal of Aging & Social Policy, 14, 43-91.

Marquart, J. W., Merianos, D. E., & Doucet, G. (2000). The health related concerns of older prisoners: Implications for policy. Aging and Society, 20, 79-96.

Mays, G. L., & Ruddell, R. (2004, November 19). Frequent fliers, gang-bangers, and old-timers: Understanding the population characteristics of jail populations. Annual Meeting of the American Society of Criminology, Nashville, TN.

McLearen, A. M., & Ryba, N. L. (2003). Identifying severely mentally ill inmates: Can small jails comply with detection standards? Journal of Offender Rehabilitation, 37, 25-40.

Morton, J. B. (1992). An administrative overview of the older inmate. Washington, DC: US Department of Justice.

National Institute of Corrections (2003). Corrections agency collaborations with public health. Longmont, CO: National Institute of Corrections.

Potter, R. H., & Krane Rapposelli, K. (2002). Why public health must go to jail. Large Jail Network Exchange, 2002, 25-28.

Ruddell, R. (2005a). Long-term jail populations: A national assessment. American Jails: March/April, 22-27.

Ruddell, R. (2005b). Mayberry revisited: Small jails, big problems. Submitted to the American Society of Criminology Annual Meetings, November 2005.

Sapp, A. D. (1989). Arrests for major crimes: Trends and patterns for elderly offenders. Journal of Offender Counseling, 13, 19-29.

Shapiro S., & Shapiro, M. (1987). Identification of health care problems in a county jail. Journal of Community Health, 12, 23-30.

Shimkus, J. (2004). Corrections copes with care for the aged. Correct Care, 18, 1, 16.

Silverman, M., & Vega, M. (1990). Reactions of prisoners to stress as a function of personality and demographic variables. International Journal of Offender Therapy and Comparative Criminology, 34, 187-195.

Tartaro, C. (2002). The impact of density on jail violence. Journal of Criminal Justice, 30, 499-510.

Tartaro, C. (2005). Suicide in jails and prisons. In R. Muraskin (Ed.), Key correctional issues (pp. 72-85). Upper Saddle River, NJ: Pearson.

United States Census Bureau. (2004). Population estimates, 2004. Retrieved January 30, 2005, from http://www.census.gov/popest/estimates.php

Vega, M., & Silvermann, M. (1988). Stress and the elderly convict. International Journal of Offender Therapy and Comparative Criminology, 32, 153-161.

Walmsley, R. (2003). World prison population list. London, UK: Home Office.

Walsh, C.E. (1992). Aging inmate offenders: Another perspective. Correctional Theory and Practice. Chicago: Nelson-Hall.

Author Information
Robynn Kuhlmann, M.A. Candidate
California State University, Chico
E-Mail: robynnksf@hotmail.com

Rick Ruddell, Ph.D.
California State University, Chico
E-Mail: rruddell@csuchico.edu