Spotlight Article

Incarcerated Older Adults in the Coronavirus Disease 2019 Era: A Call for Advancing Health and Human Dignity

Raya Elfadel Kheirbek, MD, MPH, FGSA,1,2,* and Brock Allen Beamer, MD1,2

1Department of Medicine, Division of Gerontology, Geriatric and Palliative Medicine, University of Maryland School of Medicine, Baltimore, Maryland, USA. 2Baltimore VA, Geriatrics Education, Research, Clinical Center, Baltimore, Maryland, USA.

*Address correspondence to: Raya Elfadel Kheirbek, MD, MPH, FGSA, Professor of Medicine, Chief, Gerontology, Geriatrics and Palliative Medicine, Department of Medicine, University of Maryland School of Medicine, 110 S. Paca Street, PP5-N-157, Baltimore, Maryland 21201, USA. Email rkheirbek@som.umaryland.edu

Received: June 19, 2022; Editorial Decision Date: August 1, 2022

Decision Editor: Brian Kaskie, PhD, FGSA

Keywords: COVID-19, Incarceration, Older adults

When the family of Mark Thompson applied for compassionate release due to his end-stage heart failure and metastatic kidney cancer, the Bureau of Prisons denied their request. A month later, he died while quarantined in solitary confinement for coronavirus disease 2019 (COVID-19). He was a 67-year-old Black man serving his last year of a 25-year sentence for selling marijuana.

Mass Incarceration and Aging

The United States incarcerates more persons than any other country. Older adults constitute the fastest-growing demographic of prisoners (Figure 1). The geriatric threshold in correctional facilities is age 55 or, in some states, age 50 (Williams et al., 2012), and it is based on a theory of increased vulnerability and accelerated aging (Han et al., 2021; Leob et al., 2008). Compared with the current 10%, it is estimated that by 2030, adults aged 55 or older will make up one-third of the people incarcerated in the United States (Skarupski et al., 2018). The number will continue to rise, without serious effort to reform the criminal justice system (Obama 2017).

Many of the older prisoners are serving long sentences imposed during the “tough on crime” and “War on Drugs” movements exemplified by the Anti-Drug Abuse Act of 1986. The laws underscored punishment rather than rehabilitation, resulting in mass incarceration, aptly described as a new Jim Crow era in the United States (Alexander, 2010). Moreover, two-thirds of incarcerated individuals are “persons of color.” Decades of systematic discrimination and a lack of proper access to mental health and social services, coupled with a rise in for-profit private prisons and an expensive bail system, resulted in disproportionate incarceration of already disadvantaged people (Han et al., 2021). The states with the least access to mental health care also have the highest rates of incarceration (Reinert et al., 2021). During his presidency, Barack Obama signed the Fair Sentencing Act into law, which helped ease the previous harsh sentencing guidelines. However, the new law is not retroactive and does not directly help those serving prior sentences. Though it was hoped the law would provide impetus to Governors, parole boards, and others with power to reduce existing sentences, there has been relatively little momentum in this regard. Aging in prisons remains a public health crisis.

Many of the older prisoners are serving long sentences imposed during the “tough on crime” and “War on Drugs” movements exemplified by the Anti-Drug Abuse Act of 1986.
Public Health Hazard for Older Prisoners

Correctional facilities, including prisons, jails, and detention centers, are built to protect the public safety from criminal activities, with little to no attention to transmission of diseases. Throughout the country, those facilities are understaffed, overpopulated, and have experienced decades of increased rates of human immunodeficiency virus and tuberculosis (Bick, 2007). The recent COVID-19 pandemic has highlighted several grim realities with American incarceration that must be addressed. The prisons are often overcrowded. Bunk beds are the norm and there can be up to 200 people sharing a single room. Given these conditions, this kind of space sharing translates into a health hazard and promotes the rampant spread of many diseases, but particularly airborne diseases. Compounding the issue of overcrowded, shared spaces are very old physical infrastructures (inadequate sanitation, ventilation) and narrow hallways that make social distancing virtually impossible. The first COVID-19 infected person was reported on March 18, 2020, in Riker’s Island, New York City, followed by an outbreak of 200 infected persons. A similar situation occurred in Cook County Jail, Chicago. Nearly 16% of all COVID-19 cases in the state of Illinois were linked to a single facility: Cook County Jail (Reinhart & Chen, 2020). The United States subsequently experienced clusters of COVID-19, and the prison system reported an infection rate that was five times higher than general population. An analysis of cases between April and June 2020 found the rate of incarcerated persons was 3,251 per 100,000 inmates, as compared with a rate of 587 cases per 100,000 in the general population (Hawks et al., 2020; Saloner et al., 2020).

The numbers of infections and deaths are likely even higher than reported. Many prisoners did not report symptoms because they feared solitary isolation. There was also limited testing done on incarcerated people, including those who died shortly after presenting with symptoms of COVID-19 (Aspinwall & Neff, 2020; Schneider, 2020).

For many of their waking hours, correctional officers and staff share the physical space (and air). They too are at increased risk of contracting an infection. Overall, during the pandemic, between April 22, 2020 and January 15, 2021, 1 in 6 corrections officers were out sick or in quarantine. Moreover, these individuals would then leave the facility to enter the community at large (Nowotny et al., 2021; Toblin et al., 2021).

The elevated risks to prisoners and surrounding communities posed by the pandemic offered an opportunity to reassess and redress some of the injustices that led to overcrowding in the first place. Specifically, reducing the prison population could have been accomplished by releasing older adults and others who were medically vulnerable to protect them from the virus. The American Medical Association and the National Academy of Sciences, Engineering, and Medicine urged the immediate release of older, disabled, and nonviolent offenders (Wang et al., 2020). This advocacy was followed by
Several Governors, permitting the release of nonviolent offenders without waiting for a judicial ruling. Based on a memo sent by the Attorney General, the Federal Bureau of Prisons was moved to release nonviolent offenders over the age of 60 who had served at least 50% of their sentence and who had viable plans for home confinement and monitoring.

Despite the public health emergency and guidance from the American Medical Association and National Academy of Sciences, Engineering, and Medicine, less than 10% of persons meeting eligibility were released. Deaths in prisons rose 46% from prior years (Pavlo, 2020). Corrections officials argued that because these older people often did not have family support, it would be harmful to release them into communities that were under-resourced and underserved, especially during the pandemic.

More effort could have been undertaken to reduce transmission of the virus, advance safety, and uphold human dignity. Despite recommendations from the Centers for Disease Control and Prevention and other public health agencies, interventions like improved ventilation, contact tracing, and quarantine were not widely implemented in these facilities (Barnert et al., 2021). There were missed opportunities to protect both staff and inmates. Vaccinations are an effective tool to prevent COVID-19 infection and minimize the risks of serious illness or death from the virus, especially for older adults with comorbid conditions (Barksy et al., 2021; Hawks et al., 2020; Tartof et al., 2021). However, trust is a critical factor in accepting vaccination, especially for incarcerated persons. Most recent data demonstrate that less than 50% of incarcerated people have received at least one vaccine dose. Trust continues to be eroded when incarcerated people are given spoiled vaccines. In the state of Maryland, when this happened, notification was delayed for months and hundreds of people were affected. This failure undermined the efforts to vaccinate this vulnerable population.

Decarceration of older adults is the most effective solution to reduce transmission of disease (Akiyama et al., 2020), and it can be accomplished through a compassionate release policy. In 1984, the Sentencing Reform Act was originally introduced into law, and it was subsequently modified in 2018 under the First Step Act. This Act allows inmates to petition the sentencing judge for early release, after having served a predetermined number of years, for a medical, personal, and familial hardship or age-related circumstances. It has currently been endorsed by most U.S. prison jurisdictions. Older adults have the lowest recidivism rates of any other incarcerated group (Hunt & Easley, 2017).

However, the effectiveness of the compassionate release policy is limited for many reasons, including the lack of awareness about the policy among incarcerated persons and their families and the burdensome process to apply. This is further complicated by the prognostic uncertainty about the end of life, narrow eligibility criteria for release, victims' families and law enforcement objections, and insufficient availability of appropriate community placements. Many prisoners die before they can be compassionately released.

**Recommended Policy Change to Overcome Barriers**

Federal and states officials must consider whether continuing to incarcerate someone who is disabled and vulnerable or dying is a judicious use of resources. Recommendations to strengthen the compassionate release policy include the following:

- Shifting the responsibility of seeking compassionate release from inmates and their families to federal and state authorities. Make the consideration automatic, and expedite release.
- Replacing eligibility for release based on the type of offense committed with a determination of the actual threat for the community.
- Broadening medical and geriatric eligibility criteria to include progressive frailty and dementia.
- Considering families of victims and law enforcements, but not allowing their opinions to outweigh the potential benefits of releasing an inmate.
- Facilitating applications for Medicaid and food stamps and partnering with the community to provide resources for safe environments that meet the needs of individuals after release.
- Expanding postrelease translational healthcare programs with the focus cognitively impaired persons.

The state of Connecticut responded to a growing number of aging inmates and a lack of social and medical support postrelease by instituting a “nursing-home-release” parole policy. Through a contract with a private nursing home, a 95-bed facility was made available for people being released on parole. Inmates are selected for placement through a collaborative process between the correctional officers and medical providers, based on an assessment of safety risks and the individual’s medical prognosis (Binswanger et al., 2007). The facility was the first to be approved for federal nursing home funding under this policy, through the Centers for Medicare & Medicaid Services. As a result, Medicare or Medicaid covers half of the cost of care.

---

**Designing release policies, whether rooted in compassion or in a desire to decrease costs, must be facilitated.**
Conclusion
The COVID-19 pandemic has shone a spotlight on the confluence of problems in the U.S. incarceration system and created a perfect storm for mass COVID-19 outbreaks. Prisons and jails had the largest single-site outbreaks since the beginning of the pandemic, where vulnerable older adults were most affected. Decarceration and improving carceral health care are critical. This will require courage and the will to create and aggressively implement bold and just policies, the lack of which will continue to hunt our consciousness. The voice of Reverend Martin Luther King still resonates today: “injustice anywhere is a threat to justice everywhere.”

Funding
We acknowledge the support of the University of Maryland Baltimore, Institute for Clinical & Translational Research (ICTR) and the National Center for Advancing Translational Sciences (NCATS) CTSA grant number 1UL1TR003098.

Conflict of Interest
The authors declare no conflict of interest related to this work.

References
Akiyama, M. J., Spaulding, A. C., & Rich, J. D. (2020). Flattening the curve for incarcerated populations—COVID-19 in jails and prisons. The New England Journal of Medicine, 382(22), 2075–2077. doi:10.1056/NEJMmp2005687

Alexander, M. (2010). The new Jim Crow: Mass incarceration in the age of colorblindness. New York: The New Press. ISBN: 978-1-59558-103-7.

Aspinwall, C., & Neff, J. (2020, April 24). These prisons are doing mass testing for COVID-19—and finding mass infections. The Marshall Project. https://thethemarshallproject.org/2020/04/24/these-prisons-are-doing-mass-testing-for-covid-19-and-finding-mass-infections

Barnert, E., Kwan, A., & Williams, B. (2021). Ten urgent priorities based on lessons learned from more than a half million known COVID-19 cases in US prisons. American Journal of Public Health, 111(6), 1099–1105. doi:10.2105/AJPH.2021.306221

Barsky, B. A., Reinhart, E., Farmer, P., & Keshavjee, S. (2021). Vaccination plus decarceration—Stopping COVID-19 in jails and prisons. The New England Journal of Medicine, 384(17), 157–165. doi:10.1056/NEJMsa064115

Han, B. H., Williams, B. A., & Palamar, J. J. (2021). Medical multimorbidity, mental illness, and substance use disorder among middle-aged and older justice-involved adults in the USA, 2015–2018. Journal of General Internal Medicine, 36(5), 1258–1263. doi:10.1007/s11606-020-06297-w

Hawks, L., Woolhandler, S., & McCormick, D. (2020). COVID-19 in prisons and jails in the United States. JAMA Internal Medicine, 180(8), 1041–1042. doi:10.1001/jamainternmed.2020.1856

Hunt, K.S., & Easley, B. (2017, December 7). The effects of aging on recidivism among federal offenders. United States Sentencing Commission. https://www.usscc.gov/sites/default/files/pdf/research-and-publications/research-publications/2017/20171207_Recidivism-Age.pdf

Loeb, S. J., Steffensmeier, D., & Lawrence, F. (2008). Comparing incarcerated and community-dwelling older men’s health. Western Journal of Nursing Research, 30(2), 234–258. doi:10.1177/0193945907302981

Nowotny, K. M., Seide, K., & Brinkley-Rubinstein, L. (2021). Risk of COVID-19 infection among prison staff in the United States. BMC Public Health, 21(1), 1036. doi:10.1186/s12889-021-11077-0

Obama, B. (2017). The President Role in Advancing Criminal Justice Reform, The Harvard Law Review Association, Volume 130, Number 3. https://harvardlawreview.org/wpcontent/uploads/2017/08/811-866-Online-Rev-vf.pdf

Pavlo, W. (2020, April 4). Barr’s memo to release federal inmates fails to address BOP policies to release them. Forbes. https://www.forbes.com/sites/walterpavlo/2020/04/04/barrs-memo-to-release-federal-inmates-fails-to-address-bop-policies-to-release-them/#3d71de014f3

Reinert, M., Fritze, D., Nguyen, T. (2021, Sep 16). The state of mental health in America 2022. Mental Health America. https://mhanational.org/issues/state-mental-health-america

Reinhart, E., & Chen, D. L. (2020). Incarceration and its dissemination: COVID-19 pandemic lessons from Chicago’s Cook County Jail. Health Affairs, 39(8), 1412–1418. doi:10.1377/hlthaff.2020.00652

Saloner, B., Parish, K., Ward, J. A., DiLaura, G., & Dolovich, S. (2020). COVID-19 cases and deaths in federal and state prisons. JAMA, 324(6), 602–603. doi:10.1001/jama.2020.12528

Schneider, E. C. (2020). Failing the test—The tragic data gap undermining the U.S. pandemic response. The New England Journal of Medicine, 383(4), 299–302. doi:10.1056/NEJMp2014836

Skarupski, K. A., Gross, A., Schrack, J. A., Deel, J. A., & Eber, G. B. (2018). The health of America’s aging prison population. Epidemiologic Reviews, 40(1), 157–165. doi:10.1093/epirev/mxx020

Tartof, S. Y., Slezak, J. M., Fischer, H., Hong, V., Ackerson, B. K., Ranasinghe, O. N., Frankland, T. B., Ogun, O. A., Zamparo, J. M., Gray, S., Valluri, S. R., Pan, K., Angulo, F. J., Jodar, L., & McLaughlin, J. M. (2021). Effectiveness of mRNA BNT162b2 COVID-19 vaccine up to 6 months in a large integrated health system in the USA: A retrospective cohort study. Lancet, 398(10309), 1407–1416. doi:10.1016/S0140-6736(21)02183-8

Toblin, R. L., Cohen, S. I., & Hagan, L. M. (2021). SARS-CoV-2 infection among correctional staff in the federal bureau of prisons. American Journal of Public Health, 111(6), 1164–1167. doi:10.2105/AJPH.2021.306237

Wang, E. A., Western, B., & Berwick, D. M. (2020). COVID-19, decarceration, and the role of clinicians, health systems, and payers: A report from the National Academy of Sciences, Engineering, and Medicine. JAMA, 324(22), 2257–2258. doi:10.1001/jama.2020.22109

Williams, B. A., Stern, M. F., Mellow, J., Safer, M., & Greifinger, R. B. (2012). Aging in correctional custody: Setting a policy agenda for older prisoner health care. American Journal of Public Health, 102(8), 1475–1481. doi:10.2105/AJPH.2012.300704