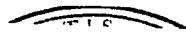


# **Issues in Maryland Sentencing**

*The Aging Maryland  
Prison Population*



**A Report  
Presented To**

**State Commission on Criminal Sentencing Policy**

**Andrew L. Sonner, Chair**

**May 2001**

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# MARYLAND STATE COMMISSION ON CRIMINAL SENTENCING POLICY

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## INTRODUCTION TO *ISSUES IN MARYLAND SENTENCING SERIES*

This report is one of a series of studies completed for the State Commission on Criminal Sentencing Policy in December 2000 by graduate students in the seminar, "Criminal Justice System Planning: Policy Analysis for Crime Control," in the Department of Criminology & Criminal Justice at the University of Maryland.

Each report considers issues facing the Commission and Maryland's criminal justice community (alternative sanctions, aging inmates, judicial compliance with sentencing guidelines, sentencing disparity, and criminal code recodification) and represents intensive research and interviewing of system activities and participants. The recommendations made in this and the other reports are those only of the authors, but their ideas and suggestions deserve attention and consideration by all those concerned about future criminal justice policy-making in Maryland and in the nation as a whole.

We hope that readers will find the material here interesting and useful in their policy deliberations on these issues. Any questions or comments about this or other reports in the series should be addressed to Michael Connelly, Executive Director of the Commission. All reports are available on our web site, [www.gov.state.md.us/sentencing](http://www.gov.state.md.us/sentencing), but we will also gladly send full copies of any or all of the reports in which the reader may be interested.

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# THE AGING MARYLAND PRISON POPULATION

Neil Duckett, Tara A. Fox, Travis C. Harsha, Jeff Vish

## EXECUTIVE SUMMARY

This paper examines the elderly prisoner problem in Maryland and throughout America and discusses possible remedies for the Maryland Division of Correction (DOC) and Maryland's State Commission on Criminal Sentencing Policy (SCCSP) to address the problem effectively and efficiently.

Maryland's prison population, like the rest of the nation, is aging, presenting challenges to its criminal justice system. From 1990 to 2000, the Maryland Division of Correction (DOC) saw a 137 percent increase in numbers of prisoners over age 50 (from 544 inmates to 1287) (Maryland DOC, 1990, 2000). Nationally, the number of inmates 55 and older increased 750 percent from 1979 to 1997 (from 6500 inmates to 49,013) (Hoelter & Holman, 1998). Longer sentences and time served, an aging baby-boom population and longer life expectancy are fueling this elderly prisoner population growth (Feldman, 1989; Morton, 1992; Wheeler, Connelly, & Wheeler, 2000). Along with this growth, states are seeing increasing demands and costs in meeting the special needs of these inmates, particularly medical care (Edwards, 1997; Hoelter & Holman, 1998; Wheeler et al. 2000).

Within the next 10 years, Maryland's elderly prisoner population (defined in Maryland as those over age 60) is expected to at least double, to a total of over 485 inmates, a figure which should still represent less than two percent of the entire projected prisoner population. Though statistically small, the increasing number of elderly prisoners will undoubtedly have a disproportionate impact on the Maryland DOC's health care budget, given the fact that nationally the elderly tend to require more medical care than do younger people. DOC and the SCCSP should continue to closely monitor the growth of the elderly prisoner population and its effect on prison spending. At this time, however, the level of services and care available for elderly prisoners seems sufficient.

## OVERVIEW

Maryland's prison population, like the rest of the nation, is aging, presenting challenges to its criminal justice system. From 1990 to 2000, the Maryland Division of Correction (DOC) saw a 137 percent growth in numbers of prisoners over age 50 (from 544 inmates to 1287) (Maryland DOC, 1990, 2000). Nationally, the number of inmates 55 and older increased 750 percent from 1979 to 1997 (from 6500 inmates to 49,013) (Hoelter & Holman, 1998). Longer sentences and time served, an aging baby-boom population and longer life expectancy are fueling this elderly prisoner population growth (Feldman, 1989; Morton, 1992; Wheeler, Connelly, & Wheeler, 2000). Along with this growth, states are seeing increasing demands and costs in meeting the special needs of these inmates, particularly medical care (Edwards, 1997; Hoelter & Holman, 1998; Wheeler et al. 2000). This paper examines the elderly prisoner problem in Maryland and

throughout America and discusses possible remedies for the Maryland Division of Correction and Maryland's State Commission on Criminal Sentencing Policy (SCCSP) to address the problem effectively and efficiently.

### **Defining Elderly**

Who are the "elderly?" According to a recent National Center on Institutions and Alternatives (NCIA) study, 44 states have no official definition of elderly prisoners (Hoelter & Holman, 1998). The Department of Justice recommends states adopt age 50 as their baseline for defining elderly, as the average prisoner approximates the average health condition of persons 10 years older in the free community (Falter, 1993; Morton, 1992). The Maryland DOC has found the majority of its chronic medical and functional problems occur in inmates over age 60 and has therefore set this age to define its elderly prison population [Correctional Action Agenda Plan (CAAP) II, 1999].

### **National Profile of the Elderly Inmate**

The United States Department of Justice profiled older inmates nationwide as follows: 1) over 95 percent are male; 2) the majority are white (although minorities are disproportionately represented); 3) their health is fair to poor, with a history of substance abuse and depression; 4) most are single, widowed, separated, or divorced; 5) most have less than a high-school education; 6) most are unskilled or semiskilled, often with lower-level clerical or sales abilities; 7) based on criminal history, they are one of the following: long-term offender, chronic recidivist, or late-life first-term offender (late-life first-term offenders usually commit crimes against a person such as homicide, aggravated assault, and vehicular homicide); 8) have much lower recidivism rates following release than younger prisoners; 9) most are better behaved than younger inmates; 10) prefer to live in separated units from younger inmates (primarily for safety reasons); and 11) they are the most expensive to incarcerate (estimate \$60,000 per year versus \$20,000 per year for younger inmates, primarily due to medical costs) (DOJ, 2000).

### **APPLICATION TO MARYLAND**

Using several different tables to show prison trends and inmate characteristics, this paper discusses the elderly prisoner problem as it applies to Maryland. Due to limitations of the Maryland DOC's current Management Information System, limited data were gathered from 1990 to 2000. All records for the 2000-study year were active inmates as of October 5, 2000. For all tables, totals may not add to 100 percent due to rounding. All data used in figures were extrapolated from raw data provided by Maryland Department of Public Safety and Correctional Services Office of Research and Statistics.

As the Maryland DOC defines its elderly inmates as those over age 60, most of these statistics deal with those inmates over age 60 (CAAP II, 1999).

### **Review by Age, Average Sentence Length/Stay and Total Prison Population with Projections**

Table 1 represents the first trend reviewed, age, average sentence length/stay and total prison populations in 1990, 1995, and 2000. From 1990 to 2000, the number of Maryland prisoners over age 60 increased from 119 to 240, a 102 percent increase. And during this same period, the number of prisoners over age 50 increased from 544 to 1287, a 137 percent increase. The table

also shows how the total prison population, average age and sentence (excluding life sentences) have gone up. The 2010 projections come from multiplying the 2000 figures and the percentage change from 1990 to 2000 (past 10-year trend), then adding this number to the 2000 figures.

The Maryland DOC currently houses 23,795 offenders with 1,287 offenders older than age 50 (representing about 5 percent of the total prison population). Included in this group are 240 offenders older than age 60 and 12 older than age 74 (Maryland DOC, 2000).

**TABLE 1**

**Maryland Prison Trends:**

**Age, Average Sentence Length/Stay and Total Prison Population (FY 90, 95 and 00)**

Maryland Prison Trends	1990 # (% of pop)	1995 # (% of pop)	2000 # (% of pop)	% Change (1990- 2000)	2010 Projection
Age 61+	119 (1%)	166 (1%)	240 (1%)	102%	485
Age 51 to 60	425 (2%)	602 (3%)	1047 (4%)	146%	2576
Age 51+	544 (3%)	768 (4%)	1287 (5%)	137%	3050
Total Prison Population	17194	21267	23795	38%	32837
Avg. Age	31	32	34	9%	37
Avg. Sentence (months)	136	142	156	14%	178
Avg. Stay (months)	39	43	54	40%	75

Note 1: Maryland defines elderly prisoners as those over age 60

Note 2: Department of Justice recommends age 50 as the standard for geriatric prisoners

Note 3: Avg. age, sentence and stay are for total prison population

Note 4: Percent next to age group numbers represents percent of total prison pop. in study year  
 Note 5: Projections = multiply 2000 figure by % change from 1990-2000 and add to 2000 figure

**Life Sentenced Inmate Population**

Table 2 shows the number of Maryland life sentenced inmates for total prison population in fiscal year 1990, 1995 and 2000. From 1990 to 2000, the number of life sentenced inmates for total population increased from 1287 to 2103, a 63 percent increase. The 2010 projection was determined by multiplying the 2000 figure and the percentage change from 1990 to 2000 (past 10-year trend) then adding this number to the 2000 figure.

**TABLE 2**

**Maryland Prison Trends:**

**Life Sentenced Inmate Population (FY 90, 95 and 00)**

	1990	1995	2000	%	2010
	# (%)	# (%)	# (%)	Change (90-00)	Projection
	of pop)	of pop)	of pop)		
LIFE SENTENCE	1287 (7%)	1734 (8%)	2103 (9%)	63%	3428

Note 1: Percent represents percent of total prison population in study year

Note 2: Projections = multiply 2000 figure by % change from 1990-2000 and add to 2000 figure

**Current Age for All Life Sentenced Inmates**

Table 3 shows the breakdown by age for all Maryland inmates with life sentences in October 2000. About 16 percent of inmates over age 50 are currently serving life sentences. Almost 60 of those serving life sentences are between ages 31 and 50, which will impact older offender numbers in 10 to 20 years.

**TABLE 3**

**Maryland Inmate Characteristics:**

**Current Age for All Life Sentenced Inmates (10/5/00) (N=2,103)**

AGE	10-20	21-30	31-40	41-50	51-60	61+
LIFE	33	482	655	594	264	75
% of LIFERS	2%	23%	31%	28%	13%	4%

NOTE 1: Percent is of total life sentenced prisoners

### Age at Intake for Entire Prison Population

Table 4 shows the trend of intakes by age for Maryland. From 1990-1999, Maryland committed 40 new prisoners a year (average) over age 60, representing less than 1 percent of intakes each year. And during this same time, Maryland committed 191 new prisoners a year (average) age 51 to 60, representing 2 percent (average) of intakes each year.

TABLE 4

#### Maryland Prison Trends:

Breakdown by Age at Intake for Entire Prison Population FY 91-99 (# in group/% by year)

AGE	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	#	#	#	#	# (%)	# (%)	# (%)	# (%)	# (%)	# (%)
	(% of pop)	(% of pop)	(% of pop)	(% of pop)	of pop)	of pop)	of pop)	of pop)	of pop)	of pop)
10-20	1323	1261	1341	1221	1286	1261	1472	1606	1538	1457
	14%	14%	14%	13%	13%	11%	11%	12%	11%	11%
21-30	4786	4653	4710	4351	4754	5159	5589	5136	4909	4690
	52%	51%	50%	48%	46%	45%	42%	39%	36%	36%
31-40	2410	2420	2603	2631	3195	3751	4608	4627	4990	4772
	26%	27%	27%	29%	31%	33%	34%	35%	37%	37%
41-50	602	597	671	734	831	1036	1351	1503	1752	1746
	6%	7%	7%	8%	8%	9%	10%	11%	13%	13%
51-60	125	141	123	107	159	181	243	246	294	286
	1%	2%	1%	1%	2%	2%	2%	2%	2%	2%
61+	38	29	27	26	36	38	56	41	54	51
	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
TOTAL	9284	9101	9475	9060	10,261	11,426	13,389	13,159	13,537	13,002

**Receipt Age for Current Inmates over Age 60**

Table 5 shows at what age current Maryland inmates over age 60 were incarcerated for their current sentence. Almost 67 percent of these inmates entered after age 50 (161,240).

**TABLE 5**

**Maryland Inmate Characteristics:**

**Breakdown by Receipt Age for Inmates Over Age 60 (10/5/00) (N=240)**

AGE AT RECEIPT	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80
# (% of pop)	5 (2%)	4 (2%)	10 (4%)	10 (4%)	11 (5%)	17 (7%)	22 (9%)	31 (13%)	51 (21%)	49 (20%)	20 (8%)	8 (3%)	2 (1%)

**Race and Sex for Inmates over Age 60**

Table 6 shows the breakdown of race and sex of Maryland inmates over age 60 in October 2000. Females account for about three percent of the older inmates and four percent of the total prison population. Males account for about 97 percent of the older inmates and 96 percent of the total prison population. Blacks account for about 51 percent of the older inmates and 77 percent of the total prison population. Whites account for about 48 percent of the older inmates and 21 percent of the total prison population.

**TABLE 6**

**Maryland Inmate Characteristics:**

**Breakdown by Race and Sex for Inmates Over Age 60 (10/5/00) (N=240)**

	BLACK	WHITE	OTHER	ROW TOTAL
MALE	116	114	2	232 (97%)
FEMALE	6	2		8 (3%)
COLUMN TOTAL	122	116	2	240 (100%)
TOTAL	(51%)	(48%)	(1%)	

NOTE 1: Percent is of prisoners over age 60

**Most Serious Offense Groups for All Inmates**

Table 7 shows the top four offense groups for which all Maryland inmates were incarcerated: 1) drug abuse (23%), 2) murder (18%), 3) robbery (15%), and 4) assault (13%).

**TABLE 7**

**Maryland Inmate Characteristics:**

**Breakdown by Most Serious Offense Groups for All Inmates (10/5/00) (N=23,795)**

1. DRUG ABUSE	5429 (23%)
2. MURDER	4340 (18%)
3. ROBBERY	3543 (15%)
4. ASSAULT	3110 (13%)

NOTE 1: Percent is of total prison population

**Most Serious Offense Groups for Inmates Over Age 60**

Table 8 shows the top five serious offense groups for which Maryland inmates over age 60 were incarcerated: 1) murder (37%), 2) rape (15%), 3) sex offense (14%), 4) drug abuse (8%), and 5) robbery (6%). Of the inmates over age 60 committing these offenses, the following are serving life terms: 57 for murder, 14 for rape, 1 for sexual offense, and 1 for drug abuse.

**TABLE 8**

**Maryland Inmate Characteristics:**

**Breakdown by Most Serious Offense Groups for Inmates Over Age 60 (10/5/00) (N=240)**

1. MURDER	88 (37%)
2. RAPE	35 (15%)
3. SEX OFFENSE	34 (14%)
4. DRUG ABUSE	18 (8%)
5. ROBBERY	15 (6%)

NOTE 1: Percent is of prisoners over age 60

**Most Serious Offenses for Inmates Aged 51-60**

Table 9 shows the top six serious offense groups for which Maryland inmates age 51 to 60 were incarcerated: 1) murder (32%), 2) drug abuse (14%), 3) rape (13%), 4) robbery (10%), 5) assault (10%), and 6) sex offense (6%).

**TABLE 9**

**Maryland Inmate Characteristics:**

**Breakdown by Most Serious Offense Groups for Inmates Aged 51-60 (10/5/00) (N=1047)**

1. MURDER	331 (32%)
2. DRUG ABUSE	147 (14%)
3. RAPE	132 (13%)
4. ROBBERY	103 (10%)
5. ASSAULT	85 (8%)
6. SEX OFFENSE	60 (6%)

NOTE 1: Percent is of prisoners age 51 to 60

**Sentence in Months for Inmates over Age 60**

Table 10 shows the original sentence in months for Maryland inmates over age 60 in October 2000. Over 67 percent are serving 15 years to life.

**TABLE 10**

**Maryland Inmate Characteristics:**

**Breakdown by Sentence (in months) for Inmates Over Age 60 (10/5/00) (N=238)**

0-3	4-6	7-	13-	19-	25-	37-	61-	97-	121-	181+	LIFE
	12	18	24	36	60	96	120	180			
1	1	3	3	5	9	7	13	16	21	84	75
0%	0%	1%	1%	2%	4%	3%	6%	7%	9%	35%	32%

KEY: SENTENCE IN MONTHS  
 # PRISONERS IN CATEGORY  
 % OF PRISONERS OVER AGE 60  
 NOTE: Missing two observations

**Percentage of Sentence Served for Inmates over Age 60**

Table 11 shows the percentage of sentence served for Maryland inmates over age 60 in October 2000. Excluding life sentences, 58 elderly inmates have served over 50 percent of their sentence.

TABLE 11

**Maryland Inmate Characteristics:**

**Breakdown by Percentage of Sentence Served for Inmates over Age 60 (10/5/00) (N=240)**

% SENTENCE SERVED	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100	LIFE
# INMATES	6	21	25	28	24	27	19	7	4	1	75
%elderly pop	3%	9%	10%	12%	10%	11%	8%	3%	2%	0%	31%

**POSSIBLE REMEDIES**

The needs of elderly inmates should be assessed institution-wide by a multidisciplinary group from different fields and functional areas (Morton, 1992). The Maryland DOC should develop a comprehensive plan tailoring the following components to elderly offenders: 1) intake, assessment and classification; 2) housing options; 3) medical care; 4) mental health services; 5) programs; 6) staff training; 7) community involvement; and 8) transition and community reintegration (DOJ, 2000; Morton, 1992).

The Maryland DOC has been proactive in addressing the elderly inmate problem. In November 2000, the Division hosted the United States Department of Justice "Health Issues and Geriatric Inmates" pilot training workshop to create a strategic plan for Maryland to address the elderly prison population problem.

**Intake, Assessment and Classification**

To effectively tailor programs to elderly inmates, assessment information should include assessment of: physical and mental health, life skills, family ties, work history and skills, community relationships, and criminal history.

The Maryland DOC conducts intake and annual screenings for those over age 50 (Swetz, 2000). The annual physical assessment also gathers data on inmate's family contact, benefits/entitlements eligibility, mental health and substance abuse history, mental and physical functioning, health status and release status to tailor care accordingly. All inmates are eligible for work, training and treatment dependent upon health status, medical needs and availability of space.

**Housing Options**

Some housing options include: community corrections, mainstreaming, special units in correctional facility, special facility, secure nursing home, hospice, and compassionate release. The main question for most prison administrators is to mainstream or separate elderly offenders from the rest of the prison population (Morton, 1992). There are strong arguments for both sides.

Although Maryland's elderly prison population has more than doubled between 1990 and 2000, the Division reported in its 1999 Correctional Action Agenda Plan II (CAPP II) "the total

number of older inmates is still low enough to be managed within existing facilities. Elderly inmates are generally housed in institutions where inpatient infirmary care is available, although they often do not require such care. Approximately 75 older inmates are housed in designated space where there are sufficient staff to render care consistent with their special health needs. Finally, the Division does not believe that new construction or the renovation of an existing facility for elderly inmate is necessary at this time. The growth in this population will continue but will not become critical in the near future even with an increase in long-term or no-parole sentences. This is due to the fact that most inmates currently receiving long sentences, with little chance of parole, are only in their twenties or thirties when received in prison. At some point in the future, however, this population could pose major housing problems and the department will continue to monitor this group" (CAPP II, 1999, Sect. 2, pp. 11-12).

In April 1999, Maryland DOC housed 218 inmates age 60 and older (214 males and 4 females) (Swetz, 1999). Among these 1999 inmates were: 72 lifers, 10 age 75+, 26 with impaired memory, 8 who require frequent medical care, 38 with heart problems, 14 with lung disease, and 13 with senile dementia. According to Barbara Boyle, Director of Social Work and Addiction Services, Maryland Department of Public Safety and Correctional Services, 40 of these inmates could benefit from a special care environment. "This number has remained constant over the last three years. It may grow as the population with very long or life sentences ages" (Boyle, 1999). Dr. Anthony Swetz, Director of Medical Services, Maryland Department of Public Safety and Correctional Services believes "all 218 of these individuals over the age of 60 years would benefit from a specialized facility" (Swetz, 1999).

### **Medical Care**

Components of effective medical care for elderly inmates include: 1) physical health assessment (assessed initially and on regular basis, health screening instruments designed for those over age 50, and good communication between health care staff and other staff); 2) preventative activities (inmate health education, nutrition, and recreation); and 3) medical care delivery (appropriate to needs of individuals; monitoring and treatment of chronic diseases; provision of nursing care, emergency services, specialists; meet standards of agency's health care accrediting organization; broad range of levels of care).

Elderly prisoners have significant needs for healthcare that surpass the needs of younger inmates. Inmates over age 55 suffer from, on average, three chronic problems (e.g., hypertension, diabetes, alcoholism, emphysema and stroke). (Morton, 1992). People age 65 and older spend twice as much time in medical facilities. Since 1983, Social Security benefits have been suspended for convicted felons while they are incarcerated (Morton, 1992). It is frequently documented throughout the literature on the topic that the typical prisoner is physiologically 10 years older than his/her actual age because of their high risk sexual and health behaviors and high incidence of tobacco and alcohol use or abuse (Aday, 1994; Curran, 2000; Morton, 1992). The myriad of medical conditions experienced by the elderly is compounded by the lifestyle of the inmate prior to incarceration. Outside of prison walls, the elderly in the general population receive assistance with healthcare costs through Medicare and Medicaid. Nationally, inmates are not only ineligible for such benefits but are at the mercy of a somewhat substandard system of prison healthcare. Once again other life issues including strained relationships with family and friends, the adjustment to prison life, and dealing with age-related illnesses compound these

problems. Texas and California currently estimate that the daily cost for medical care of the elderly is three times that of younger inmates (Fabelo, 1999; Florida Corrections Commission, 1999).

In order to address the healthcare needs of this population, one must consider the overall picture. Although the Maryland elderly inmate population is currently small, it is growing as the earlier projections suggest. Maryland may wish to consider a separate facility for the future housing of elderly and other infirmed prisoners (as discussed in previous housing section). As suggested in a publication regarding the aging prison population of Oklahoma (Wheeler et al., 1995), such a measure may ultimately reduce costs by centralizing the care of such inmates in one location. The use of such a facility would also alleviate many of the fears older inmates have of being preyed upon by younger ones.

By addressing lifestyle issues such as diet, exercise and preventive programs, correction officials can slow down the aging process, resulting in considerable savings to the correctional system. As Morton points out, "one heart bypass operation necessitated by poor diet, limited exercise, and smoking can cost in excess of \$150,000" (Morton, 1992, p. 6).

The Maryland DOC currently uses the following cost control methods: hospice, telemedicine, privatization of medical care, inmate co-payments, and managed care (Swetz, 2000).

### **Mental Health Services**

Older inmates have a higher proportion of mental problems than younger persons—15 to 25 percent of elderly offenders have some form of mental illness (Morton, 1992). The most common illnesses in rank order are: depression, senile dementia, and substance abuse (primarily alcohol abuse).

The division must ensure accurate assessment of these conditions and render appropriate treatment by trained and compassionate staff.

### **Programs**

Nationally, many corrections programs are geared for younger inmates. Programs must be geared for elderly inmates considering their physical and mental condition and diverse interests.

Effective programs include: educational (adult basic education, general equivalency diploma, basic literacy, health education, the effects of the aging process, death and dying); recreational programs (stretching and cardio-vascular strengthening exercises and opportunity to be active in leisure and sports activities); life skills training (preparation for daily living upon release); spiritual/religious (a variety of offerings in essential); and work programs (appropriate to inmate's abilities).

Many states have introduced special programming for their elderly inmates to keep inmates physically and mentally active, thus lending to the overall sustainment or improvement of health and keeping medical costs down. Programs may range from recreational and leisure activities to educational and vocational training. Keeping in mind the diversity of this population, leisure activities should be modeled to allow for individual differences based on interest and ability. Focusing on the overall wellness of inmates, institutional programs work to the advantage of

both the inmate and the facility. An added benefit to such programming is the preparation of prisoners for release.

Recreational and leisure activities allow for inmates to experience activities they enjoyed previous to incarceration and introduce them to new activities that provide a cathartic environment away from the drab prison environment. Such activities may include arts and crafts, woodworking, and gardening. These activities may also allow prisoners to earn money and "good time" credits (Wheeler et al., 1995). Other activities such as walking and physical therapy work to keep inmates physically fit, thus impeding the aging process. Educational and vocational training ultimately prepares inmates for release upon serving their respective sentences. Many prisoners will need to find a means of supporting themselves after release. Often, inmates lack the required skills to be considered marketable in society.

### **Staff Training**

The shortage of prison employees adequately trained in the special needs of the elderly inmate is another concern. Staff's insensitivity to the medical and mental health conditions of the elderly often compounds the problems (Florida Corrections Commission, 1999; Morton, 1992). Those working with older inmates need training specifically designed to recognize the unique emotional and social needs of this age group. Topics should include: sensitivity to aging; legal issues; grieving, death and dying; pre-release and aftercare; supervision of elderly offenders in prison; programming; and medical and nutritional concerns.

An additional problem to be dealt with by elderly prisoners is the difficulties associated with adjustment to the prison environment. Older prisoners face a more difficult period of adjustment than younger inmates do. This is especially true of the late-life offender who may have led a fairly normal life up until the point of his or her incarceration. Many are often displaced from family members. Often, family members do not remain in contact with the inmate. This is especially true in cases where acts of violence or sexual aggression have been committed. It is necessary for correctional staff to receive training to not only understand and recognize that these problems exist, but also know how to react to their needs, both medical and social. The lack of understanding may perpetuate the inmates' maladjustment to prison life and affect their overall well being. As with healthcare providers, correctional staff must recognize the difference between the normal aging process and the disease process. By developing a training program for the staff, potential problems may be staved off early.

### **Community Involvement**

Effective use of community resources demands the design of specific community involvement strategies, including activities such as: public relations, volunteers, citizen advisory boards, community coalitions, direct offender services, consultants, private providers, and community partnerships.

### **Transition and Community Reintegration**

Effective transition and community reintegration components include: educational/vocational services, day treatment, tutoring services, neighborhood outreach, community service supervision, and family/individual counseling.

Elderly prisoners must be prepared for life on the other side of prison walls upon their release. The DOC must consider the preparation of elderly prisoners being reintroduced into the community. It is important to note that those individuals being released may fall into one of a number of categories. Addressed earlier, one group includes those who are terminally ill or infirmed; briefly, it is necessary to provide either hospice care or placement into an appropriate facility. Another group includes those who will be released and must find a job to support themselves. Those inmates who have been incarcerated for a long period of time may not have anywhere to go and will likely require life-skills training in order to sustain themselves after release. This lends credence to programming with an emphasis on life-skills through educational or vocational training. A third category, which may overlap others, consists of those who have no family or home to return to. Those individuals may require temporary housing until they are back on their feet. As well, inmates who have served their sentences but are unable to care for themselves after release pose a problem. Arrangements for their placement into nursing or assisted living facilities may be necessary.

### **Early Release**

Although highly controversial, early release may be the lesser of evils for low-risk offenders. It is widely known that elderly offenders pose very little threat to a prison population or society as a whole. Additionally, recidivism is extremely low upon release (Aday, 1994; Turley in Butterfield, 1997; Florida Corrections Commission, 1999; Curran, 2000). For example, as a condition of parole, electronic home detention may be considered as an alternative costs to corrections at approximately \$8 dollars a day as opposed to \$65 dollars a day (Curran, 2000). The National Center on Institutions and Alternatives estimates that releasing nonviolent elderly offenders aged 55 and above would save taxpayers 900 million dollars during the first year (Curran, 2000; Hoelter et al., 1998). One program solely dedicated to the release of elderly prisoners is POPS—the Project for Older Prisoners. Founded by Professor Jonathan Turley, a handful of prisoners are interviewed for the program by law students to assess the risk of releasing the inmate. Candidates must be at least age 55, have already served the average time for their offense, and have been evaluated as unlikely to commit further crimes in the future. The victim, or the victim's family, must also agree to the prisoner's early release. As a result of these strict standards, no inmate released under the POPS program has ever returned to prison for committing another crime (Florida Corrections Commission, 1999; Turley, 1994)

Perhaps the strongest argument in favor of early release is in the case of those who are dying or infirmed. The Maryland DOC offers medical parole for terminally ill inmates or those in need of extensive or chronic medical care which is accessible in the community, if approved by Maryland Parole Commission (Edwards, 1997). Maryland's Division of Correction Directive 130-100 (1994) recommends considering an inmate for medical parole "if, in the opinion of the regional medical director, the inmate will not jeopardize public safety if released, and the inmate: 1) has an imminently terminal condition, or; 2) has a medical condition that incapacitates the inmate to the extent that continued imprisonment is not required to ensure public safety, or; 3) has a medical condition that, if the inmate were released, could more appropriately be treated through direct access to community treatment facilities" (DCD 130-100, 1994, p. 1).

### **Recommendations from Florida**

Florida Corrections Commission (1999) recommended to its DOC the following:

1. Adopt age 50 as the chronological starting point in the definition of elderly inmates.
2. Examine the existing practices and programs regarding the elderly and develop an explicit and integrated set of policies and programs to address the special needs of this group. Some of the issues to be addressed include: mainstreaming vs. segregation, individualized programming, fiscal and legal implications, classification and assignments, physical plant and architectural designs, and older female offenders.
3. Conduct a study to determine the current and projected long-term care needs of the older inmate population. This study should be a cooperative effort between the DOC and a state university expressing an interest in conducting research in this area of corrections.
4. Increase the use of citizen volunteers to assist both staff and the elderly inmate population.
5. Design a training program for those staff working in facilities with a high number of elderly inmates to increase awareness of the special needs of the elderly inmate population. The program should be designed and taught by individuals with formal training in gerontology.
6. Staff training should also include instruction for transitional staff and Correctional Probation Officers on state laws dealing with the abuse, neglect, and exploitation of the elderly and recognizing these conditions.
7. Seek new funding resources to support research and programming related to the elderly inmate population.
8. The DOC should collect data on the existing medical costs of the current elderly inmate population.
9. The DOC should incorporate into its comprehensive correctional master plan the potential growth of the elderly inmate population and its associated needs.
10. The DOC should designate a sufficient number of current facilities to accommodate the elderly inmate population, at a suitable level of security, as "elder inmate institutions" and concentrate specially trained staff and appropriate resources at those facilities.
11. The DOC should designate an entire facility to health care for all seriously ill or infirm inmates. Special units should be reserved for elderly prisoners.

### **OUTCOME MEASURES**

The recommendation of remedies to resolve any matter is, at face value, a mere suggestion without evaluation. Remedies must be designed to meet a specific set of goals. In this case, the goals of these proposed remedies are to: 1) provide the best care possible for elderly inmates while 2) keeping DOC costs to a minimum. The basic premise behind an impact evaluation is to determine if, in fact, the intervention has affected the target population (Rossi, Freeman & Lipsey, 1999). An impact evaluation is designed to assess whether or not the specified remedies

are responsible for any changes or if extraneous factors are to credit. Evaluations should be designed to control for both reliability and validity.

Some outcome measures for an impact evaluation could include: rate of recidivism (measured by arrest, conviction, and incarceration) and cost savings to community (cost-benefit analysis considering community versus prison options, medical savings, and bedspace saved) (Hoelter et al., 1998).

In order to know if an intervention has had its desired effect on a specific population, one must know what the current status of the situation is. Maryland is in desperate need of an up-to-date, standardized information system. To date, it is very difficult to access information for analysis. The future may hold promise for such evaluations using data from the state. Until then, however, it may be necessary to extrapolate current trends by using data from other states such as Florida and Texas.

It is recommended that consideration be given to improving and upgrading the state's information system. In addition, it is advisable for the DOC to place a public request for proposals in order to select from a pool of candidates to evaluate Maryland's situation before and after the implementation of any interventions.

### **OBSTACLES TO OVERCOME IN IMPLEMENTATION AND EVALUATION**

The primary obstacles to the implementation and evaluation of proposed remedies are: capital (how to fund), operational (staffing and training required), political ("tough on crime" debates), legal (compliance with governing laws), and technological (good management information system to gather and track data well which Maryland currently does not have).

The best way to overcome these obstacles is to include all stakeholders in the planning process (Gottfredson, 1984). This will allow all to understand the views (for and against) the various proposals and facilitate discussion on how to overcome any obstacles. This also facilitates buy-in, which will be needed to effectively implement the program (Gottfredson, 1984; Welsh & Harris, 1999).

What to do with Maryland's aging inmates is an emotionally and politically charged subject regardless of which side is observed. This fact is especially true in light of society's current view of crime and punishment. Surprisingly, there are many more organizations that support better treatment for the aging in prison than object. However, victims and their families are the most vocal, and speak with the angriest voice of the rights and liberties that we should possess as citizens. Some police officers and politicians (especially in the area of alternative sanctions) have strong objections to "making it easier" on these aging inmates. Additionally, budget analysts need to be convinced that the selected program will be more cost-efficient while yielding the desired outcome.

The feelings of the victims and their families are easily understood. Some desire retribution and revenge for the loss or injury of loved ones. Some deeply fear potential retribution issued by those incarcerated if released. Because nothing gets passed without the support of elected policymakers, and understandably, they refuse to commit political suicide by making decisions without the support of constituents, the confidence and support of the victims and their families

must first be gained. The support of this group will not be easily attained. However, as mentioned earlier, confidence and support may be gained through the integration of their concerns and the demonstration of the absolute necessity and validity of the proposed program. Once the support of this influential group is gained, the support of the policymakers will likely follow. Law enforcement also needs to be convinced that its efforts are not purposeless, that offenders are being punished, and that the program provides for public safety.

As with any criminal justice sanction, the question "How will this be funded?" must be answered. As well, public concern over proposed sanctions and programs must be addressed. While providing healthcare is not negotiable, alternatives to spending may be. It is recommended that in order to address this obstacle, the Division of Corrections seek a method of tracking current healthcare expenditures. The State of Maryland's current system of record maintenance does not allow for such costs to be analyzed. Additionally, the introduction of programming for elderly inmates may help to either sustain or improve both the mental as well as physical health of inmates, therefore reducing medical costs.

The collaboration of all relevant stakeholders should be gained during the planning phase of the program (Welsh & Harris, 1999; Gottfredson, 1984). This will prevent many trips back to the drawing board because the majority of the obstacles will have already been encountered and negotiated. The planning phase is possibly the most critical phase of the program, for it is, potentially, the most volatile and emotionally charged of all phases. Finally, throughout the development of the project, current information must continue to flow to all relevant stakeholders, and cooperative decisions should be made in open forums whenever possible.

## **RELEVANCY FOR MARYLAND SENTENCING POLICY**

Maryland's elderly inmates, although currently few in number, present implications for future sentencing considerations. Mandatory minimum sentences, which force judges to confine an unprecedented number of nonviolent offenders, restrictions on parole, and the introduction of truth-in-sentencing laws have placed in prison those who may be more effectively punished or even rehabilitated in the community for less cost to the state. Some recommendations for the SCCSP include: 1) considering age as mitigating factor in sentencing, 2) developing joint sentencing commission/DOC subcommittee to explore sentencing effects and alternatives, and 3) considering community confinement and structured supervision for specific nonviolent offenders.

### **Age as Mitigating Factor**

Although federal court decisions often support the position that age is not ordinarily a relevant factor in sentencing, there are states that consider age in mitigation. One such state is Alaska, which defines explicitly the reason age warrants mitigation in sentencing. Alaska's definition takes into account if the conduct of an aged defendant was substantially a product of physical or mental infirmities resulting from the defendant's age (James, 1992). James (1992) also points out that a lengthy sentence for an elderly offender could result in a virtual "life" sentence, although the legislative intent was clearly not to impose such a penalty.

### **Joint Subcommittee to Explore Sentencing Effects and Alternatives**

Based on the present research, it is believed that the aging inmates in Maryland's prisons do not constitute an immediate operational problem. However, considering the increasing number and

disproportionate costs of elderly inmates, it is advisable to develop a joint Sentencing Commission/DOC subcommittee to monitor the effects of current and future sentencing rules upon the elderly prison population and explore alternative sentences for elderly offenders. The subcommittee's goal should be to develop a general plan with several viable courses of action for selection by decision-makers. Candidate selection is particularly important. While 51.4 percent of parolees and probationers returned to prison were between the ages of 18 and 29, only 1.4 percent were 55 or older (Hoelter et al., 1998). A proper risk assessment and selection of candidates for alternative sentencing would, in theory, deny those who are most likely to recidivate when released into the community.

### **Community Confinement and Structured Supervision**

The Coalition for Federal Sentencing Reform "propose[s] it is sound penal and social policy to provide structured supervised release for prisoners who: 1) are 55 years of age or older; 2) committed a nonviolent offense; 3) have served a substantial part of their sentence (one-third or more); and 4) are deemed to not present a significant risk to the community" (Hoelter et al., 1998, p. 3). The Coalition estimates if all elderly nonviolent prisoners over age 55 were reassigned to supervised release, it would save the nation's criminal justice system approximately \$900 million in the first year. These savings could be realized without sacrificing the goals of public safety or justice (Hoelter et al., 1998).

### **CONCLUSION**

Within the next 10 years, Maryland's elderly prisoner population (defined in Maryland as those over age 60) is expected to at least double, to a total of over 485 inmates, a figure which should still represent less than two percent of the entire projected prisoner population. Though statistically small, the increasing number of elderly prisoners will undoubtedly have a disproportionate impact on the Maryland DOC's health care budget, given the fact that nationally the elderly tend to require more medical care than do younger people. DOC and the SCCSP should continue to closely monitor the growth of the elderly prisoner population and its effect on prison spending. At this time, however, the level of services and care available for elderly prisoners seems sufficient.

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