Prisoners' Rights are Human Rights:
An Analysis of the Impact of Aging in Georgia's Prison Healthcare System

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Health

Introduction

The United States prison system is witnessing an increasing population of older adult inmates as the prison population continues to age. Looking first at the aging population of prisoners, it is important to note that the number of middle-aged or older prisoners continues to increase at a constant rate as a result of longer prison sentences, stricter release requirements, and increased convictions, especially on drug charges as a result of the War on Drugs.

The United States detention system is potentially the largest in the world, and it houses more than 2.3 million people in approximately 6,000 state and federal prisons, juvenile correctional facilities, local jails, military prisons, immigration detention facilities, and prisons in United States territories (American College of Obstetricians and Gynecologists, 2011). Among that total, approximately 66% are housed in the state and federal prisons (American College of Obstetricians and Gynecologists, 2011), and prisons are designed to house incarcerated people temporarily or for a short time while awaiting trial or serving a short sentence. Incarcerated individuals age 50 years and older constitute approximately 16% of the state and federal prison population, noting that this rate is increasing, given the aging of the population, longer sentences, or reduction of parole or early release because of more tough crime laws (American College of Obstetricians and Gynecologists, 2011). Older incarcerated individuals require a unique level of care than do younger incarcerated individuals, because of increased comorbidity burden and physical and cognitive disabilities (American College of Obstetricians and Gynecologists, 2011).

The classification of “older prisoners” has yet to receive an official age cut off in the social care field, however, it is usually defined as 55 years or older (Snyder, van Wormer, Chadha, & Jaggers, 2009). In 2009, the vast majority of older inmates were male, at 92 percent. The majority of older female inmates were serving first-time, long-term sentences for nonviolent crimes, most of which were drug- or property-related (Snyder et al., 2009). Over one-third of older female inmates test at an IQ level below 70, and most older inmates test at a sixth grade level (Snyder et al., 2009). Only about one-third of older inmates are married, which may contribute to feelings of loneliness and social isolation (Snyder et al., 2009).

Health Care for Older Adults in Prison

Aging in the incarceration system has continued to grow since the beginning of the War on Drugs and the three strikes and out rule. The aging in the incarceration system is becoming a major ethical and financial problem for the United States. From 1993 to 2013 there has been a 400% increase in people incarcerated from ages 30-36

years old (Psick, Ahalt, Brown, & Simon, 2017). On average, a person who is considered an older adult in prison costs $68,000 to keep them in prison compared to younger people which on average are $22,000 (Reese, 2019). Aging in prison starts at a much younger age than aging in the rest of the country. Older adults are considered to be 50 years old in prison with hearing, vision, and sight impairments that accompany a deterioration in physical and mental health (Amno et al., 2004). As of 2016, prisons in the United States housed 288,987 inmates who were over the age of fifty, resulting in a significant population of inmates with the potential need for medical treatment for the previously mentioned and other less common diseases (Stoliker & Galli, 2019). If this trend continues, an estimated one-third of the incarcerated population will be over the age of fifty by 2030 as prisoners currently incarcerated will likely still be in prison and arrests in the later stage of life will continue to increase as baby boomers and Generation X continue to age (Di Lorito, Völlm, & Dening, 2018). Typically, older adult inmates have more health concerns in the areas of chronic illness, nursing, diet, medication, and physical therapy than younger inmates (Snyder et al., 2009). Additionally, older adult offenders typically see the onset of serious health problems earlier than older adults in the general population (Snyder et al., 2009). Prisoners over fifty years of age are at higher risk for cardiovascular disease, dementia, hepatitis C, hypertension, osteoporosis, depression, schizophrenia, PTSD, and anxiety disorder when compared to their younger counterparts, regardless of pre-existing conditions (Franke et al., 2019).

Social Concerns

Older adults both in prison and in the general population report elevated feelings of loneliness, however some social and emotional issues experienced by inmates are a result of social isolation. Offenders report having fear of dying alone as well as exhibiting shame from dying alone as a prisoner (Snyder et al., 2009). Inmates find it difficult to maintain relationships with family and friends on the outside, which compounds feelings of social isolation. Inconvenient visiting hours, childcare concerns, and humiliating visiting procedures all inhibit visitation from loved ones (Snyder et al., 2009). Hospice social workers report facing difficulties when providing care to inmates as the harsh prison environment is not suitable for compassionate end-of-life care (Snyder et al., 2009). As the population of terminally ill inmates increases, correctional officers in the U.S. are now charged with the task of caring for ill inmates (Albanese, 2019).

However, at Louisiana State Penitentiary at Angola, there has been a successful prison hospice program that trains inmates as hospice volunteers to care for the dying individual in the absence of the social worker or family visits (Snyder et al., 2009).

Beyond feelings of isolation, terminally ill offenders often lack access to essential end of life resources, such as estate planning, hospice care, advance directives, and do-not-resuscitate documentation (Snyder et al., 2009).

Some of the disparities in health care can be linked to the ineligibility of incarcerated people for receiving Medicaid and Medicare coverage while in prison (Winkelman, Choi, & Davis, 2017). Incarcerated individuals are therefore left to depend on prison employees for health care services, causing limited access to routine medical exams and prescription medications necessary to ensure quality of life (Wilper et al., 2009). While incarcerated, prisoners have relatively little say in their own medical care when they are forced to forego private health insurance through an employer and become ineligible for Medicaid benefits through the marketplace (Department of Health and Human Services, 2020). Prisoners within the private prison system are required to pay medical copays to contribute to prison revenue and in theory help provide medical care. This money is taken from commissary accounts which are funded by prison job contributions and contributions from family members and are typically used for buying personal care products like toothpaste, deodorant, and feminine hygiene products. Medical copays can divert money from everyday needs and result in decreased quality of life for privately incarcerated individuals (Wilper et al., 2009)

Mental Health Care

The nexus of criminal justice and mental health represents a health-disparate group often stigmatized and therefore overlooked by policymakers and society as a whole. As the population of incarcerated individuals grows, the heterogeneity of prisoners in the system becomes more pronounced (Franke, Vogel, Eher, & Dudeck, 2019). Aging in prison, compounded with the stressors of prison life and the neglect of medical and health needs of prisoners leaves older prisoners vulnerable to developing a psychiatric disorder or exacerbating a pre-existing psychiatric condition.

With the already limited mental and medical health care services available for prisoners, the rate of morbidity associated with mental illness among prisoners continues to increase among the aging population of prisoners, especially compared to the general population (Di Lorito et al., 2018). Non-incarcerated adults of the same cohort are five to six times more likely to receive antidepressant treatment and have regular contact with a mental health specialist when necessary as compared to their incarcerated counterparts. The disparity between adults who receive psychoactive medication and treatment is even more pronounced, with an estimated 18% of prisoners with a mental illness who require these drugs actually receiving them through prison health care (Stoliker & Galli, 2019). Looking beyond life within the criminal justice

system, individuals who are released and suffer from a psychiatric condition have a 50-70% rate of recidivism within a year as a result of a lack of mental health services both in prison and in the community for parolees (Murphy et al., 2017).

Stigmatization within the prison system can contribute to victimization of individuals with a physical or intellectual disability, as these individuals may be seen as straying from the norms of masculinity, reputation, and violence observed within the microcosm of a prison (Pare & Logan, 2011). When compounded with the lack of medical care available for the disabled, inmates who demonstrate physical or mental infirmity are more likely to experience reduced quality of life within the prison system and when released compared to the rest of their cohort (Murphy et al., 2017). Because medical care within prisons is not covered under federal health insurance (Medicare or Medicaid), medical expenditures for prisons increase when the most basic level of mental health services and medical care are provided. The cost of more comprehensive care programs tend to discourage most prisons, especially privatized prisons, from providing the necessary treatment for inmates (Pro & Marzell, 2017).

Disability Care

Wheelchairs, prosthetic devices, and special shoes may be medically recommended for aging inmates with limited mobility or ambulatory impairments (Snyder et al., 2009). However, prison architecture is typically unsuitable for the accommodations an aging prison population needs. For example, doors are not wide enough to allow for wheelchairs, oftentimes handrails are absent, and infrastructure does not lend to fall prevention (Snyder et al., 2009). Among those incarcerated, older adults and individuals with a mental illness or physical disability continue to be systemically underserved due to lack of access to properly equipped healthcare professionals (Stoliker & Galli, 2019). While the number of prisoners with specific treatment needs continues to expand, the basic health services that were designed to help the general population of prisoners have stayed fairly consistent, failing to adapt to the changing health needs of the incarcerated (Franke et al., 2019). Older prisoners, those with a mental illness, and the physically disabled are disproportionately affected by adverse health outcomes while also lacking the specialized care needed to sustain their quality of life while incarcerated (Franke et al., 2019). As a result, the gap in care between prisoners with and without specific needs for medical care continues to widen, reducing the quality of life among the affected population of inmates and increasing the cost of healthcare as it comes into higher demand among prisoners.

Preventative Care

There are many concerns regarding the cost of care when discussing preventative healthcare for incarcerated individuals. The prison system is required by

federal law to provide quality care to people if they seek acute care, emergency action, dental care, and psychological care according to the Eighth Amendment (Manville, 2003). Ruled under the decision *Estelle v. Gamble*, a new federal law declared that all people in prisons have the right to access medical care without delay, and no one can stand between that person and their medical needs. Although prisons are required to provide care, they also require copays. The concept of using co-pays was made to deter unwarranted doctor visits; however, it comes out to be a person's entire monthly wage they make in prison (Sawyer, 2017). The typical wage per hour for a person in prison is from 0.00 cents an hour to 0.40 cents an hour but co-pays in prison are between 0.00 dollars to $7.50 (Sawyer, 2017). If a person in the United States had to pay the equivalent to the co-pay per wage people would have to spend hundreds and even a thousand dollars for a doctor's visit.

The co-pays that are difficult to get around prevent a lot of people from getting the care they need. Co-pays may push a much-needed doctor visit further into the future creating a need for care in an environment that isn't receptive to treating prisoners medical needs adequately (Sawyer, 2017). Additionally, if a co-pay delays the doctor's visit the illness could progress and increase the cost of the final treatment (Sawyer, 2017). While incarcerated, prisoners have relatively little say in their own medical care when they are forced to forego private health insurance through an employer and become ineligible for Medicaid benefits through the marketplace (Department of Health and Human Services, 2020).

Seeking Treatment For Acute Illnesses/Early Stages

Acute care that may seem inconsequential and not worth an entire month's pay could affect more people in the prisons including staff and lead to an even more expensive treatment. The rate of infection for tuberculosis, Hepatitis C, and HIV is massively higher in individuals in prisons (Macmadu & Rich, 2015; Crosby, Binswanger, Clark, & Taxman, 2012). The prevalence of HIV in prisons is four to five times higher than in the rest of the population (Macmadu & Rich, 2015). A person in prison has a 9 to 10 times higher chance of having Hepatitis C than the rest of the population (Macmadu & Rich, 2015). Tuberculosis is moderately rare in the general population affecting about 1%; prisons have a 20 to 25% chance of having people test positive for TB. Hepatitis and tuberculosis both have vaccination and treatment, yet people in prison are not getting access and infecting others. According to the Centers for Disease Control and Prevention, vaccines have been proven useful and less expensive than the alternatives which help the prison system and outside communities. Although the prison system can and ethically should provide vaccines, some facilities only offer the vaccine to people who have already been infected (Center for Disease Control, 2002). Acute and

preventive measures need to be ensured for the health of the prisoners and to lower overall spending of taxpayer dollars.

Chronic Disease

According to the CDC, chronic diseases are defined as diseases that last for one year(Center for Disease Control, 2019). These diseases require medical attention during the entire duration of that time. In general, chronic diseases cannot be prevented by vaccines and can be difficult to cure. Chronic diseases include illnesses such as heart disease, cancer, diabetes, and asthma (Shiel, 2018). Health behaviors can serve as a large contributor to chronic diseases. For example, poor diet and lack of exercise contributes to heart disease, strokes, and diabetes while the use of tobacco can contribute to chronic disease such as lung cancer.

Heart Disease

Cardiovascular disease, also known as heart disease, is currently the leading cause of death in the United States. Cardiovascular disease is related to blocked blood vessels that can lead to a heart attack. Symptoms for heart disease can include: chest pain, shortness of breath, pain in your legs, and pain in the neck/jaw (Mayo Clinic, 2018). High blood pressure and high cholesterol are both major contributors to heart disease. This relates to poor eating habits. For example, high levels of sodium are associated with high blood pressure. A healthy diet can reduce a person's chances of having heart disease, a stroke, and diabetes.

Cancer

Cancer is defined as the growth and spread of abnormal cells somewhere in the body (American Cancer Society, 2019). The most common types of cancer include: lung, breast, prostate, melanoma, and bladder cancer. The cause of cancer is yet to be determined but, many health behaviors are factors that contribute to a person's risk of cancer. Risk factors include behaviors such as use of tanning beds, excess body weight, and tobacco use. Approximately 90% of lung cancer cases are caused by smoking or second-hand smoke. Although lung cancer is common, skin cancer is the most common in the United States (Center for Disease Control, 2019). Cancer can lead to death if not properly treated. Although cancer has risks, it can be detected early through preventative measures such as screenings.

Chronic Diseases While Incarcerated

The population of incarcerated older adults is a key factor to consider when examining the prison system, as they experience higher rates of chronic illness and

disability than other inmates (CDCR, 2010). Recovery is often slower, and to care for these illnesses is to provide medical treatment for several years or even a lifetime (CDCR, 2013). Treatments for older inmate populations heavily rely on surgery, medicine, therapy, and several types of medical procedures (CDCR, 2013).

Chronic diseases are found often in prisons amongst the prison population. Although individuals are diagnosed with chronic diseases they aren't always properly taken care of. Inconsistent healthcare in prison can worsen chronic disease symptoms. Prisons tend to focus on infectious diseases in prisons because these diseases can spread quickly within the population. With a prison having a high volume of people, the medical staff in prisons sometimes have to prioritize infectious disease. Although infectious disease is important, chronic diseases require special attention that is currently not met in prisons. Psychiatric illnesses are also in the forefront of concern for medical staff in prisons (Firger, 2016). These are important because they can result in injury to others, self-injury or suicide. With the increase in aging in the prison population, more prisoners are being diagnosed with chronic diseases. Although prisoners with chronic diseases gain less attention than those with infectious diseases, they still receive medication and treatment. These individuals are given treatment but are very rarely taught things such as disease management and healthy eating habits. If given the opportunity for re-entry into society, these individuals do not have the knowledge or resources for self-care and disease management since it is rarely explained to these individuals.

Chronic diseases are common in prisons for many reasons. A common factor in chronic diseases in the prison system, is the lack of physical activity in people that are incarcerated. Due to limited time allotted for physical activity, limited resources, and a sedentary lifestyle prisoners' physical activity is limited. Living in a stressful and high-risk environment can impact a person's mental health. As a result, their level of physical activity can be compromised.

The aging prison population is of concern when chronic diseases are discussed. Not only are prisoners living longer in prison but, they are aging quicker. Accelerated aging has been found to be due to the lifestyle in prisons that contribute to environmental stressors. Also, the lack of healthcare attention before and during prison life contributes to accelerated aging. This means that the bodies of these individuals are usually 10-15 years older than their true age. As a result, aging and chronic diseases in the prison system affect the population in many ways. Through change in policy, chronic diseases can be tackled in the prison system. More emphasis on prevention and health education can both contribute to better outcomes related to chronic diseases.

Women's Healthcare

Older incarcerated women, with a mean age of 56 years old, have reported to have an average of four chronic medical conditions, and receive five daily medications for these chronic conditions (Centers for Disease Control and Prevention, 1999). These women have reported to have arthritis (61%), hypertension (53%), ulcers due to menopause (30%), ulcers and conditions due to digestion (29%), and heart disorders (26%). 66% of these women also reported to have hearing disabilities, while 84% reported to have vision impairments (Centers for Disease Control and Prevention, 1999). These older women reported to have demonstrated comorbidity, or the onset of multiple conditions, during their time of incarceration (Centers for Disease Control and Prevention, 1999).

In regards to women's health services, research discusses that gynecological services for incarcerated women have repeatedly been deemed inadequate (Fickensher, Lapidus, Silk-Walker, & Becker, 2001). Gynecological exams are not screened when these women are admitted to the correctional facility, and the exams are not routinely or annually provided to these women. When evaluating the process for these screenings, women have reported that gynecologic history is not considered or even asked by health providers. Some correctional facilities have also been reported to not have health providers trained in obstetrics and gynecology, leading to a lack of adequate gynecologic care (Fickensher, Lapidus, Silk-Walker, & Becker, 2001). Due to these conditions, women are likely to be at risk for chronic and potentially cormid conditions, such as breast cancer, ovarian cancer, endometriosis, chronic pain, issues with periods and menopause, abnormal pap smears, undetected diseases, and improper or poor diagnoses of such conditions. (Fickensher, Lapidus, Silk-Walker, & Becker, 2001).

It has been reported that 57% of women in federal and state correctional facilities have been sexually and physically abused. 79% of jailed women have been physically or sexually abused (Centers for Disease Control and Prevention, 1999). These sexual and physical abuse rates are increasing, and can indicate numerous correlating conditions that follow. FPr example, these increasing rates of sexual and physical abuse among the imprisoned women can often lead to lifelong psychological issues, such as depressive disorders, stress disorders, anxiety disorders, learning disabilities, and substance abuse (Fickensher, Lapidus, Silk-Walker, & Becker, 2001).

Incarcerated women who are subject to sexually transmitted infections (STI) have limited access towards preventative healthcare. Demonstrated by a Rhode Island incarceration facility study done, 33% of these women tested positive for an STI when they were admitted into the facility (American College of Obstetricians and Gynecologists, 2011). The Centers for Disease Control and Prevention reported that

27% of these newly incarcerated women have trichomoniasis, chlamydia, gonorrhea, and HIV (Centers for Disease Control and Prevention, 1999).

The National Commission on Correctional Health Care recognizes that the rate of women becoming incarcerated is increasing rapidly annually, so the commission has presented guidelines for women's health services (Maruschak, 2008). The commission recommends that incarceration facilities must require to fulfill recognized community standards for women's services (Maruschak, 2008). These correctional facilities and women's advocacy groups need to unify and collaborate to provide leadership to advocate for development of procedures and policies that address women's special health care needs in corrections (Maruschak, 2008).

Culture

Introduction

For most people in America's prisons today, the reasons for their incarceration may be more multifactorial and integrated into the social and cultural framework of America than it seems at first glance. The War on Drugs, policing practices, racial targeting, and policy reforms have led to a U.S. prison population larger than it has been at any point in history – a population that continues to grow at an unsustainable rate. This increase in incarcerated individuals since the 1980s has incurred expenditures that threaten to overrun the federal funding provided, leading to the increased federal subsidization of private, for-profit prisons run by third-party contractors. When examining the factors that affect prisoners while incarcerated, both in federal and private penitentiaries, the culture inside of prisons is an important factor in understanding the experience of prisoners. Violence, overcrowding, discrimination based on sexual identity, disability, and mental illness, and access to health care are major factors that affect individuals while they are incarcerated. Once they are able to reenter society, they are faced with opportunities for recidivism. As a convicted felon reentering society, these individuals must make a difficult transition back to a more normal life with the help of transitional care and community support programs, which will be discussed in detail throughout this section.

Prison Medical Spending Practices

The annual prison spending is $77 billion and $7.7 billion of that goes into healthcare for people incarcerated, accounting for 10% of total annual expenditures (Ahalt, Trestman, Rich, Greifinger, & Williams, 2013). In order to find a viable option for limiting federal prison expenditures, it is important to look at state-level models that have been successful in cutting costs in a way that does not worsen patient care. In

Maryland they decreased their spending in prisons over 185 million dollars in five years, and their incarceration rate has decreased by 29% (Reese, 2019; Zhang, 2019). This was achieved by reducing prison sentences and using drug treatment facilities as an alternative for nonviolent drug offenders (Reese, 2019; Zhang, 2019). The incarceration system pays for healthcare through tax payer dollars and with the cost of prisons increasing by 674% from 1983 to 2008, the system is becoming very expensive to keep running (McGarry, 2010). The increase in incarcerated individuals is related to minimum sentencing requirements and the War on Drugs, placing a huge financial burden on the government and by extension, the American taxpayers (The Sentencing Project, 2019). The system is becoming less sustainable, as the funding being put towards prisons and healthcare for inmates is struggling to keep up with the demand created by new inmates.

War on Drugs

The "War on Drugs," sometimes called the "Drug War", refers to a cultural campaign accompanied by strict policies regulating drug policy and sentencing that has shaped the American criminal justice system. The Drug War is a set of political and legal state practices that use or threaten physical force when enforcing strict drug laws. This physical force includes military-like policing and severe sentencing with the alleged interest of reducing drug use and disrupting the drug trade in the United States (Rosino & Hughey, 2018). In the 1980s, the Reagan administration rolled out a plan to crack-down on drug use in the United States which included a social norming campaign known as "Just Say No" and introduced large-scale policies that increased penalties for possession and distribution of illicit substances (Kerr & Jackson, 2016).

The Anti-Drug Abuse Act of 1986 created incentives for increased policing and prosecution of drug crimes and established new mandatory minimums for prison sentences categorized by drug type and quantity (Kerr & Jackson, 2016). This new legislation led to a wave of increased incarceration rates. From the initiation of the War on Drugs to its zenith, between the years 1980 and 1993, state incarceration rates increased by 148 percent, moving from approximately 130 to 322 per 100,000 people (Schoenfield, 2012). The United States prison population has grown by approximately 400 percent and the incarceration rate has increased nearly five-fold between 1980 and 2014 (Carson., 2014). In 2016, there were approximately 1.5 million people in the United States prison system, and the incarceration rate is the highest among all Organization for Economic Cooperation and Development countries (Kerr & Jackson, 2016).

Not surprisingly, drug offending was the primary contributor to this growth. At the height of the Drug War in 1990, 46 percent of inmates committed to New York state prisons were sentenced for a drug-related offense (Schoenfield, 2012). These strict

drug sentencing policies resulted in an increase from 19,000 inmates in 1980 to 186,000 in state prison for drug offenses in 1993 (Schoenfield, 2012). The Drug War was not an inexpensive endeavor, either. Between the years 1980 and 1984, the Federal Bureau of Investigation (FBI) saw anti-drug funding increase from $8 million to a staggering $95 million – a nearly 12-fold increase (Kerr & Jackson, 2016).

Racial targeting

Perhaps most controversially, residual policies from the War on Drugs disproportionately target racial and ethnic minorities. In the United States, drug prohibition laws have mirrored fears about some racial groups as threatening or dangerous (Rosino & Hughey, 2018). Understanding how the U.S. policing system perpetuates institutionalized racism is critical to analyzing the societal implications of the Drug War. Historically, law enforcement has been used to maintain and enforce institutional racism (Kerr & Jackson, 2016). The history of these policing practices goes as far back as slave patrols that monitored the behavior of the African American workforce and continue in modern history as well, such as police regulation of civil rights demonstrations and instances of police brutality (Kerr & Jackson, 2016). Inequitable policing and sentencing practices of resource-deprived and poor African Americans maintains an unofficial racial caste system that was reinforced during the Jim Crow Era (Kerr & Jackson, 2016).

Representations of African Americans as criminals in mass media link dark skin with criminality and normalize racialized criminal justice practices (Rosino & Hughey, 2018). These representations in the media lead racially-isolated white people to call for stricter drug enforcement and more punitive policies that are influenced by racial fear (Rosino & Hughey, 2018). “Get tough on crime” policies and other inequitable criminal justice policies continue the legacy of legally sanctioned oppression of African Americans in the United States (Kerr & Jackson, 2016). Racist policing practices are the modern form of social control, similar to chattel slavery and segregation (Rosino & Hughey, 2018). Research shows that whites and African Americans use and distribute illicit drugs are approximately the same rates, but the arrest rate for drug possession is up to three times higher for African Americans (Floyd et al., 2010). Whites are more likely to have tried cocaine and marijuana than blacks and equally likely to have used heroin, but African Americans are more likely to be arrested.

Drug policies targeting African Americans significantly contributed to the spike in prison admissions for African American drug offenders (Snyder, 2011). The “three-strikes” policies created during the Reagan administration crack down on drug policing and extended sentences for drug-related crimes (Kerr & Jackson, 2016). Every single defendant was a racial minority in over half of the federal courts that tried drug cases by 1992 (Floyd et al., 2010). This discrepancy is significantly attributable to drug

policy, as the national arrest rate increased 205% for African Americans, compared to 122% overall (Snyder, 2011). Despite similar participation rates in drug offenses to whites, drug policies have contributed to the over-policing of African Americans and poor neighborhoods (Kerr & Jackson, 2016). Between 1980 and 2009, arrest rates for drug possession and drug sale/manufacture was three and four times higher respectively for African Americans than for whites (Snyder, 2011). These staggering rates of incarceration of African Americans have several consequences politically and economically, as inmates are disenfranchised and their opportunities for acquiring income are severely limited. These high incarceration rates persist forty years later as these policies have continued, and in some aspects escalated during successive administrations (Kerr & Jackson, 2016).

Violence and overcrowding

Violence is a major issue inside of prison, but there is limited data and research on the cause and effect on incarcerated individuals. Overcrowding and lack of mental health resources contribute to the violence seen in the incarceration system, as a lack of resources and supervision can lead to unchecked violence. In April of 2019, a report was issued about an overcrowded prison in Alabama where rape and murder were highly prevalent among the inmates. This is a direct violation of the Eighth Amendment which stipulates that people in prison should be protected from cruel and unusual punishment (Benner & Dewan, 2019). With a population of 182% capacity, the prison was unable to control the situation and ensure the safety of their prisoners. Unfortunately, this is an indicator of a fairly common occurrence in many overcrowded and underfunded prisons around the U.S.

Discrimination and the LGBTQ Community in Prisons

In Georgia, the discrepancies between actual and advertised medical care were brought to light in the case of Ashley Diamond, a thirty-six-year-old transgender woman who was sentenced to serve in a men's facility and denied access to hormone treatments and other prescription medications while incarcerated (Andrews, 2017). She filed a lawsuit against the Georgia Department of Corrections claiming she was denied access to necessary medical care and placed in a dangerous environment where her gender identity placed her at risk of violence and sexual assault. Her case gained support from the Justice Department and she was able to settle with the Georgia Department of Corrections for sustained damages after being released from prison (Andrews, 2017). Ms. Diamond's experience is representative of the discrepancies between imposed federal standards and the actual treatment of incarcerated individuals, especially those of a sexual minority. When her legal right to medical care

was denied by prison healthcare workers, her rights as a prisoner were violated, as stipulated by *Estelle v. Gamble* (Pentsou, 2019).

Private Prisons

The United States has the fastest growing prison population in the world and the movement to privatize prisons has shifted responsibility for inmates to third party contractors who run prisons on a for-profit basis. As of 2017, approximately 8.2% of incarcerated individuals in the United States are being held in a private corrections facility, representing a 120% increase in private prison populations between 2000 and 2016; comparatively, federal prison populations only rose by 31% during the same period (Natterman & Rayne, 2017). Privatization of the prison system has been necessitated due to increased incarcerations, beginning in the War on Drugs era, that have over-crowded federal facilities that were already overwhelmed and understaffed. Prisoners who are transferred into private prisons are being used to create a profit for contractors who have little regard for their wellbeing and medical care.

Private and public prisons have been unable to provide comprehensive medical and mental health care for inmates (Bacak & Ridgeway, 2018). Even after the landmark Supreme Court case *Estelle v. Gamble* sought to establish medical rights for prisoners, the medical care in private correctional facilities often fails to meet inmate needs (Pentsou, 2019). Just forty years after *Estelle v. Gamble*, the court's decision fails to address the general quality of care in prisons because the ruling is too limited in scope for application to private prisons (ACLU, 2020). In 2012, *Parsons v. Ryan*, a class-action lawsuit leveraged against the Arizona Department of Corrections, alleged that the private prisons in the state not only failed to provide adequate medical care but also caused several deaths and preventable injuries (Rothschild, 2019).

Sentencing policy has played a role in the shift from public to privatized prisons, as the Trump administration and former Attorney General Jeff Sessions reversed Obama-era policy that was attempting to phase out private prisons and issued a directive to U.S. prosecutors to pursue serious charges and the toughest possible sentences (Gotsch & Basti, 2018). As a result, prison admissions have increased since 2017, with longer average sentences for the newly convicted than in years prior; this move will allow private facilities to extend their contracting abilities and gain more profit from the incarcerated (Gotsch & Basti, 2018). Furthermore, there is no evidence that lengthened sentences and inmate outcomes in private prisons as a result of incentivized policies have any effect on lowering rates of recidivism (Kerwin, 2015; Mukherjee, 2019).

Private prisons are also less likely to consider parole, either on a regular basis or in the case of medical parole because it cuts into prison profitability. Most private prisons have an occupancy clause or “lockup quota” within their contracts that require a certain number of inmates to be imprisoned at a time (Leacock, 2017). It is common to find a minimum occupancy clause within the contracts of most private prisons, as this ensures that privatized institutions will always have a steady stream of revenue regardless of whether they choose to adequately fund basic health services for their inmates (Leacock, 2017). Compounded with lengthened sentences and more stringent parole requirements, minimum occupancy requirements are just another way for privatized prisons to draw a profit while keeping prisoners living with substandard medical treatment (Zullo, 2017). The efforts to lower costs and gain a profit, in even the most well-intentioned private prisons, can leave blind-spots in health care administration, allowing marginalized prisoners and those in need of regular medical or mental health services to slip through the cracks of the system (Zullo, 2017). In the long run, using medical parole could help decrease the financial and capacity burden on public and private prisons alike. Changing the way that inmates receive medical care would require policy changes, but reinstating Medicaid eligibility for individuals on parole would help decrease the financial responsibilities for private prisons who are already ill-equipped to properly treat incarcerated persons (Wilper et al., 2009). As prison populations continue to rise and the cost of medical care for the inmate population increases, the need for alternative solutions to private prisons becomes an more imminently pressing policy issue surrounding the flawed and corrupt criminal justice system in America.

Re-entry into Society

Re-entry into society after incarceration can be a difficult transition for ex-inmates especially for older adults. Factors such as poor health, limited ability to work, no access to governmental assistance all contribute to the difficulties of re-entry (Maschi & Kaye, 2020). Pre- and post-management, including interventions before and after release from prison, has been shown to help with reentry into society. Community resources also play a huge role in the smooth transition when these adults re-enter society. Transitional care programs, support reintegration programs, and pre-release programs are resources currently available for former prisoners. A transitional care program is very helpful with ill inmates and can include planning with the soon-to-be parolee, the family of the patient, and the providers that will be taking care of them upon reentry into society. Transitional care is a resource already available in the community and is essential for people that have been incarcerated upon their return to a community by connecting ex-offenders to counseling, housing, legal aid, and resources for

reapplying for insurance (Li, 2018). This serves as a body of support for the person and can be useful for connections to resources.

Unsuccessful reentry into society can impact communities negatively. Due to lack of housing and services, re-entry can lead to re-incarceration and further harm to the community by means of crime or vandalism. Community resources such as transitional housing, mental health services, and job opportunities all contribute to the success rate of re-entry into the community. Local and national governments must make policy changes to improve the efforts and effectiveness of these programs (Bayview Senior Services, 2019).

Recidivism

Recidivism is a major issue for people who are leaving prison all across the country. In Georgia, two out of three people who are released from prison are likely to be rearrested within three years without intervention (Stop Recidivism, 2019). People with a GED had a 20% less chance of returning to prison, and people with a college diploma had 44% less chance of returning. Education status can impact the quality of life for prisoners and parolees alike. 41% of people in the incarceration system do not have a high school diploma whereas 90% of the non-incarcerated population now holds a GED and 33% have a bachelor's degree or higher (U.S. Census Bureau, 2018). Having better education programs in prisons would increase self confidence and motivation and could lead to a decrease in the recidivism rate (Bender, 2018). Improving the quality of inmate education seems to be an effective method for lowering tax dollar expenditures and keeping the recidivism rate low. When people are engaged in education programs they have a 43% lower chance of not returning to prison, and each dollar spent on these education programs can save taxpayers approximately five dollars (Department of Justice). In addition to educational programs, cognitive therapies and GED programs have been shown to reduce recidivism rates by giving those at risk useful job skills or degrees to use when they are paroled rather than reoffending (Department of Justice). The $74 billion that currently goes into the prison system annually can be utilized to provide benefits for people and helping parolees reenter society with marketable skills rather than feed the circle of incarcerating people if they are rearrested.

Medical Parole and Compassionate Release

Medical parole and compassionate release programs are two options that allow the criminal justice system to account for aging prison populations. Compassionate release programs allow inmates to die in a home care setting or community health facility (Snyder et al., 2009). Medical parole is a policy that intends to benefit prisoners

with chronic health conditions by releasing them to parole before the expected parole date, and compassionate release is parole associated with hospice care (Pro & Marzell, 2017). Unlike compassionate release, medical parole does not imply a terminal prognosis. As of 2013, approximately twenty-four inmates across the United States were granted compassionate release (Albanese, 2019). These low numbers are due to the long wait times for applications to be processed and minimal action taken by most states (Albanese, 2019). Medical parole is granted by a parole board under the criteria of "severity of the disease, capacity of the prison medical system to treat the disease, and the cost implications of continued incarceration" (Pro & Marzell, 2017).

Under the community healthcare model, parolees transitioning out of prison under medical parole would become eligible for Medicare or Medicaid services again if they qualify for those programs, reducing costs for prisons and ensuring a more continuous and comprehensive level of care (Franke et al., 2019). It is important to note that the Affordable Care Act has expanded Medicaid eligibility, allowing more medical parolees to find coverage more consistently than in years prior. Relying on medical parole for older inmates with mental illness or a physical disability has the potential to reduce the burden placed on prisons, save taxpayer dollars that are being spent on inadequate care systems within prisons, and diminish recidivism rates among prisoners released later in their sentence on non-medical parole (Di Lorito et al., 2018).

Policy reform

There have been a number of policy reforms designed to lessen the Drug War's harsh sentencing mandates. These reforms grant judges increased discretion when sentencing first-time and addicted drug offenders. Reforms may include sentencing options other than prison, like treatment facilities. Additionally, some states will allow the resentencing of currently incarcerated people who are serving sentences under old laws (Schoenfield, 2012). In 2010, President Barack Obama signed the Fair Sentencing Act into law, which was aimed at reducing the sentencing disparity between crack and powder cocaine from a ratio of 100:1 to 18:1. This law did not completely eliminate that disparity, however, as it still exists today (Schoenfield, 2012).

Prison reform allows policymakers to respond to the opportunities and challenges presented by these aging inmate populations. When released, the vast majority of aging inmates in the United States qualify for federal coverage under Medicare and Medicaid (Chiu, 2010). This demonstrates that states may reduce federal healthcare costs associated with incarcerated individuals by allowing older adults to complete their sentence under community supervision rather than in prison (Chiu, 2010).

Due to the size of aging incarcerated populations and their need for medical care for chronic conditions, it is important that lawmakers invest in reforms that minimize

end-of-life prison costs and improve medical care (Chiu, 2010). Primarily, incarceration institutions should reconsider policies that affect aging inmate populations, both related to health practices and non-health practices (Chiu, 2010). Existing prison staff must be retrained to identify and respond to the individual's diagnoses and new staff should receive comprehensive training in order to start reforming the way prisons are run.

The budget should be monitored to support the conversion of prisons into institutions more capable of providing adequate primary care (Farrington, 1986). Prison officers can help by identifying methods to support incarcerated individuals that lower overall medical costs, such as by changing the handles in showers to reduce the risk of falls or installing wheel-chair accessible ramps for disabled inmates. Housing can prioritize access to dining halls, exercise institutions, and hospitalization to overall improve health services (Farrington, 1986).

Conclusion

When examining the American prison system, the disparities in care that occur in the name of reducing expenditures of taxpayer dollars have noticeably lowered the quality of life for the incarcerated. The culture of the American justice system facilitates the increased prevalence of incarcerations, as policies enacted during the War on Drugs made it easier for law enforcement to arrest people and for courts to sentence people more harshly than ever before for minor offenses. Within prisons, individuals face discrimination for mental and physical disabilities and older inmates with pre-existing conditions may struggle to get the medical care they need to manage chronic diseases. Once released on parole, ex-inmates must make the transition back to society, relying on the availability of community resources and familial support to reenter society. For people released from prison without access to adequate resources, recidivism is a likely option. Pre-release and reentry programs have been proven to be successful in reducing recidivism and helping the recently incarcerated develop and use skills to get a job. Making changes to the way prisons are run will likely start with policy changes in state and federal penitentiaries that ensure prisoners' rights to medical care despite the challenges of the prison health care system.

What is Needed

Population of Interest

The target population in this case includes incarcerated persons in Georgia over the age of 55, many of whom have chronic illnesses. As the aging population in prison

increases, there is additional strain on prison infrastructure and medical resources. Additionally, there is a lack of resources available for ex-offenders matriculating into society. In this we will address needs of persons both in the prison system and people who have recently reentered civilian life. The challenge of improving health care for incarcerated individuals lies in balancing the provision of adequate care with expenditures of taxpayer dollars.

Primary and Secondary Prevention

Vaccinations

Infectious disease prevention is critical to maintaining the health of older persons. Older adults are more likely to have weakened immune systems, making acute diseases such as the flu potentially deadly. Vaccinations are essential to establishing herd immunity within a prison to protect inmate health, especially that of older adults.

Primary Care and Screenings

Improving the quality of primary care available to incarcerated individuals could help reduce the prevalence of preventable or modifiable risk factors that lead to infirmity and chronic disease in older inmates. Use of screening for older inmates would help identify current health issues and help their primary care providers treat them more effectively while in prison. Expenditures towards primary care would be instrumental in reducing the cost of tertiary care in older inmates and ultimately help reduce total medical expenditures for prisons.

Policy Reform

As previously discussed in this paper, Reagan-era drug policies have significantly contributed to skyrocketing rates of aging inmates. While unlikely to solve current problems associated with aging in prison, reforming policing and sentencing policies will prevent overcrowding and poor quality of care in prison for future generations.

Prison Resources

Visitation

Older adult inmates often report feelings of loneliness and social isolation, which may exacerbate poor health conditions and lower quality of life. Inconvenient visiting

hours that often occur during regular business hours and invasive visiting procedures may deter family and friends on the outside from seeing the inmate. Offering a wider range of visiting hours and eliminating frisking procedures for visitors may improve relationships between inmates and loved ones thereby decreasing feelings of social isolation.

Culturally Sensitive Care

It is necessary for prison staff to be trained on how to serve inmates with a wide range of cultural sensitivities, such as language barriers and LGBTQ identities. Culturally-sensitive social and health care is imperative to ensuring inmates' safety and promoting physical and mental health.

Medicaid Expansion

Recent Medicaid expansions may assist older parolees gain access to medical and mental health services after leaving prison, but it is unclear whether these expansions will actually reduce the rate of recidivism without accompanying extension of services who are already incarcerated (Domino et al., 2019). Currently, inmates do not have access to public or private insurance, and required co-pays are cost-prohibitive. Expanding government insurance programs to cover incarcerated persons and reducing co-pays are necessary for improving access to medical care.

Disability Accommodations

Prisons are rarely structured to accommodate inmates who are older or have physical disabilities, as evidenced by the narrow doorways, lack of grab bars in bathrooms or showers, and inconsistency of ramps that would accommodate wheelchairs. Current prison infrastructure limits the mobility of older adults and makes it more difficult for them to retain normal day-to-day functioning.

Mental health care

Inmates often suffer from mental illnesses that require psychiatric care. Prisons often enforce strict punishments, such as isolation, for inmates exhibiting symptoms of mental illness. Comprehensive mental health education for both inmates and prison administration is necessary for making sure these conditions are acknowledged and properly handled.

Inmate and Parolee enfranchisement

An often-overlooked aspect of inmate health and social justice is inmate and parolee enfranchisement. Voting allows inmates to have a voice in the political system, which is instrumental for establishing criminal justice reform policies.

Continuity of Care

Continuity of care is lacking for both the incarcerated and the paroled, as medical and mental health services are expensive to provide and the stigma against prisoners drives a reluctance to spend taxpayer dollars on those who have been convicted for breaking the law. As a result, the services provided for prisoners and parolees alike are lacking and inadequate to treat the issue. When likened to comparable care provided for non-incarcerated individuals, this gap in care becomes more evident (Franke et al., 2019). When inmates are paroled, they are in a similarly difficult situation, as they no longer have the health insurance coverage they may have had when entering prison. In addition to the other challenges ex-inmates face when re-entering society, finding health insurance from either a private provider or through federal insurance may place additional stress on previously incarcerated individuals. The struggle to find a job due to felon status contributes to gaps in healthcare, as ex-convicts may struggle to find employment opportunities that offer good benefits.

Reentry Into Society

Compassionate Release (hospice/nursing home)

Creating new nursing homes for incarcerated persons in need of medical attention may be needed to accommodate the aging prison population (Psick et al., 2017). These facilities would be closely monitored to prevent inmates from being able to escape or cause harm to the public while operating outside of prisons to reduce expenditures. The current system of compassionate release is not effective and rarely used because the process is slow and few cases are actually considered. This is due in part to social stigma surrounding incarceration; people are generally unwilling to support a service that releases an incarcerated individual from prison.

Medical Parole

In California, when people who have committed some of the highester crimes are released at age 50, the recidivism of these adults is less than 5% (Psick et al., 2017). Releasing people early from prison, specifically older adults, is difficult because of a lack of support from communities and policies (Psick et al., 2017). There are adequate ways for people in the prison system to be released, but there needs to be additional policies made for their benefit. As the number of people aging in the incarceration system increases there will be an increase in the amount of money spent on the prison system when the money could be spent on preventing people from going to prison at all.

Medical parole is granted by a parole board under the criteria of “severity of the disease, capacity of the prison medical system to treat the disease, and the cost implications of continued incarceration” (Pro & Marzell, 2017). Hospitalizations, caregiving, nursing home visits, and other medical procedures are required to be provided to ensure adequate healthcare for incarcerated older adults and facilitating these services under the blanket of medical parole could help reduce prison expenditures. (CDCR, 2013).

Community Resources

The resources available to ex-inmates upon leaving prison vary by location, but generally speaking medical care, legal aid, transitional housing, addiction support services are available through a variety of community organizations. Education programs can help the previously incarcerated to receive a GED, apply for jobs, obtain professional clothing, and prepare to reenter the workforce following their release from prison.

Reducing Recidivism

Ex-inmates often encounter difficulties adjusting to life outside of prison that may ultimately lead to them returning to the prison system. Programs need to be established to reduce recidivism and facilitate smooth reentry. These programs may include educational programs that allow inmates to obtain a GED or other trade certification, information on how to land a job, create a budget, and navigate life on the outside. There needs to be external community support programs for released persons to help them adjust to civilian life and provide resources. Transitional housing is one such program that would facilitate an individual in establishing a new life outside prison.

Available Resources:

Center for Prisoner Health and Human Rights

The Center for Prisoner Health and Human Rights was established in 2005 in Rhode Island to serve as a hub of correctional health research and programming. The Center is connected to the Miriam Hospital and other research hospitals in Rhode Island and around the country and serves to improve the health and human rights of justice-involved populations through education, advocacy, and research. The Center strives to improve prisoner health by focusing on three core areas, which are 1) raising awareness at the national and state levels about the healthcare challenges of incarcerated and other justice-involved populations; 2) providing education and training opportunities for college, graduate, and medical students, and encouraging student engagement and leadership in justice issues; and 3) collaborating with local justice

system stakeholders to identify and support projects that respond to the intersection of incarceration recidivism and public health in Rhode Island.

Incarceration and Public Health Advocacy Network
The Center is creating a series of ten lectures that focus on the topic of Incarceration and Health for use by public health colleges across the country. This lecture series features experts in the field from around the country. Several medical schools have also expressed interest in the lecture series and the series has been adapted for national law schools as well.

Medicaid Enrollment and Incarcerated Populations
The Center ran a program from May 2015 to October 2016 in partnership with the Rhode Island Department of Corrections in which the staff enrolled over 400 individuals awaiting trial into Rhode Island's Medicaid program. The staff also provided service referrals in the community.

Resources by State
The Center provides a list of resources on accessing prisoner legal services in each state. These links still put the burden of research on the person seeking services, but the collection of links may be helpful.

ACLU National Prison Project

The National Prison Project is a program by the American Civil Liberties Union that is committed to ensuring that the nation's prisons, jails, and detention centers are compliant with the Constitution, domestic law, and international human rights principles. The Project is dedicated to ending policies that have contributed to the United States having the highest incarceration rate in the world. The Prison Project uses the legal tools of litigation, advocacy, and public education to promote prison health and the humane treatment of incarcerated persons.

Protecting Health and Safety in Prisons
Much of the National Prison Project's litigation includes claims of deficient medical and/or mental health care. The National Prison Project uses legal tools to advocate for prisoner's access to proper medical, dental, and mental health care while in prison. The project also seeks to link public health efforts to prison health reform to improve health outcomes of inmates. The National Prison Project works to reduce mortality and morbidity associated with time in prison and assesses how improved health can lead to better criminal justice outcomes.

Protecting Human Dignity in Prisons

Another goal of the National Prison Project is to ensure that inmates are treated with respect and able to maintain a sense of human dignity. Through litigation, public education, and other advocacy, the project strives to protect the human dignity and constitutional rights of people in prisons and jails in the United States. This includes ending rape and assaults in prisons and protecting prisoners with mental illness and other disabilities.

Southern Center for Human Rights

Access to Healthcare in Prison

The Southern Center for Human Rights (SCHR) brings class action lawsuits to fight for standard health care in prisons. The SCHR acknowledges that prison healthcare is often substandard and poses public health challenges to inmates and newly released persons. The SCHR has filed several class action lawsuits on behalf of prisoner health.

Mental Health

Inmates with mental illnesses are often misunderstood and mistreated by prison administration, leading to them being sent to lockdown for failing to obey prison rules. When individuals who suffer mental afflictions like hallucinations and delusions are sent to solitary lockdown, their symptoms often get worse. The SCHR files lawsuits on behalf of people who have been mistreated by the prison system on account of their mental illness.

Technical College System of Georgia

The Technical College System of Georgia is teaching inmates to weld to reduce recidivism. This program is designed to help fill Georgia's career force with welders and provide inmates a means of earning an income to better acclimate to civilian life. The program has been proven to lower recidivism rates for people who took part in the program versus those who did use the resource in Georgia in 2015. The program allows people who are incarcerated to gain technical experience to help them be successful after release.

The Senior Ex-Offender Program

The Senior Ex-Offender Program is the first program in the United States focused on senior ex-offenders. This program specifically focuses on ex-offenders 50 years of age and older. Their services are pre- and post- release from prison and include counseling,

mental health services, clothing, etc. This program also offers case management to ensure their clients receive quality health care as well as partnership with the local sheriff department to help connect ex-offenders with other community resources. With the goal to help ex-offenders re-engage in their communities, housing is a major priority within this program. Two transitional homes are offered to ex-offenders that are participants in this program.

Georgia Calls

Georgia Calls is a non-profit re-entry program specific to the state of Georgia, based in Buford, GA. This program focuses on assisting ex-offenders with smooth transition into society, job training and job skills development (Dubin, 2015). This is very important since finding a job and being capable of having a job are both real concerns for ex-offenders. This program includes paid work experience in the Georgia Calls in-house call center and teaches the skills needed to seek other job opportunities while providing work experience. This program also offers resources such as a recruiting fair for job opportunities.

The Last Mile

The Last Mile is a program that teaches people in prison about technology, digital communication and business (Wells, 2017). From learning how to code and technological skills people who were in the program earned jobs outside of prison (Wells, 2017). They offer diverse learning opportunities like java and vocational studies. The program lasts6 months with eight hour days. They currently serve in four states, but Georgia is not included in this. However, this could be truly beneficial for people who need to gain additional education experiences once they leave prison.

The Prison Entrepreneurship Program

The Prison Entrepreneurship Program pairs people who have been released with an executive in the workplace who can help people gain additional skills and leadership qualities (The Prison Entrepreneurship Program, 2020). For participants of the program, it was reported that the recidivism rate for the graduates of this program is 7% (The Prison Entrepreneurship Program, 2020).

Marshall Project

This is a non-profit organization that focuses on criminal justice and the news surrounding it (Reese, 2019). The resource is primarily used for journalism and

information about the incarceration system in the US. Their goal is to educate people on the justice system.

References:

ACLU. (2020). Medical and mental healthcare. Retrieved from https://www.aclu.org/issues/prisoners-rights/medical-and-mental-health-care

Ahalt, C., Trestman, R. L., Rich, J. D., Greifinger, R. B., & Williams, B. A. (2013). Paying the Price: The Pressing Need for Quality, Cost, and Outcomes Data to Improve Correctional Health Care for Older Prisoners. *Journal of the American Geriatrics Society, 61*(11), 2013-2019. Retrieved from http://proxy-remote.galib.uga.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=gnh&AN=EP91929576&site=eds-live

Ahalt C, Trestman RL, Rich JD, Greifinger RB, Williams BA. Paying the price: the pressing need for quality, cost, and outcomes data to improve correctional health care for older prisoners. Journal of the American Geriatrics Society. 2013;61(11).

Albanese, T. (2019). The adoption and implementation of compassionate release for terminally ill and elderly inmates: Comparing the United States' and China's guidelines for medical parole petitions. *Suffolk Transnational Law Review, 42*(1), 169-200. Retrieved from http://proxy-remote.galib.uga.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=lgs&AN=139507693&site=eds-live

American Cancer Society. (2019). Cancer Facts and Figures 2019. Retrieved from https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2019/cancer-facts-and-figures-2019.pdf

American College of Obstetricians and Gynecologists. (2011). Health care for pregnant and postpartum incarcerated women and adolescent females. Committee Opinion No. 511. Obstetrics and Gynecology, 118, 1198-1202.

Andrews, J. (2017). The current state of public and private prision healthcare. *The Wharton School Public Policy Initiative*. Retrieved from https://publicpolicy.wharton.upenn.edu/live/news/1736-the-current-state-of-public-and-private-prison/for-students/blog/news.php

Bacak, V., & Ridgeway, G. (2018). Availability of Health-Related Programs in Private and Public Prisons. In (Vol. 24, pp. 62-70).

Bayview Senior Services. (2019). Senior Ex-Offender Program. Retrieved from https://bhpmss.org/senior-ex-offender-program/

Bender, K. Education Opportunities in Prison are Key to Reducing Crime. 2018. Center for American Progress. Retrieved from https://www.americanprogress.org/issues/education-k-12/news/2018/03/02/447321/education-opportunities-prison-key-reducing-crime/

Brenner, K., & Dewan, S. Alabama's Gruesome Prisons: Report Finds Rape and Murder at All Hours. 2019. *New York Times.* Retrieved From https://www.nytimes.com/2019/04/03/us/alabama-prisons-doj-investigation.html

Bretschneider W, Elger BS. Expert perspectives on Western European prison health services: do ageing prisoners receive equivalent care? Journal of Bioethical Inquiry. 2014;11(3):319–332.

Carson., E. A. (2014). Prisoners in 2014. *US Department of Justice, Bureau of Justice Statistics*.

Centers for Disease Control and Prevention. *(2019).* Cancers. Retrieved from www.cdc.gov/chronicdisease/resources/publications/factsheets/cancer.htm.

Center for Disease Control. (2002). Hepatitis B Vaccination of Inmates in Correctional Facilities ---Texas, 2000--2002. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5330a3.htm

Centers for Disease Control and Prevention. (1999). High prevalence of chlamydial and gonococcal infection in women entering jails and juvenile detention centers—Chicago, Birmingham, and San Francisco, 1998. Morbidity and Mortality Weekly Report, 48, 793–796.

Centre for Justice and Reconciliation. 10 Keys to Improving Condition in Overcrowded Prisons.Retrieved from http://restorativejustice.org/am-site/media/overcrowding-en.pdf

CDCR. Inmates Sentenced Under the Three Strikes Law and a Small Number of Inmates Receiving Specialty Health Care Represent Significant Costs. California Department of Corrections and Rehabilitation; Sacramento, CA: 2010.

CDCR. Lifer Parolee Recidivism Report. California Department of Corrections and Rehabilitation; Sacramento, CA: 2013.

Chiu T. It's about time: aging prisoners, increasing costs, and geriatric release. VERA Institute of Justice; 2010. Farrington DP. Age and crime. Crime and Justice. 1986;7:189–250.

Cropsey, K. L., Binswanger, I. A., Brendan Clark, C., & Taxman, F. S. (2012). *The Unmet Medical Needs of Correctional Populations in the United States*, United States

Department of Health and Human Services. (2020). Health coverage for incarcerated people. Retrieved from https://www.healthcare.gov/incarcerated-people/#

Department of Justice. Prison Reform: Reducing Recidivism by Strengthening the Federal Bureau of Prisons. (2017). Retrieved from https://www.justice.gov/archives/prison-

Di Lorito, C., Völlm, B., & Dening, T. (2018). Psychiatric disorders among older prisoners: a systematic review and comparison study against older people in the community. *Aging & Mental Health, 22*(1), 1-10. doi:10.1080/13607863.2017.1286453

Domino, M. E., Gertner, A., Grabert, B., Cuddeback, G. S., Childers, T., & Morrissey, J. P. (2019). Do timely mental health services reduce re-incarceration among prison releasees with severe mental illness? *Health Services Research, 54*(3), 592-602. doi:10.1111/1475-6773.13128

Dubin, Steve. (2015). Georgia CALLS Reentry Program Welcomes 8 New Participants. Retrieved from https://patch.com/georgia/buford/georgia-calls-reentry-program-welcomes-8-new-participants-0

Fickensher, A., Lapidus, J., Silk-Walker, P., & Becker, T. (2001). Women behind bars: Health needs of inmates in a county jail. Public Health Reports, 116, 191-196.

Firger, Jessica. (2016). Doing Double Time: Chronic Diseases a Chronic Problem in Prisons. Retrieved from

https://www.newsweek.com/double-time-chronic-diseases-chronic-problem-490009.

Floyd, L. J., Alexandre, P. K., Hedden, S. L., Lawson, A. L., Latimer, W. W., & Giles Iii, N. (2010). Adolescent drug dealing and race/ethnicity: A population-based study of the differential impact of substance use on involvement in drug trade. *American Journal of Drug & Alcohol Abuse, 36*(2), 87-91. Retrieved from http://proxy-remote.galib.uga.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=s3h&AN=48767524&site=eds-live

Franke, I., Vogel, T., Eher, R., & Dudeck, M. (2019). Prison mental healthcare: recent developments and future challenges. In (Vol. 32, pp. 342-347).

Gavin, N. I., Gaynes, B. N., Lohr, K. N., Meltzer-Brody, S., Gartlehner, G., & Swinson, T. (2005). Perinatal depression: A systematic review of prevalence and incidence. Obstetrics and Gynecology, 106, 1071-1083.

Gotsch, K., & Basti, V. (2018). Capitalizing on mass incarceration: U.S. growth in private prisons. *The Sentencing Project,*. Retrieved from https://www.sentencingproject.org/publications/capitalizing-on-mass-incarceration-u-s-growth-in-private-prisons/

Help For Felons.(2019). Reentry Programs For Ex-Offenders By State. Retrived from https://helpforfelons.org/reentry-programs-ex-offenders-state/

Kerr, J., & Jackson, T. (2016). Stigma, sexual risks, and the war on drugs: Examining drug policy and HIV/AIDS inequities among African Americans using the Drug War HIV/AIDS Inequities Model. *International Journal of Drug Policy, 37*, 31-41. doi:10.1016/j.drugpo.2016.07.007

Kerwin, P. (2015). Study finds private prisons keep inmates longer, without reducing future crime. Retrieved from https://news.wisc.edu/study-finds-private-prisons-keep-inmates-longer-without-reducing-future-crime/

Leacock, S. (2017). Private prison contracts and minimum occupancy clauses. *American University Business Law Review*. Retrieved from http://www.aublr.org/2017/11/private-prison-contracts-minimum-occupancy-clauses/

Li, Melissa. (2018). From prisons to communities: Confronting re-entry challenges and social inequality. *American Psychological Association*. Retrieved from https://www.apa.org/pi/ses/resources/indicator/2018/03/prisons-to-communities

Macmadu , A., & Rich, J. D. (2015). Correctional Health Is Community Health. Retrieved from https://issues.org/correctional-health-is-community-health/

Manville, D. E. (2003). Federal Legal Standards for Prison Medical Care. Retrieved from https://www.prisonlegalnews.org/news/2003/may/15/federal-legal-standards-for-prisonmedical-care/

Maruschak, L., Berzofsky, M., & Unangst, J. (2015). Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-2012. In *Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-2012*.

Maruschak, L. M. (2008). Medical problems of prisoners (NCJ 221740). Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Maschi, T., Kaye, A., (2020). Incarcerated Older Adults. Retrieved from https://www.giaging.org/issues/incarcerated-older-adults/

Mayo Clinic. (2018). Heart disease. Retrieved from https://www.mayoclinic.org/diseases-conditions/heart-disease/symptoms-causes/syc-20353118

Mukherjee, A. (2019). Impacts of private prison contracting on inmate time served and recidivism.

Murphy, G. H., Chiu, P., Triantafyllopoulou, P., Barnoux, M., Blake, E., Cooke, J., . . . Beecham, J. K. (2017). Offenders with intellectual disabilities in prison: what happens when they leave? *Journal of Intellectual Disability Research, 61*(10), 957-968. doi:10.1111/jir.12374

Natterman, J., & Rayne, P. (2017). The prisoner in a private healthcare setting: What providers need to know. *Journal of Health Care Law & Policy, 19*(1), 119-147. Retrieved from http://proxy-remote.ghalib.uga.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=lft&AN=121411676&site=eds-live

Pare, P.-P., & Logan, M. W. (2011). Risks of Minor and Serious Violent Victimization in Prison: The Impact of Inmates' Mental Disorders, Physical Disabilities, and Physical Size. In (Vol. 1, pp. 106-123). Pro, G., & Marzell, M. (2017). Medical parole and aging prisoners: a qualitative study. *Journal of Correctional Health Care, 23*(2), 162-172. Retrieved from http://proxy-remote.galib.uga.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=lhh&AN=20173246650&site=eds-live

Pentsou, A. (2019). Assertion of qualified immunity by private state actors after Filarsky: An application to the employees of prison health care contractors. *Southern Illinois University Law Journal, 43*(2), 361-401. Retrieved from http://proxy-remote.galib.uga.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=lft&AN=136723845&site=eds-live

Pro, G., & Marzell, M. (2017). Medical parole and aging prisoners: A qualitative study. In (Vol. 23, pp. 162-172).

Psick, Z., Ahalt., C., Brown., R., & Simon J. (2017). Policy Boomers: Policy Implications of Aging Prison Population. *Int J Prison Health, 13(1): 57-63.* doi: 10.1108/IJPH-09-2016-0053

Reese, H. (2019). What Should We Do about Our Aging Prison Population? Retrieved from https://daily.jstor.org/what-should-we-do-about-our-aging-prison-population/

Rosino, M. L., & Hughey, M. W. (2018). The War on Drugs, racial meanings, and structural racism: A holistic and reproductive approach. *The American Journal of Economics and Sociology*(3-4), 849. doi:10.1111/ajes.l2228

Rothschild, M. (2019). Cruel and unusual prison healthcare: A look at the Arizona class action litigation of Parsons v. Ryan and systemic deficiencies of private health services in prison. *Arizona Law Review, 61*(4), 945-981. Retrieved from http://proxy-remote.galib.uga.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=lgs&AN=139984020&site=eds-live

Sawyer, W. (2017). The steep cost of medical co-pays in prison puts health at risk. Retrieved from https://www.prisonpolicy.org/blog/2017/04/19/copays/

Sawyer, W., & Wagner, P. (2019). Mass Incarceration: The Whole Pie 2019. Retrieved from https://www.prisonpolicy.org/reports/pie2019.html

Schoenfield, H. (2012). The war on drugs, the politics of crime, and mass incarceration in the United States. *Journal of Gender, Race and Justice*(2-3), 315-353. Retrieved from http://proxy-remote.galib.uga.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=edsgao&AN=edsgcl.344208532&site=eds-live

Shiel, William. (2018). Medical Definition of Chronic Disease. Retrieved from https://www.medicinenet.com/script/main/art.asp?articlekey=33490

Simmons, L. How to Fix Overcrowded Jails. (2016). Stanford Business. Retrieved From https://www.gsb.stanford.edu/insights/how-fix-overcrowded-jails

Snyder, C., van Wormer, K., Chadha, J., & Jaggers, J. W. (2009). Older adult inmates: the challenge for social work. *Social Work, 54*(2), 117-124. Retrieved from http://proxy-remote.galib.uga.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=swh&AN=59568&site=eds-live

Steurer S., Linton, J., Nally, J., & Lockwood, S. The Top-Nine Reasons to Increases Correctional Education Programs. (2010). *Corrections Today.*

Stoliker, B. E., & Galli, P.M. (2019). An Examination of Mental Health and Psychiatric care among Older prisons in the United States. Victims & Offenders, 14(4),480-509. doi:10.1080/15564886.2019.1608883

Stop Recidivism. The Impact Of Recidivism. (2019, August 21). Retrieved from https://stoprecidivism.org/impact-of-recidivism/

The Prison Entrepreneurship Program (2020). *PEP | Prison Entrepreneurship Program*. [online] Pep.org. Available at: https://www.pep.org/ [Accessed 28 Feb. 2020].

US Census Bureau. (2018, March 19). High School Completion Rate Is Highest in U.S. History. Retrieved from https://www.census.gov/newsroom/press-releases/2017/educational-attainment-2017.html

Weinbaum, C., Lyerla, R., & Margolis, H. (2003). Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5201a1.htm

Wilper, A. P., Woolhandler, S., Boyd, J. W., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2009). The Health and Health Care of US Prisoners: Results of a Nationwide Survey. *American Journal of Public Health, 99*(4), 666-672. doi:10.2105/AJPH.2008.144279

Winkelman, T. N. A., Choi, H., & Davis, M. M. (2017). The Affordable Care Act, Insurance Coverage, and Health Care Utilization of Previously Incarcerated Young Men: 2008-2015. In (Vol. 107, pp. 807-811).

Zhang, C. (2019). Maryland's prison population drops to 1980s levels, continuing a multiyear decline. Retrieved from https://www.baltimoresun.com/news/crime/bs-md-prison-population-vera-20190423-story.html

Zullo, R. (2017) An Input Adjustment Method for Challenging Privatization: A Case from Michigan Prison Health Services *Labor Studies Journal, 42*(2), 85. doi:10.1177/0160449X16678326