

THE AGING OF PRISONERS IN THE
MASSACHUSETTS DEPARTMENT OF CORRECTION

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accessible at www.realcostofprisons.org/writing/

The Massachusetts prison population is aging rapidly. This report will clarify why that is important and why you should care.

ORIGINS

For at least the last 40 years, the ongoing wars on crime and drugs as well as inflated local and national concerns about public safety have resulted in increasingly long and often harsh prison sentences. Prior to the mid-1980's, sentences were much shorter and frequently abbreviated by deductions for good behavior and statutory (automatic) good time. In Massachusetts public and judicial perceptions that sentences needed to be longer and harsher and the passage of the "Truth in Sentencing" law in 1995, substantially lengthened sentences for most crimes. Additionally, the imposition of mandatory minimum sentences, especially for drug crimes, further increased the length of incarceration for most of those convicted.

Now, 15 - 20 years later, we are reaping the consequences of these policies. The prisoner population is disproportionately aging because those sentenced to these longer terms, often far exceeding 20 years or even life, are still in prison. This situation may be further exacerbated by the passage of the 2012 "Crime Bill". While this bill did shorten some mandatory minimum sentences for lower level drug crimes, it also newly made mandatory the automatic imposition of life without the possibility of parole sentences for 18 additional non-homicide crimes if the offender is adjudicated a habitual offender (i.e. convicted for the third time). In the past, many of these inmates would have been released long ago. The majority of these aging prisoners committed their crimes in their younger years but are still in prison now, and likely to stay or even die there.

TRENDS

Historically and continuing today, most of those incarcerated in state prisons commit their crimes while relatively young, typically in their twenties and thirties. Consequently, for much of the twentieth century, prisons were predominantly populated by men under 40 years old. For example, as late as 1999, 71% of the population in Massachusetts state prisons was under 40 years old. Today, only 15 years later, this percentage has fallen to 53%, a 25% reduction. Many studies have documented that most offenders "age out" of committing new crimes after age 50, and this is especially true for the most serious crimes, namely those associated with interpersonal violence. Similar data apply to those released from prison after completion of their sentences. Recidivism rates decrease sharply as prisoners age, and for those over 50 recidivism rates are typically under 10% and even more rarely the result of new crimes. Consequently, it is likely that much of the increasing incarceration of the elderly is unnecessary, serving mostly to provide for those seeking retribution and vengeance rather than protecting the public safety.

An additional trend of importance is the effect of age on the cost of incarceration. It is generally accepted that prisoners age more rapidly than those in the free world, resulting in higher health care costs at younger ages. Most assessments agree that prisoners over age 50 should be considered "elderly". Although some in minority groups may actually receive better health care in prison at young ages than their free world counterparts (because of extreme lack of access or insurance before imprisonment), at the time of incarceration the typical prisoner is notably sicker than street counterparts (likely a composite of poverty, disorganized lifestyles, addiction and mental illness). Subsequently, the overall low quality of prison health care accelerates aging due to delays and neglect, leading to a lack of preventive care and frequent complications and exacerbations due to delayed diagnosis. These factors are associated with a poor health care status and premature aging

among older prisoners, thereby resulting in increased health care expenditures for prisoners over 50 years of age¹. Numerous studies have suggested that the overall costs of incarceration for those over age 50 are at least two to three times the average costs, each frequently exceeding \$100,000 to \$150,000 annually.

DATA

Prisoner age distribution data for the Massachusetts Department of Corrections (MA-DOC) is presented in the two accompanying tables. Unfortunately, available data is constrained by some quirks, omissions and delays in published reports. Thus, the data is not always directly comparable for trends over time. Prior to 2010 the MA-DOC reported prisoner age data based on a jurisdiction population which included those criminally sentenced but held in county, out-of-state prisons or federal facilities (a relatively small number, typically <5%), but excluded those not criminally sentenced (i.e. pre-trial and civilly committed detainees, a fairly large number often exceeding 10%), even though they are held in MA-DOC custody. Since 2010, the jurisdiction population definition includes all of the above groups, regardless of where they are held.

Further, prior to 2010, the age data reported lumped all those between ages 40-64 into a single group. For those years groups were allocated to the age ranges shown in bold in TABLE 1 (<20, 20-29, 30-39, 40-64, >65). Since 2010, however, ten year age ranges plus those >60, as shown in TABLE 2, have been routinely reported. These unfortunate choices make difficult the longitudinal assessment of the population of greatest interest to this report: those between the ages of 50-59, and also the comparison of those over 60 as these numbers are not immediately discernable. Also troublesome is that it is difficult to longitudinally identify the 60-64 or 65-69 age groups for all periods.

The observation in Table 2 that the percentage of prisoners

¹ For example, an informal survey of Lifers Group members at MCI-Norfolk revealed that 96% of those over 50 take prescription medications, with a mean of 6 medications each. By contrast, only 60% of those under 50 take a mean of 3 medications each.

in the 40-49 year old age group appears to cluster consistently around 25% of the total population provided the incentive to estimate the result of such a calculation on the earlier data which did not separate out this age range from the remainder of the 40-64 age group. Consequently, Table 1 shows two additional age ranges labeled "40-49 Est." and "50-64 Est.". The "40-49 Est." group, as shown, is calculated at an arbitrary 25% of the total population for each year. The "50-64 Est." group is then the difference between the "40-49 Est." group and the 40-64 age group reported by the MA-DOC (shown as "40-64 Act'1").

Review of the data in Table 1 is consistent with the generalized observations offered in the Trends section above. Progressive decreases over time are seen in the percentages of the younger age groups (<40), along with clear increases in the older age groups (>40). What is most striking are the relative magnitudes of the annual changes in the composition of the prison population over time. Thus, the 20-29 year olds decrease by 22% (31.9 to 24.9); the 30-39 year olds decrease by 20% (37.0 to 29.4); the 40-64 year olds increase by 49% (28.1 to 42.0); and the >65 year olds increase by 310% (1.0 to 3.1). Although the increase in the oldest group seems most impressive, their impact on overall costs is not yet significant because, even in 2012, they account for only 3.1% of the total. We have noted above, however, that prisoner health care costs have been shown to rise well before the age of 65.

What, then, can we glean from studying the "50-64 Est." group? Not only do they have the most impressive increase, 548%, from 3.1% to 17.0%, by 2012 they represent a very significant 17% portion of the total (almost 2000 inmates). Furthermore, although this number in Table 1 is based on a 25% estimate for the 40-49 age group, we can conclude that at least for 2010 and 2012 these numbers are right on target because from independently published data, as shown in Table 2, the true values for the 40-49 age group in 2010 and 2012 are 25.7% and 25.1%, respectively. Obviously, these numbers are already subsumed in the reported 40-64 age group reported between 1999 to 2012 in Table 1, but it was

not at all obvious that, in such a large age range, where the most important change was occurring. Based on Table 1, it now appears that the most impactful change is in the very age group, those over 50, that will result in dramatic increases in health care costs to be incurred by the MA-DOC in the ensuing years. And, indeed, health care costs already have continued to increase during the past decade, both as a percentage of the budget and in actual dollars. The same trends can be observed in Table 2. The composite percentage of those 50 and older increases from 16.8% in 2009 to 22.8%, a 36% increase, in only 5 years. Due to the constantly changing population numbers it is most appropriate to compare percentages rather than numbers of inmates. Table 2 provides additional data about the rapid aging of the inmate population, confirmed by the substantial increases in the older age groups. By 2014, the group 60 and older has risen to 7.3%, which is no longer negligible. This group, which can be predicted to continue to grow under current policies, will disproportionately drive health care costs upward even faster than those between 50-59.

IMPLICATIONS & CONCLUSIONS

It is apparent that MA-DOC prisoners are aging rapidly, with the most important increases occurring in those over 50. This will only accelerate unless changes are made. Current criminal justice reforms in Massachusetts have been focused predominantly on reducing penalties for drug crimes and have actually increased many other penalties, including a proliferation of mandatory life-without-parole (LWOP) sentences. These "reforms", paradoxically, result in the release of mostly younger prisoners, as already evidenced by the results of the 2012 "Crime Bill". Since the implementation of that bill, the only proportion of inmates that has decreased are those serving 7 years or less. Those with longer sentences have increased, confirming that this bill did not reduce the number of the aging, long-termers. All these results were predictable based on the policies consistently implemented since the 1980's.

Recent independent evidence has shown that offenders

generally "age out" of crime, especially after age 50, with concomitant reductions in the rates of recidivism after that age. Substantial evidence has also accrued that even the so-called "worst offenders" -- those serving life sentences -- rarely re-offend upon release if they are older than 50 and have served long sentences. These findings strongly suggest that the release of many long-time, older prisoners is fully compatible with public safety. Additional evidence suggests that humanitarian principles would also best be served by the release of many elderly prisoners, especially those sick or infirm, who are currently simply warehoused in prisons after serving many years and who pose minimal risks if released. Many European and other developed countries have successfully implemented such policies with no adverse consequences for public safety. It is a shameful paradox that the USA, a country professing devotion to the principles of fairness, freedom and democracy, is the only nation that finds it necessary to incarcerate so many. The U.S. incarcerates a vastly larger proportion of its citizens, roughly one in every hundred adults, than any other country with no evidence that this increases public safety. To the contrary, there is evidence that these policies, through continued disruption of families and community devastation, actually decrease public safety.

There is little doubt that this aging prisoner population is already and will increasingly burden the MA-DOC with rapidly increasing health care costs. Even in the free world, health care costs are threatening to become unsustainable. Costs for the incarcerated are additionally substantially increased by security concerns, including supervision during transport and while receiving care, whether as outpatients or while hospitalized. In addition, the rapid increase in technological complexity of medical diagnosis and treatment will require more and more referrals to advanced centers for care that is beyond the capabilities of prisons and yet is required to meet Eighth Amendment standards. If these aging prisoners were released, these costs would mostly be shifted to Medicaid and Medicare and

thereby largely borne by the federal government rather than the state. Even the presently proposed expansion of Medicaid coverage for prisoners requiring >24 hour hospitalization will not resolve such concerns as more care, even for serious conditions, is delivered on an outpatient basis.

What, then are possible remedies to alleviate these economic and humanitarian concerns? It seems clear that policies need to be adjusted to be more selective about determining which prisoners truly need to remain long-term or indefinitely incarcerated.

For all prisoners, an emphasis on academic and vocational education and other rehabilitative programs urgently needs to be implemented. The costs for such efforts will amply be defrayed by the concomitant proposed decrease in incarceration and health care expenditures. For those eligible for parole, a policy advocating "presumptive" parole should be instituted. This does not mean that everyone would be paroled, but that parole will be granted unless there is evidence that the prisoner is not rehabilitated. For those serving extreme term-of-year or LWOP sentences, a realistic and robust use of sentence commutations would be an appropriate alternative. In the past, commutations were readily granted after significant portions of terms had been served and prisoners demonstrated evidence of rehabilitation. This option, however, has virtually disappeared from current practice, largely for political reasons. Although the federal government is now considering commutations, this is only for excessive drug sentences. There is little reason that such a policy should not be expanded to all excessive sentences, especially for the elderly, infirm, or those with complex medical needs.

Finally, new legislation and policies need to be implemented to replace the ones that brought us to this impending crisis. Legislation should be implemented to limit excessive sentences and especially mandatory LWOP sentences. LWOP is a death sentence and consequently should require judicial and public oversight and discretion. Use of bifurcated jury verdicts before the imposition

of LWOP similar to procedures currently employed for death by execution is a viable option; at the very least, judges' discretion should be restored for LWOP sentences. Use of mandatory sentences in general should be limited or largely abolished.

Additionally, legislation is needed to facilitate the effective and long-term implementation of the presumptive parole and commutation policies suggested above. Defining rational mechanisms and criteria allowing parole and commutations is required to legitimize and authorize granting these reprieves. This is necessary in order to minimize inevitable political backlash resulting from rare, but inevitable adverse outcomes. Parole and commutations panels as well as governors need to be "immunized" politically in the case of an unfortunate event. Failure to predict a single adverse outcome should not invalidate programs that are otherwise achieving desirable results. Some may ask: Why take any risks? Simply continue harsh sentences and release no one. But, that is precisely how we have become the nation of incarceration, a situation which is unsustainable from both economic and humanitarian grounds. The rest of the world has achieved the goals we are proposing. Is it not time to expect Massachusetts to join them?

TABLE 1
PRISONER AGE DISTRIBUTION*
1999 -2012

| Age | 1999 | 2000 | 2002 | 2004 | 2006 | 2008 | 2010 | 2012 |
|---------------|--------------|--------------|-------------|-------------|-------------|--------------|--------------|--------------|
| < 20 | 215 | 169 | 84 | 91 | 70 | 73 | 85 | 62 |
| % | 1.9 | 1.6 | 0.9 | 1.0 | 0.7 | 0.7 | 0.7 | 0.5 |
| 20 - 29 | 3555 | 3236 | 2648 | 2394 | 2591 | 2738 | 2851 | 2925 |
| % | 31.9 | 30.2 | 27.6 | 26.4 | 27.5 | 27.0 | 25.1 | 24.9 |
| 30 - 39 | 4134 | 3927 | 3461 | 3025 | 2909 | 3198 | 3377 | 3445 |
| % | 37.0 | 36.7 | 36.0 | 33.4 | 30.9 | 31.6 | 29.7 | 29.4 |
| 40 - 49 Est. | 2790 | 2678 | 2402 | 2265 | 2351 | 2533 | 2840 | 2931 |
| % | [25] | [25] | [25] | [25] | [25] | [25] | [25] | [25] |
| 50 - 64 Est. | 341 | 569 | 857 | 1129 | 1301 | 1359 | 1898 | 1992 |
| % | 3.1 | 5.3 | 8.9 | 12.5 | 13.8 | 13.4 | 16.7 | 17.0 |
| 40 - 64 Act'l | 3131 | 3247 | 3259 | 3394 | 3652 | 3892 | 4738 | 4923 |
| % | 28.1 | 30.3 | 33.9 | 37.5 | 38.8 | 38.4 | 41.7 | 42.0 |
| > 65 | 123 | 133 | 155 | 156 | 183 | 231 | 310 | 368 |
| % | 1.0 | 1.2 | 1.5 | 1.7 | 1.9 | 2.2 | 2.7 | 3.1 |
| Crim Sentence | 11158 | 10712 | 9607 | 9060 | 9405 | 10132 | 10259 | 10491 |
| Jurisdiction | 11792 | 11377 | 10534 | 10242 | 10699 | 11364 | 11361 | 11723 |

*Percentages are calculated for each year, based on the total populations as shown in bold, underscored numbers. Because the DOC changed the definition of jurisdiction population in 2010 and correspondingly reported age data based on two different measures of total populations, horizontal comparison of numbers may be misleading; however, trends in horizontal percentages are comparable. See text for explanation of "40-49 Est." and "50-64 Est." values.

TABLE 2
PRISONER AGE DISTRIBUTION
2009 - 2014

| Age | 2009* | 2010 | 2012 | 2013 | 2014 | Change: 2009-2014 |
|--------------------------|-------|-------|-------|-------|-------|----------------------|
| < 20 | 50 | 85 | 62 | 56 | 49 | - 1 |
| % | 0.4% | 0.7% | 0.5% | 0.5% | 0.4% | - 2.0% |
| 20 - 29 | 3082 | 2851 | 2925 | 2693 | 2581 | - 501 |
| % | 26.9% | 25.1% | 25.0% | 23.6% | 23.4% | - 16.3% |
| 30 -39 | 3561 | 3377 | 3445 | 3348 | 3231 | - 330 |
| % | 31.1% | 29.7% | 29.4% | 29.4% | 29.3% | - 9.3% |
| 40 - 49 | 2831 | 2918 | 2943 | 2848 | 2658 | - 173 |
| % | 24.8% | 25.7% | 25.1% | 25.0% | 24.1% | - 6.1% |
| 50 - 59 | 1347 | 1475 | 1608 | 1701 | 1710 | + 363 |
| % | 11.8% | 13.0% | 13.7% | 14.9% | 15.5% | + 26.9% |
| ≥ 60 | 577 | 655 | 740 | 757 | 805 | + 228 |
| % | 5.0% | 5.8% | 6.3% | 6.6% | 7.3% | + 39.5% |
| <u>Change: 2009-2012</u> | | | | | | |
| 60 - 69 | 468 | 525 | 577 | | | + 154 |
| % | 4.1% | 4.6% | 4.9% | | | + 36.4% |
| ≥ 70 | 109 | 130 | 163 | | | + 54 |
| % | 0.9% | 1.1% | 1.4% | | | + 49.5% |
| Jurisdiction | 11438 | 11361 | 11723 | 11403 | 11034 | - 3.5% |

*Data for 2009 corrected for change in definition of jurisdiction population.