# Guest editorial

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## CommunityAcademic Partnerships: an Opportunity to Improve the Lives of Incarcerated Older Adults

### *Introduction*

Unprecedented growth in the number of older adults involved in the criminal legal system (under arrest, in court, in prisons or jails, on probation or parole) has occurred over the past 20 years (Williams *et al.*, 2012a, 2012b; Williams *et al.*, 2021). Due to decades of draconian and racially biased sentencing policies (e.g. "three strikes") and overtly discriminatory drug laws and policing practices (Rich *et al.*, 2011), these older adults are disproportionately poor and Black or Latino (Maschi and Aday, 2014; Maschi *et al.*, 2017). Approximately 1 in 4 Black men and 1 in 6 Latino men carry a lifetime risk of incarceration (Bonczar, 2003). Many also experience disparities in health, including high rates of early-onset disease and disability and behavioral or social risk factors (e.g. substance use disorders, mental health conditions, trauma, homelessness) (Binswanger *et al.*, 2009; Baillargeon *et al.*, 2010; Williams *et al.*, 2010; Maschi *et al.*, 2011; Barry *et al.*, 2016). Yet, this population remains understudied (Ahalt *et al.*, 2012, 2013, 2015).

Research that contributes to our understanding of the life course experiences of older adults involved in the criminal legal system, and the drivers of later life health disparities in this population, including criminal legal system involvement itself, is limited (Ahalt *et al.*, 2012, 2015). Moreover, much of the research about this population has failed to study the geriatric conditions (e.g. functional and cognitive impairment, falls, elder abuse and polypharmacy) that are critical to understanding the health and wellbeing of older adults at each phase of the criminal legal system involvement (from police arrest through community reintegration after incarceration (Williams *et al.*, 2006; Metzger *et al.*, 2017; Ahalt *et al.*, 2018; Barry, 2018; Greene *et al.*, 2018).

Addressing these knowledge gaps requires a nationwide research infrastructure because the growing number of researchers who study aging and criminal legal system involvement – many of them early in their careers – represent a range of academic disciplines (e.g. medicine, public health, nursing, social welfare, criminology, sociology, law, social work and more) spread across diverse geographical settings with few centered at any one institution. As a result, vital interdisciplinary research collaborations are limited, and junior researchers often lack the mentorship and resources needed to pursue a successful research career in this area.

In response, we developed *The Aging Research in Criminal justice and Health* (ARCH) *Network,* funded by the National Institute on Aging, to bring together researchers dedicated to studying the life course experiences of older adults involved in the criminal legal system and the drivers of later life health disparities in this population together in a community of collaboration and support. We soon learned that the aging of the prison population is a global phenomenon, and members from xx nations beyond the US now belong to our consortium. Our approach has been to facilitate conversation and collaboration across a diverse range of

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disciplines and between academics and community constituents to address the gaps in our understanding of the needs, health and care of this understudied population.

### *The need for community/academic partnerships*

Too often, community leaders who have a history of incarceration or criminal legal system involvement themselves or in their family are not directly involved in academic research. As a result, their invaluable insights into the issues and needs that are most pressing for criminal legal system-involved older adults are not adequately incorporated into research designs. Here, we highlight three examples of how we envision community/academic partnerships transforming the landscape of what we know about the life course experiences of older adults involved in the criminal legal system. These three examples, (1) the health of older women involved in the criminal legal system, (2) the role of peer caregiving within correctional facilities and (3) the optimal detection and management of psychiatric disorders in prison settings, are just three ways in which community members can inform a more robust research agenda. Each section is cowritten by an academic and community partner, and each reveals a person-centered approach to clarifying the most important research questions.

### *The health of older women involved in the criminal legal system*

There are more than 200,000 women in US jails and prisons, an eightfold increase since 1980 (Carson, 2020; Zeng and Minton, 2021). This population is growing older, but incarceration among older women is rarely the focus of research, policy or programming (Aday and Farney, 2014). Yet, compared with incarcerated older men, older women experiencing incarceration are more likely to have serious health problems and significant mobility challenges (Wahidin, Noelle and Kelly, 2005; Carlen, 2006), including menopause which can exacerbate many health conditions and is itself a major health concern for one in three older women in prison (Jaffe *et al*., 2021).

The majority of incarcerated women are survivors of violence, and traumas which may cast shadows on physical and mental health in older adulthood (McDaniels-Wilson and Belknap, 2008). For example, Louise served 32 years for taking the life of the perpetrator who brutally sexually abused her grade school-age daughter, and Millie served more than 20 years for fighting back against her abusive husband – even though no life was lost. The burden of incarceration is not shared equally among all older women; there are disproportionate impacts of racism and stigma in the criminal legal system on women of color, poor women and women with substance use disorders (Marilyn and Meda, 2017). Incarcerated older women also often face immeasurable stress, poor diet, a dehumanizing culture and health care and facilities not designed to meet their needs. This takes a tremendous toll on the individual's body and mind, and thus, generates increased costs for society (Ahalt *et al*., 2013).

Despite the high costs associated with incarcerating older adults, there has been little focus on disproportionate sentences (Doering, 2020) faced by women aging behind bars which often do so without family or community support. For example, Helen was convicted of conspiracy to commit murder despite having no knowledge that her actions were linked to a crime. No one died, and no one was harmed. Nevertheless, she received a life sentence. Helen's kidneys were failing for the past several years of her life, and she was escorted out of prison twice weekly for dialysis treatment, hands and feet shackled to prevent escape and a guard on each side. Helen was found unsuitable for parole at age 85 because she did not have firm enough employment plans and was therefore deemed a risk to public safety. She died, alone and unnoticed, at 86 years old in a prison skilled nursing facility. When most people think about incarceration, few picture someone like Helen. Yet, her story is far from unique.

Community/academic partnerships have the power to shed light on the "forgotten population" (Handtke *et al.*, 2015) of incarcerated older women and shift our focus to policy and practice that can support decarceration via parole, compassionate release and sentencing reform. There is tremendous potential for community/academic partnerships focused on the health needs of older women to center the voices of diverse older women experiencing incarceration, raise issues of greatest import and leverage interventions for maximum effect. Community-based older women with histories of incarceration have the capacity to help researchers identify areas of concern and critical points of intervention. Partnerships between academicians, community members, patients who are incarcerated and their loved ones and correctional health-care professionals are all needed to appropriately identify the health care needs of older women that are most in need of investigation to identify avenues for to ensure adequate treatment and to advocate for humane policies that decrease the number of older women behind bars.

### *The role of peer caregiving within correctional facilities*

Another important example of how community/academic partnerships can inform research is in the area of informal caregiving within correctional facilities. In carceral settings, many persons who are incarcerated serve as caregivers for their fellow-incarcerees in formal (e.g. infirmary) and informal (e.g. dorms, on the yard) settings. For example, caregivers known as "Gold Coats" in the California Department of Corrections and Rehabilitation (CDCR) provide a wide range of support to older adults or persons with a life-limiting illness who are incarcerated in the California Men's Colony state prison. Gold Coats may aid people in their activities of daily living, such as feeding, or by assisting the mobility impaired or transporting older adults who use wheelchairs throughout campus to medical or dining spaces, and facilitating programs and activities (Berry *et al.*, 2016). Caregivers like these are often provided extensive and continuous training by professional health care staff (Wion and Loeb, 2016; Stewart and Edmond, 2017; Prost *et al.*, 2020).

While the work of Gold Coats and other formal peer caregivers is an important, clearly defined role with related expectations, much of the around-the-clock care for older adults in these settings is provided in an unofficial and loosely structured approach. For instance, most residents assigned to an upper bunk in the CDCR California Medical Facility are able-bodied. These residents perform supportive services for their elderly peers who are assigned to lower bunks, providing haircuts and assistance with personal hygiene, transferring and transportation and lending an extra set of eyes or ears for those with sensory impairment. Even those with hearing impairment have guided those with visual impairment, a clear manifestation of compassion and trust in a setting often described as care-less (Daniel, 2005). Peer caregivers also provide unofficial mental health support. This is especially common when a peer is distraught after learning of a death in the family, a terminal diagnosis or disability or when facing death by incarceration (Kaplan, 1989; Foster and Magee, 2011; Prost *et al.*, 2020). Peers often facilitate discussions surrounding depression, disrupt suicide attempts and offer creative solutions for processing difficult experiences in the carceral milieu.

Without community partnership, researchers may learn little about how peer caregiving takes shape within a prison setting and would lack the opportunity to shed light on what aspects are most effective or meaningful to the people engaged on both sides of this care. Collaboration between community leaders and academic partners such as faculty or university-affiliated research institutes has led to the development, implementation and evaluation of tailored caregiving interventions related to the management of chronic illness, pain or cognitive impairment in older adults (Berry *et al.*, 2016). And while caregiving is largely altruistic, the risk of victimization by peers does exist (e.g. the taking of older adults' money and personal property by caregivers) knowledge which researchers that engage the perspectives of community members are able to uncover (Prost *et al.*, 2020). Even community partners with

little knowledge of the criminal legal system, such as Area Agencies on Aging, may be instrumental in educating and empowering older adults in correctional settings about such risks or signs of elder abuse. Local hospice providers also may be especially well-situated to offer training and continuing education to formal and informal caregivers regarding their own grief and bereavement (Supiano *et al.*, 2014; Prost *et al.*, 2020) – such efforts can support peer caregivers' health and well-being and, by extension, contribute to improved care and health outcomes among older adults in carceral settings.

### *Optimizing detection and management of psychiatric disorders in prison settings*

More than two decades ago, Koenig *et al.* evaluated characteristics associated with mental illness in 95 incarcerated males, age 50 or older, from one US federal correctional facility (Koenig *et al.*, 1995). More than half of the study participants met one-month criteria for a psychiatric disorder. The findings highlighted mental illness and unmet treatment needs as significant problems among incarcerated people. Yet, since this seminal study was published, the number of incarcerated older persons in the US has nearly quadrupled (Williams *et al.*, 2021, new reference), and their suicide rates have increased (Carson, 2021; Ann Carson, 2020) but only a handful of studies have evaluated mental illness and treatment of mental illness in this medically vulnerable population.

Community/academic partnerships offer a unique opportunity to advance our knowledge of the burden of mental illness among incarcerated older adults. The Aging Inmates' Suicidal Ideation and Depression Study (Aging INSIDE) is an example of one such initiative. Through a partnership with the Connecticut Department of Correction, investigators from the University of Connecticut School of Medicine have been evaluating the mental health of incarcerated persons age 50 or older for several years. Important findings have emerged that have implications for developing interventions targeting incarcerated older adults. For example, we have found that difficulty conducting activities needed for daily living in prison, such as standing in line for medications or walking to the chow hall, is associated with worse depressive symptoms and higher levels of suicidal ideation (Barry *et al.*, 2020). Thus, environmental modifications or peer caregiver support (as discussed in the previous section) may be particularly important to target these populations to improve symptoms. In this issue of the *International Journal of Prisoner Health*, we learn about the impact of the COVID-19 pandemic on older incarcerated persons' mental health through findings from Aging INSIDE. Findings from this study also highlight the link between mental health and self-rated health, with implications for prison health care costs and services.

With the aging of the prison population, the number of incarcerated older adults living with dementia is likely to grow. Partnerships between academia, local chapters of the Alzheimer's Association and departments of correction may be useful for educating corrections officers and correctional health-care professionals about the signs and symptoms of mild cognitive impairment and dementia. In the prison setting, detecting these conditions may be especially difficult given the structured environment and limited opportunities for incarcerated people to make plans or engage in more complex tasks such as managing their own medications. Impaired cognitive functioning that goes undetected could also leave older adults in prison more vulnerable to peer-to-peer victimization or unjust disciplinary action from correctional staff. Thus, community/academic partnerships may be particularly important for optimizing educational efforts that ultimately will support the detection and treatment of mental illness in incarcerated older adults.

## *Conclusion*

Researchers in academic settings have the unique opportunity to highlight the experiences and needs of a growing population of profoundly medically and socially vulnerable older adults – those wrapped up in the criminal legal system, with a special focus on those who are

incarcerated. But doing this well requires partnership with community leaders to identify the most salient questions that merit investigation and analysis. The ARCH Network has endeavored to bring community leaders and academic researchers together across states, nations and disciplines to discuss the most pressing and concerning issues faced by older adults in the criminal legal system. This issue of the International Journal of Prison Health reflects original research and commentaries that have emanated from many of the researchers who were part of these efforts.

As the world faces an ever-aging population, many nations are experiencing an increasing number of older adults who are engaged in the criminal legal system and also who are aging behind the bars of prisons or jails. The articles in this special issue run the gamut from analysis of policies related to end of life decision-making in prisons, to the impact of COVID-19 on the mental health of incarcerated older adults (both from a researcher's perspective and from the first-person account of a peer caregiver who endured the pandemic while confined to prison), to a step-by-step approach for health-care professionals to petition compassionate release for their patients.

Despite a rapidly aging population, older adults are oftentimes forgotten, their needs pushed to the margins to make way for the experiences and necessities of younger persons. The articles in this issue, including narratives, research and policy recommendations, all place older adults at center stage. Collectively they call on us to stop marginalizing the complex health care and social needs of older adults in the criminal legal system, and they force us to ask how we can stem the rising tide of older adults with complex needs who are engaged in the criminal legal system.

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