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The Crisis of Elderly Care in California Prisons: Examining Healthcare Services for Older Incarcerated Individuals

California's prison population is aging rapidly, with the number of incarcerated individuals aged 55 and older nationwide in state and federal prisons "growing 24% compared to an average increase of 15% across all other age groups" (Widra, 2023). Despite this, less than 5% of U.S. prisons provide hospice care, highlighting the neglect of end-of-life and aging incarcerated individuals' healthcare needs (*Humane Prison Hospice,* 2024). The difference between the number of older incarcerated individuals compared to the resources they may need near the end of their lives highlights a critical gap in the healthcare system for aging incarcerated individuals. As the population of older incarcerated individuals grows, so does the urgency to examine how well California's prisons, managed by the California Department of Corrections and Rehabilitation (CDCR), address these challenges, particularly during the COVID-19 pandemic.

In my research, I raise the question, what are the health needs and challenges of older incarcerated individuals in California prisons? Specifically, how does the physical healthcare of older incarcerated individuals, 55 and older, differ depending on each California state prison managed by the CDCR during COVID-19, and are older incarcerated individuals provided adequate and appropriate healthcare services? To attempt to answer this question, I analyzed available data from medical inspection reports from 2019 - 2024 made by the Office of the Inspector General on 32 of the CDCR-run California state prisons. I isolated the data from these

medical reports to three questions involving chronic care follow-up appointments, medications, and immunizations. I chose these questions since older incarcerated individuals are a significant portion of the population who have chronic health conditions. I then compared them to the rate of COVID-19 infections within each prison per 1,000 incarcerated individuals from the start of COVID-19 to now.

Context and Significance

Healthcare in California's Prisons

California's state prisons have had poor health care since the mid-1900s. When a class action lawsuit called *Plata v. Newsom* in 2001 pointed out flaws similar to a previous lawsuit, *Shumate v. Wilson,* in which California prisons had "inadequate medical services, including sick call, triage, emergency care, nurses, urgent care, chronic care, specialty referrals, medical screenings, follow-up care, examinations, medications, diets, terminal care, health education, and dental care" (Feng, 2022). As a result, CDCR was ordered to address its deficiencies (Legislative Analyst Office, 2023). However, they failed to do so, and consequently, California prison healthcare is scrutinized by the federal government (Legislative Analyst Office, 2023). These issues affect older incarcerated individuals disproportionately due to higher odds of living with more than one chronic illness or a need to rely on medical support.

Gaps in Data and Representation

There are significant gaps in available public data regarding the healthcare of older incarcerated individuals. Aged incarcerated individuals are underrepresented in research, which is an issue because those who are 55 and older in prison need different healthcare and support than younger adults, much like juveniles. Nevertheless, while juveniles have their own categories in most

research, especially healthcare, those 55 and older rarely do. Even when data nationwide, including the CDCR, was available for subjects like infection rates, mortality rates, or health inspections, they did not separate their findings by age of adult. Consequently, this lack of data indicates that state prisons around the United States are underprepared to understand the needs of older incarcerated individuals.

Ethical and Economic Considerations

Having a lack of data for older incarcerated individuals not only reflects a broader failure to address their unique needs but also has serious legal and ethical implications. When older incarcerated individuals do not get timely and adequate medical care, it violates their Eighth Amendment rights, which protects against cruel and unusual punishment (Williams, 2012). Since older incarcerated individuals are an often overlooked group, they need people to speak up and advocate for them. Older incarcerated individuals should not die from preventable diseases due to a lack of training and disregard from prison staff. Additionally, when older incarcerated individuals' health needs are not met, they are more likely to experience early onsets of disabilities and chronic illnesses. This raises the cost of healthcare, placing a financial strain on California and its prisons. Nationwide, "a 2012 American Civil Liberties Union (ACLU) report found that it costs $31,135 per year to house an average prisoner, but it costs $68,270 per year to house a prisoner aged 50 and older" (Nowotny, 2015). Spending time caring for older incarcerated individuals will reduce the number of chronic illnesses that they have, and this reduces the cost, saving money to spend on other programs. Addressing these issues will reduce costs and uphold incarcerated individuals' rights.

Literature Review

Demographic Trends: The Rising Population of Older Incarcerated Individuals

California's older incarcerated population is growing faster than in many other states, as California prisons experienced an increase in those 55 and older from 4% in 1990 to 21% in 2014 (Psick, 2017). In California, this demographic grew faster because of policies like Three Strikes and tough-on-crime laws, which increased mass incarceration. Additionally, longer sentencing and stricter parole eligibility criteria or less parole as a whole have also contributed to the increasing number of older incarcerated individuals (Widra, 2023).

The most common causes of death in prisons are heart disease, cancer, liver disease, AIDS, and respiratory disease (Carson, 2021). While these issues are common outside of prison as well, older incarcerated individuals experience more deaths attributed to infectious diseases and typically have three chronic conditions, higher than the rate in the general population (Nowotny, 2015). In addition, prison accelerates aging as "on average, [incarcerated individuals] are physiologically 10 to 15 years older than their community counterparts" (Nowotny, 2015). By age 55, they are already considered geriatric, and according to the Prison Policy Initiative, five years in prison increased the odds of death by 78% and reduced life expectancy "at age 30 by 10 years." This rapid aging of the carceral system leads to more chronic issues. In a study, those who are 59 are found to have the same health conditions as a 75-year-old who has never been incarcerated in areas like mobility, cognitive, and functionality impairments (Kaiksow, 2023). It was noted that among health issues like mobility, vision, hearing impairments, cognitive decline, urinary incontinence, and chronic lung disease, there was a 20% to 80% increase in prevalence in those who have a history of incarceration compared to those without (Garcia-Grossman, 2023). As a result, there is more strain on the carceral medical system regarding the availability of

nurses. Effectively, a prison sentence means giving up years of their life while incarcerated and in the long run.

Deficiencies in Geriatric Care within Prisons

However, while California is experiencing an aging prison population, few medical staff in prison specialize in geriatric care. In a study, prison medical workers reported inexperience with advanced care planning, and while "85% of participants reported familiarity with advanced care planning, only 42% offered an accurate definition" (Rachel Ekaireb, 2018). Additionally, older incarcerated individuals may find it challenging to keep up with the physical requirements demanded daily in prison. One explanation for this is the prison structure. Prisons were built to accommodate a younger population (Psick, 2017). For instance, prisons lack accommodations for older incarcerated individuals, such as wheelchair accessibility and shower handrails, and 69 percent of older incarcerated individuals reported experiencing at least one impairment in daily living (Williams, 2012; Nowotny, 2015). Additionally, 29 percent of those 55 and older were reported to be assigned top bunks (Nowotny, 2015). These inadequacies are unaccommodating to their changing needs.

Prevalence of Infectious Diseases

Infectious diseases spread quickly in prison settings, adding additional threats to older individuals' health. Diseases like HIV, hepatitis B and C, and valley fever infect incarcerated individuals at a disproportionately higher rate than in the community (Macalino, 2004; *About Valley fever*, 2024). Valley fever is a lung disease with symptoms similar to pneumonia and the flu. It is caused by the disturbance of fungi in dry soil, mainly affecting California and Arizona. The disease infection rates in certain California prisons "were hundreds of times higher than the

state average" (Klein, 2019). The infection rate of valley fever within prisons exposes the systemic flaws within prison healthcare. Moreover, the COVID-19 pandemic brought additional public attention to prison deficiencies as the nationwide infection rate was five and a half times greater among incarcerated individuals than the public, and 9 out of 10 hotspots around the nation were in prisons in 2020 (Prost, 2021).

Infectious diseases spread rapidly because most prisons in California are above 100 percent capacity, according to publicly available data on the CDCR website. Consequently, people are enclosed in tight spaces with more individuals than recommended, ripe for the spread of diseases. The outbreak of COVID-19 put those with preexisting medical conditions and older adults in a vulnerable position as they were more likely to experience severe symptoms or die. Individuals in the public who were 65 and older comprised 81% of deaths attributed to COVID-19 (*People with certain medical conditions, 2024*). Older adults could also present the COVID-19 symptoms differently, as some older adults with COVID-19 appeared "'off' or unlike themselves…with altered mental status," which made them "seem disoriented or confused" (Prost, 2021). These presentations could be misinterpreted as symptoms of aging or regular geriatric issues. This case demonstrates that geriatric nurses are crucial to recognizing and diagnosing diseases early and providing treatment promptly.

Additionally, in order to stop the spread of COVID-19, many prisons put people into solitary confinement, which would cause added physiological harm. In the case of older adults, the lack of daily activity would "decrease muscle strength and mass—linked to increased risk of falls—a reduction in independent activities of daily living and cognitive decline" (Fisher-Pinkert, 2023; Prost, 2021). Conclusively, COVID-19 demonstrated that prisons have difficulty recognizing and treating those with chronic illnesses in older adults.

Existing Programs

The difficulties exposed during COVID-19 are in part due to limited implementation of programs and solutions designed to address the unique needs of older incarcerated individuals and those with chronic illnesses. Programs like hospice care and compassionate release exist but benefit a fraction of those in need. Compassionate release is a program that frees individuals who are terminally ill and require 24/7 care to get the medical help they require (*Compassionate Release*). The program has confusing and unclear language with technical terms that are hard to understand, especially for those with a language barrier (Kaushik, 2023). The eligibility for compassionate release also varies across states, leading to further confusion, limiting those who would have benefited from it, and slowing down the process (Kaushik, 2023). Many waiting for compassionate release die before utilizing the program (*Compassionate Release*).

On the other hand, out of the few prisons that have hospice care, the program is entirely staffed by volunteers of other incarcerated individuals who are trained in spotting dementia and cognitive impairments in aged incarcerated individuals (*gold coats*). While it is crucial to know how to spot cognitive decline in incarcerated individuals, volunteers are not skilled enough to provide recommendations for the next steps in care or provide medical services. Some states have implemented nursing home prisons to tackle treatment and provide specialized training for older individuals. Nursing home prisons or units help provide specialized geriatric care, but only a few exist and are always full (*California prisons*). In California, only one unit with 17 beds exists for nursing home care, located at California Medical Facility (*California prisons*). The need for nursing home prisons highlights the issue of keeping many older incarcerated individuals locked up rather than utilizing routes like compassionate release or parole. Research also shows that they are less than half as likely to reoffend compared to those under 50 (*Older*

offenders, 2022). This suggests that compassionate release or parole for older incarcerated individuals could provide a humane and cost-effective alternative without significantly compromising public safety.

Current Outcomes

If older incarcerated individuals do not receive adequate care, they are left to take charge of their health. Incarcerated individuals may do this by understanding their medications and medical problems (Novisky, 2018). They may ask their family members to bring in books or articles related to their health conditions in order to describe their symptoms better (Novisky, 2018). Near the end of their life, incarcerated individuals also express feelings of fear over separation from loved ones (Novisky, 2018). If they do not get compassionate release, many will die in prison. Thus, there are two costs to dying in prison: one in the mental anguish the incarcerated individual has to go through and the other in the amount the government pays in medical fees. Something more needs to happen within California prison systems to help older incarcerated individuals.

Theory, Hypotheses, and Causal Mechanism

Hypotheses

Conceptual: California prisons that are less effective in providing consistent chronic care, such as timely follow-up appointments, proper medication administration, and vaccinations for chronic care patients, are more likely to experience higher rates of COVID-19 diagnoses over time.

Operational: Prisons in California with fewer observed chronic care follow-up appointments, timely medications administered, and immunizations for chronic care patients will lead to an increase in the number of COVID-19 diagnoses from 2020 until now.

Theory and Causal Mechanism

I hypothesize that California prisons that have a higher rate of administering medical care to incarcerated individuals with chronic illnesses will have fewer reported positive COVID-19 cases accounting for prison population capacity. I believe this will be the case because, as mentioned previously in the literature review, those who are older or have chronic illnesses have a much higher chance of COVID-19 being fatal or experiencing long-term negative symptoms. If there are delays in recognizing and treating those with chronic care illness noted within the medical inspections, it would also indicate that health care involving COVID-19 might also have delays in treatments, resulting in possibly fatal ramifications for older individuals. Although the CDCR's reported COVID-19 infection rates do not account for individuals' ages, the higher infection rates of COVID-19 among older adults and those with preexisting health conditions likely have a noticeable impact on these statistics. Moreover, prisons with inadequate medical follow-up would also fail to implement preventive measures in time, such as vaccinations or routine screenings. This failure could exacerbate the spread of COVID-19 throughout the prison, as older adults would unknowingly transmit the virus to others, regardless of age.

Research Design and Methods

Independent Variable

My independent variable is the quality of care based on access to medical practitioners and the timeliness that chronic care patients receive help at each CDCR-run prison. I am measuring this

based on medical inspection reports made by the Office of the Inspector General between 2019 and 2024, specifically, the questions about chronic care follow-up appointments: was the patient's most recent chronic care visit within the healthcare guideline's maximum allowable interval or within the ordered time frame, whichever is shorter, did the patient receive all chronic care medications within the required time frames or did the institution follow departmental policy for refusals or no-shows, and are required immunizations being offered for chronic care patients? Each question will be measured in the percentage of observed times the Office of the Inspector General noticed that the care was followed.

Dependent Variable

My dependent variable is the population of total incarcerated individuals at each of the CDCR prisons who have reported the number of cases and deaths caused by COVID-19. CDCR reports on COVID-19 as a combined total from 2019 until now. I then divided the COVID-19 cases into the average incarcerated population of each CDCR-run prison from 2020 to 2022. This gave me the number of COVID-19 infections per 1,000 incarcerated individuals in each California prison.

Control Variables

When analyzing the data, I will control for the average percent capacity from 2019 to 2024, found on CDCR's website under population reports and security level. These factors change the quality of healthcare that a prison is able to achieve. Knowing whether and by how much a prison is under, at, or overcapacity will impact the spread of disease and workload for medical professionals. Security level also affects healthcare because maximum security prisons prioritize detainment and safety over health and thus would be an attribute that needs to be factored in. Lastly, gender is a controlling factor because females tend to live longer and experience different

health conditions or have higher chances of certain diseases than men. Women incarcerated individuals of all ages have also been shown to use healthcare services more frequently than men (Williams, 2012). I will be able to account for this variable by comparing just the California prisons that are dedicated to incarcerated women separately from the rest of the men's California prisons.

Design Structure

My unit of analysis is California state prisons. I will analyze 32 of the CDCR-run prisons, and I will compare them against each other. I will be considering how population size, capacity, and security level have an impact on healthcare services within prisons. I will be studying multiple cases, individual California prisons, over a single point in time, the duration of COVID-19. I will analyze data from 32 adult prisons managed by the CDCR, two of which were female-only prisons, the California Institution for Women and Central California Women's Facility. Deuel Vocational Institution was the only prison not included, as it closed in September 2021. The study covers data from 2019 to the present to capture the entirety of the COVID-19 pandemic. The study is limited to California, specifically the facilities managed by CDCR.

Pearson's Correlation

In order to analyze the relationship between the availability of chronic care and the total number of COVID-19 cases at each CDCR-run prison, I used Pearson's correlation since both variables are continuous. I correlated the number of COVID-19 cases per 1,000 incarcerated individuals to each of my independent variables. I also calculated the P-values for each Pearson's correlation.

Findings

Figures

To represent my findings, I created three scatterplots relating to my independent variables regarding care quality compared to COVID-19 infection rates per 1,000 incarcerated individuals. They represent the percentage of chronic care follow-up appointments completed (Figure 1), the percentage of chronic care medications delivered on time (Figure 2), and lastly, the percentage of chronic care immunizations offered (Figure 3). Each dot represents one CDCR prison as an observation of the percent adherence to the prison medical facilities followed through the OIG medical inspection recorded.

Figure 1 demonstrates that prisons in California during the pandemic were completing follow-up appointments in a timely manner, typically more than 50 percent of the time. However, Figure 2 data points were huddled between 5 and 10 percent of observed medications received, resulting in a much lower mean and median than Figure 1 or 3. Lastly, Figure 3 had the highest mean and median at roughly 80 percent of observed immunizations offered but also had the biggest range of 88.9.

It was concerning to note that chronic care patients were at most receiving daily chronic care medications at a 32 percent rate or not at all. Since medications that an individual must take daily regulate their biological functions, missing a regular schedule to take them would disrupt the body's homeostasis. This would negatively impact an individual's daily functioning, which for individuals who already have a chronic condition leaves them even more vulnerable to COVID-19 or with worsening physical symptoms.

I observed only one outlier total located in Figure 3 from Ironwood State Prison, where they offered immunizations to chronic care patients at only 11.10 percent. However, this outlier did

not impact my data significantly; if I removed it, the trendline and relationship stayed roughly the same.

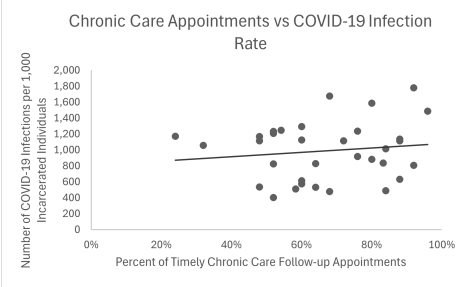

Figure 1. Data Sources: OIG and CDCR Population COVID-19 Tracking

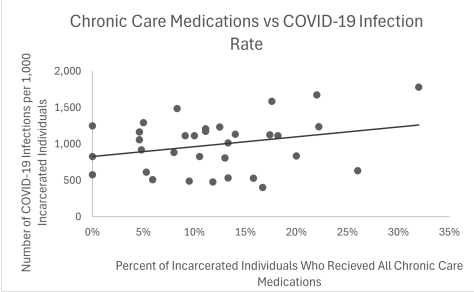

Figure 2. Data Sources: OIG and CDCR Population COVID-19 Tracking

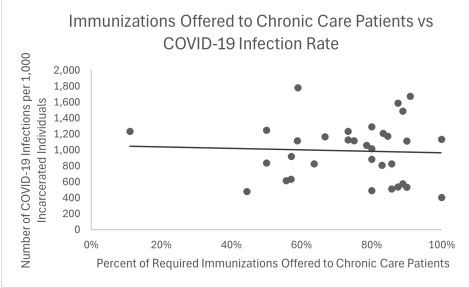

Figure 3. Data Sources: OIG and CDCR Population COVID-19 Tracking

Results and Discussion

My research found a weak positive correlation between the percent of observed chronic care follow-up appointments (Figure 1), where r equaled 0.13, and timely medications received (Figure 2), where r equaled 0.27, compared to COVID-19 infection rates. However, both correlations were insignificant, as the p-values were 0.47 and 0.12, respectively. Although, since Pearson's correlation for timely medications was 0.27 and the p-value was 0.12, this is statistically suggestive that timely medications may affect COVID-19 infection rates. The results were the opposite of what I expected, as there was a positive association instead of a negative one between better chronic care and COVID-19 cases.

While my research did not support my hypothesis, it did highlight the complexity of COVID-19 care within correctional facilities, as COVID-19 had many confounding variables that shaped the outcome of infection rates in California prisons. An implication of Figure 1 and Figure 2 is that California prisons with more individuals who are classified as high-risk due to preexisting health conditions would experience higher rates of COVID-19 transmissions because high-risk populations may have more health vulnerabilities. Therefore, it is one possible explanation for the positive relationship between chronic care recipients and COVID-19 cases.

Prisons with better chronic care ratings reported higher COVID-19 infection rates. This is likely because they can more accurately identify and report COVID due to better testing protocols, more reliable diagnostic tools, and systems in place to track and document infections among the incarcerated population. This was supported by my control variable, prison overcrowding, as prisons with adequate healthcare ratings, as reported by the OIG on the overall quality of care in each California prison, had a positive relationship between overcrowding and COVID-19 cases, which was expected as overcrowding encourages transmission rates. However, when prisons

with inadequate healthcare ratings were analyzed, the inverse was true, with a negative relationship between prison overcrowding and COVID-19 cases.

This would suggest that prisons with better healthcare more accurately reported COVID-19 cases, as the observed positive correlation between overcrowding and COVID-19 infection rates aligns with established research showing that overcrowding exacerbates disease transmission (Varshney, 2022). In contrast, the inverse relationship observed in prisons with inadequate healthcare ratings is likely inaccurate and reflects underreporting or insufficient tracking, which could mask the true extent of COVID-19 cases in these facilities. Without this measure, the contradictory results regarding my independent variables would have remained unexplained, obscuring the influence of systemic factors like reporting accuracy.

Additionally, there was no correlation between immunizations offered to chronic care patients and COVID cases (Figure 3), as r equaled -0.05, and the p-value was 0.79. An alternate explanation would be to inspect staff vaccine rates. Regardless of whether incarcerated individuals are immunized, if the staff is not, then there still will be a high disease transmission rate as vaccines are not infallible. Since there are reports that highlight correction officers had low vaccine rates and vaccine hesitancy, and the fact that most COVID diseases brought in were staff, it is likely the absence of a relationship between immunizations offered and COVID transmission rates is due to correctional officers and other prison staff's vaccine acceptance (Kerrison, 2023).

Thus, while there is a pressing need to address older incarcerated individuals' welfare to match their population growth, the data is questionable. This is concerning because we already have limited research on older incarcerated individuals. If the existing data is questionable, it leaves us

with an even more significant knowledge gap, making it nearly impossible to effectively address their growing healthcare needs.

Research Implications

Future research should consider the lack of consistent data as they examine older incarcerated individuals' healthcare. To even start to address the needs of the aged incarcerated population fully, the first step needs to be examining older incarcerated individuals as a separate age group within research. Right now, there is no standard in the United States for what is defined as an older incarcerated individual, leading to inconsistent categorizations (Skarupski, 2018). Most research considers 55 and older geriatric in a prison environment, but others across the nation might use 50 and older or 65 and older, leading to varying data results that are not easily comparable. There is essentially a void in reliable and comparable research across the United States in which researchers can effectively look at the needs of older incarcerated individuals.

In addition, in criminal justice research, juveniles are often looked at separately, and their data is segregated from adults due to their differing cognitive and mental needs. I argue that those considered geriatric also have differing mental and physical needs than the rest of adults. It would be beneficial to separate them to examine how those differences lead to diverging needs.

Essentially, the insufficient research for the older incarcerated individual cohort leads to a lack of understanding between incarcerated individuals and prison staff. As a result, misunderstandings, escalations, and excessive use of force may occur due to a lack of patience and training for such staff (UCLA, 2023). My findings further highlight that even when there is some data, there is variance in California prisons with how accurate the data is. Once consistency in reporting

occurs, research can examine the long-term impact older incarcerated individuals experience while in prison.

Research Extensions and Limitations

My research's limitation revolved around the lack of access to detailed prison healthcare data in which age was considered. There was no data on health outcomes for older incarcerated individuals, such as hospitalizations, time spent waiting to see a nurse, or the number of chronic illnesses per CDCR-run prison.

Additionally, I try to broadly compare incarcerated individuals 55 and older and how they differ at state levels, such as compassionate release numbers for aged individuals or percent mortality. I even tried looking for specific hospice programs, palliative care, specialized training, and chronic care clinics, and there was a significant absence of data in these areas. Thus, I could only find data on chronic care percentage and COVID-19 cases. Even with the COVID-19 cases, they were not separated by age. This means my data does not explicitly look at older incarcerated individuals in California prisons, but more like the relationship between healthcare for chronic care patients and spikes in COVID-19 in those certain prisons. While this is still valuable information and gets at the foundational issues that older incarcerated individuals face while in California prisons, it is not a direct examination of these issues. As such, it is tough to understand and assist aged incarcerated individuals.

If I could do this research again, I would give myself more time to collaborate with the CDCR to get pertinent information, such as the percentage of high-risk patients and most common chronic illnesses, and compare this to chronic care percent adherence. I would also examine the difference between prison institutions with basic or intermediate-level healthcare. Basic care

institutions in California prisons offer primary and urgent care to incarcerated individuals and limited consultations, while intermediate care facilities offer additional specialized consultations like oncology (*CCHCS Fact Sheet*). The best research will likely result from a direct collaboration with California prisons due to the lack of available specific public data.

There were also limitations to my dependent variable. I did not have data on the number of unique individuals who contracted COVID. Thus, the number of COVID-19 infections per 1,000 incarcerated individuals had a rate that was higher than 1,000 in most prisons. Most likely, the number of COVID cases included reinfection rates for the same individuals and did not factor in the rate between individuals who entered a prison versus the number who were released. Thus, the data could be off because each prison had an unaccounted-for variance in the number of incarcerated individuals leaving or entering the prison. This movement of individuals in and out of prisons creates inconsistencies in infection tracking, making it difficult to determine the true prevalence of COVID-19 among the incarcerated population. Additionally, not knowing how reinfections were tracked would hinder the ability to draw precise conclusions about the spread of COVID-19 in relation to healthcare quality and emphasize the need for more detailed and standardized reporting methods across all facilities.

Conclusion

This research highlights the urgent need to address the unique healthcare challenges of older incarcerated individuals within California's prison system. The findings underscore significant systemic deficiencies, including poor chronic care management, underprepared facilities for aging populations, and inadequate data collection standards. My research revealed weak correlations between chronic care percent adherence and COVID-19 infection rates, suggesting that better care systems may enhance disease reporting and do not necessarily reduce infection

rates. This outcome emphasizes the complexity of healthcare delivery in correctional environments, particularly during pandemics.

Older incarcerated individuals face compounded risks due to chronic illnesses, a higher prevalence of infectious diseases, and structural barriers such as overcrowding and lack of geriatric-trained medical staff. These inadequacies not only exacerbate health disparities but also contribute to ethical and financial concerns, violating the Eighth Amendment and significantly increasing healthcare costs. Moreover, the lack of comprehensive data on this population inhibits evidence-based policymaking and reform.

The broader impact of this work lies in its potential to inform policies aimed at improving the healthcare system within prisons. By acknowledging the absence of data for older incarcerated individuals and advocating for the inclusion of geriatric care, my research supports understanding how to uphold the rights and dignity of the aging incarcerated populations. There is also the need for interventions such as expanded compassionate release programs and dedicated geriatric facilities beyond volunteer aid, which could reduce prison housing costs while improving healthcare quality.

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