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Prisons and COVID-19: A Desperate Call for Gerontological Expertise in Correctional Health Care

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Abstract

The large and continued growth of the older adult population within U.S. prisons affects not only criminal justice policy and correctional health practice, but also gerontology. Amidst the unfolding COVID-19 crisis, associated knowledge and skills surrounding older adulthood will be critical to assuring the needs of older adults incarcerated in prisons are met during their detention, while undergoing off-site intervention in community settings, and when preparing for release. We outline several key areas for which gerontologists and associated practitioners are especially well suited in the effort to curtail morbidity and mortality driven by the disease caused by the novel coronavirus. Critical gerontological knowledge and skills needed in prison health care include awareness regarding the unusual clinical presentations of COVID-19 among older adults, deconditioning among older adults due to immobility, challenges in prognostication, and advance care planning with older adults. Specific, targeted opportunities for gerontologists are identified to reduce growing risks for older adults incarcerated in prisons.

Keywords: COVID-19, Correctional health, Prison

We cannot stem the COVID-19 pandemic in communities without controlling it in prisons, and we cannot control it in prisons without gerontological expertise. The number of older adults incarcerated in U.S. prisons has grown dramatically: More than 170,000 individuals aged 55 or older reside in U.S. prisons (Bronson & Carson, 2019), an increase of nearly 300% over the past decade alone (Bronson & Carson, 2019; McKillop & Boucher, 2018). The rapid spread of COVID-19 in prisons is particularly dangerous due to the disproportionately high rates of chronic medical conditions among all incarcerated persons and especially among older adults. Common chronic conditions among older adults in prisons include cardiovascular disease, obesity, diabetes, and hypertension (Prost et al., 2020; Williams et al., 2012), as well as substance use and mental health problems (Haugebrook et al., 2010). Geriatric conditions, including functional and cognitive impairments, are also present among older adults at higher rates and at younger ages than in nonincarcerated populations (Williams et al., 2012). Combined, the advanced age and poor health of many older adults in prisons place them at elevated risk of hospitalization, intensive care unit placement, and death if infected with the novel coronavirus.

All incarcerated persons face an increased risk of being infected with COVID-19 than persons in most community settings as social distancing is virtually impossible in carceral spaces. Most U.S. prisons operate at or above population capacity (World Prison Brief, 2020) making them tragically ideal congregate environments for the swift spread of the novel coronavirus. Persons in these settings sleep, toilet, bathe, eat, and work in very close quarters, expediting infectious disease transmission (Maruschak et al., 2009). To date, nine of the 10 "hotspots" in the United States are in prisons or jails (*New York Times*, 2020) and nearly 50,000 infections have been reported across state prisons and the Federal Bureau of Prisons (BOP; COVID Prison Project, 2020; BOP, 2020a; *New York Times*, 2020). Approximately 4,957 of these prison cases represent only one state: Aggressive testing in Ohio revealed that in two state prisons, more than 80% of the incarcerated population has COVID-19 (Ohio Department of Rehabilitation and Correction, 2020).

The increased burden of disease among persons in prisons has dire consequences for prison infirmaries which have limited acute care capacity and rely on transfer to outside community hospitals for care of patients with serious illness (Williams et al., 2020). Such transfers can quickly overwhelm nearby community hospitals (many of which are small and rural). Worse, few prison health care professionals have specialty training in geriatrics or palliative care, knowledge and skills needed desperately to combat the COVID-19 emergency. We describe the critical gerontological knowledge and skills needed by prison health care professionals to meet the challenge of providing appropriate care for older adults in prisons during the COVID-19 pandemic, and call on our colleagues in gerontology to establish and maintain partnerships with correctional health care professionals to help address the growing geriatric health crisis in prisons.

Gerontological Knowledge and Skills Needed in Prison During COVID-19

Unusual Clinical Presentations of COVID-19 Among Geriatric Patients

As in community settings, prison health care professionals are encouraged to "cohort" individuals or create "mini-communities" and to reduce contact between cohorts (AMEND, 2020). Furthermore, prison health care professionals must engage in rapid medical isolation of suspected COVID-19 patients while testing occurs to halt large-scale outbreaks. However, medical isolation is contingent on symptom identification; yet, it is common for acute infectious illness to present atypically in older adults (e.g., new-onset lethargy, anorexia, or falls; Perissinotto & Ritchie, 2014). Though COVID-19 symptom identification remains fluid, there is some indication that the presentation of the disease caused by the novel coronavirus is distinct in older persons including general malaise, tachypnea, tachycardia, or a decrease in blood pressure (D'Adamo et al., 2020). Some reports indicate that while older adults may present with cough and fever, other older adults may appear "off" or unlike themselves (Graham, 2020). Older adults may present with altered mental status and seem disorientated or confused (D'Adamo et al., 2020) or their eating and sleeping patterns may be affected (UCSF Health, 2020). Compounding this, older patients with cognitive impairment may be unable to report symptoms of COVID-19.

Disparate presentation of COVID-19 may be due to the presence of other health conditions common in persons aged 55 or older, though research in this area is still evolving (Graham, 2020). However, frequent assessment for stealth COVID-19 combined with a low threshold for testing all older adults in prisons should be the norm. And as these critical insights may be absent among prison health care professionals, gerontological experts can be integral to increasing such awareness among professionals working behind bars to avoid missing infection in older adults and thus contributing their worsening condition and to the spread of the disease.

Functional Status Changes That May Arise Due to COVID-19 Among Geriatric Patients

Regardless of age or infection status, the COVID-19 pandemic has resulted in reduced mobility for all who are incarcerated. Environmental measures used to curtail COVID-19 outbreaks in these settings vary, but often include long-term, institution-wide lockdowns, exceedingly lengthy cell commitment compared to pre-COVID-19, and at times, placement in solitary confinement (Blakinger, 2020; Shaprio, 2020). By the second week of April 2020, more than 300,000 persons now reside in partial or full lockdown in prisons throughout the country (Blakinger, 2020). Since March 31, every institution at the federal level has been on effective lockdown: "inmate internal movement is suspended with limited exceptions" (BOP, 2020b, para. 2). In Ohio, 26% of incarcerated persons are currently quarantined, with six of its prisons operating under institution-wide quarantines (Ohio Department of Rehabilitation and Correction, 2020). In Washington, reports indicate that individuals are confined to cells without windows for nearly the entire day (Blackwell, 2020). Incarcerated persons are often prevented from engaging in normal prison activities, including recreation and programming, and are forbidden access to common areas such as mess halls or dayrooms. In Connecticut, even showers have been shut down for those in quarantine (Fitch, 2020).

Given older adults' susceptibilities to deconditioning due to prolonged immobility, such restrictive measures impose unique health risks for those older than 55 years

incarcerated in prisons. Lockdowns in the setting of COVID-19 may last for weeks or months at a time. These dramatic changes in daily activity can lead quickly to decreased muscle strength and mass—linked to increased risk of falls—a reduction in independent activities of daily living and cognitive decline (Falvey et al., 2015). Thus, prison health care professionals require support from gerontological experts to identify those patients at greatest risk of decline, particularly during periods of inactivity in response to COVID-19, to develop and disseminate information regarding in-cell exercise, and to identify and encourage opportunities to optimize continued mobility in this older, vulnerable population.

The Art and Science of Prognostication

Harnessing both scientific evidence and clinical judgment to render a prognosis is a difficult task for all clinicians and remains a challenging skill under even the best of circumstances when working with older adults in prisons (Prost & Williams, 2020). Some of this difficulty is driven by challenges with prognostication in all older adults such as high levels of co- and multimorbidity (Matzo, 2004). In one study, physician prognosis predictions were on target a mere 20% of the time and both overly optimistic and pessimistic survivorship estimates were common (Christakis & Lamont, 2000). However, additional challenges such as a distrust of formal health care professionals among persons who are incarcerated may complicate prognostication (Kanbergs et al., 2019). For example, limited trust in prison health care professionals may limit self-reporting of symptoms which can fog an already opaque task. During the COVID-19 pandemic, prison clinicians must identify patients quickly who are at particularly high risk of poor health outcomes—whether due to COVID-19 or the restrictive environmental measures used to prevent or manage the outbreak—to be considered for early medical or "compassionate" release. And because many of these release mechanisms dictate a specific prognosis is detailed in the application (often less than 1 year; Holland et al., 2018), prison health care professionals will require specialized training and support from gerontologists and geriatricians to identify patients with poor prognosis, enumerate associated predictions and appropriate rationale, and communicate that rationale to necessary prison leadership and judicial personnel.

Advance Care Planning

Advance care planning in prison may bring about setting-specific issues. End-of-life discussions with persons who are incarcerated have revealed complex feelings, including grief over losses specific to incarceration: a future without freedom, separation from loved ones, loss of decision-making powers, and threats to feelings of safety and control (Sanders & Stensland, 2018). Yet it is crucial that these conversations—focusing on goals of care and identification of a health care proxy—occur prior to the precipitous decline experienced by many patients with COVID-19. Prison health care professionals have reported insufficient knowledge and skills regarding how to engage in advance care planning with their patients in prisons (Ekaireb et al., 2018). As gerontologists are skilled communicators and experts at training, they are needed to empower prison health care professionals to engage in these critical discussions with their older adult patients in the midst of the pandemic.

A Call to Gerontologists to Help Stem the COVID-19 Pandemic Among Geriatric Patients in Prisons

Contrary to popular belief, prisons are not isolated from the communities in which they are located. Hundreds of thousands of correctional personnel (administrators, security, and health care staff) cycle through these facilities daily. Gaps in knowledge and skills among prison health care professionals regarding older adults will have dire consequences for the incarcerated population, staff, and the surrounding communities (Volpenhein & Candisky, 2020). Limited knowledge regarding deconditioning may lead to an even further debilitated incarcerated older adult population, while lack of knowledge surrounding atypical disease presentation in older adults could increase the risk of spread to those who are incarcerated and to staff alike. Inadequate skills in prognostication may result in continued incarceration and therefore elevated risk of developing COVID-19 in many older adults who are eligible for release, while lack of knowledge about advance care planning conversations will result in avoidable suffering.

While the rapid aging of the prison population has become central to criminal justice policy and correctional health practice in recent years (Williams et al., 2012), COVID-19 serves as a potent reminder that knowledge and skills surrounding older adulthood are essential to reducing the risk of a large-scale public health crisis in prisons *and* communities. While the expertise described herein may be perceived as somewhat basic by leaders in geriatrics and gerontology, such expertise is needed desperately in prison health care settings during the COVID-19 pandemic. We call on our colleagues in gerontology and geriatrics to take action: bring your specialized knowledge and skills to your colleagues who are working behind bars; become advocates for the health and safety of all who live and work within prison walls and beyond for you are greatly needed.

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Conflict of Interest

None declared.

References

AMEND. (2020). *Limiting COVID-19 transmission and mitigating the adverse consequences of a COVID-19 outbreak in correctional settings: Release Cohort Test*. https://amend.us/wp-content/uploads/2020/05/release-cohort-test.amend_.ucb_.pdf

Blackwell, C. (2020). *What coronavirus quarantine looks like in prison*. The Marshall Project. https://www.themarshallproject.org/2020/03/18/what-coronavirus-quarantine-looks-like-in-prison

Blakinger, K. (2020). *What happens when more than 300,000 prisoners are locked down*? The Marshall Project. https://www.themarshallproject.org/2020/04/15/what-happens-when-more-than-300-000-prisoners-are-locked-down

Bronson, J., & Carson, E. A. (2019). *Prisoners in 2017*. US Department of Justice, Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/p17.pdf

Christakis, N. A., & Lamont, E. B. (2000). Extent and determinants of error in doctors' prognoses in terminally ill patients: Prospective cohort study. *BMJ (Clinical Research ed.)*, **320**(7233), 469–472. doi:10.1136/bmj.320.7233.469

COVID Prison Project. (2020). *National COVID-19 statistics*. https://covidprisonproject.com/data/data-v2/

D'Adamo, H., Yoshikawa, T., & Ouslander, J. G. (2020). Reply to Wachholz and Jacinto. *Journal of the American Geriatrics Society*, **68**(6), 1169–1170. doi:10.1111/jgs.16544

Ekaireb, R., Ahalt, C., Sudore, R., Metzger, L., & Williams, B. (2018). "We Take Care of Patients, but We Don't Advocate for Them": Advance care planning in prison or jail. *Journal of the American Geriatrics Society*, **66**(12), 2382–2388. doi:10.1111/jgs.15624

Falvey, J. R., Mangione, K. K., & Stevens-Lapsley, J. E. (2015). Rethinking hospital-associated deconditioning: Proposed paradigm shift. *Physical Therapy,* **95**, 1307–1315. doi:10.2522/ptj.20140511

Federal Bureau of Prisons (BOP). (2020a). *BOP implementing modified operations*. https://www.bop.gov/coronavirus/covid19_status.jsp

Federal Bureau of Prisons (BOP). (2020b). *COVID-19 cases*. https://www.bop.gov/coronavirus/

Fitch, M. (2020). *Showers "Off Limits" for prisoners housed in COVID quarantine units*. Yankee Institute for Public Policy. https://yankeeinstitute.org/2020/05/14/showers-off-limits-for-prisoners-housed-in-covid-quarantine-units/

Graham, J. (2020). Seniors with COVID-19 show unusual symptoms, doctors say. *Kaiser Health News*. https://khn.org/news/seniors-with-covid-19-show-unusual-symptoms-doctors-say/

Haugebrook, S., Zgoba, K. M., Maschi, T., Morgen, K., & Brown, D. (2010). Trauma, stress, health, and mental health issues among ethnically diverse older adult prisoners. *Journal of Correctional Health Care,* **16**, 220–229. doi:10.1177/1078345810367482

Holland, M. M., Prost, S. G., Hoffmann, H. C., & Dickinson, G. E. (2018). US department of corrections compassionate release policies: A content analysis and call to action. *OMEGA—Journal of Death and Dying*, **81**(4), 607–626. doi:10.1177/0030222818791708

Kanbergs, A., Ahalt, C., Cenzer, I. S., Morrison, R. S., & Williams, B. A. (2019). "No one wants to die alone": Incarcerated patients' knowledge and attitudes about early medical release. *Journal of Pain and Symptom Management,* **57**, 809–815. doi:10.1016/j.jpainsymman.2018.12.335

Maruschak, L. M., Sabol, W. J., Potter, R. H., Reid, L. C., & Cramer, E. W. (2009). Pandemic influenza and jail facilities and populations. *American Journal of Public Health,* **99**, S339–S344. doi:10.2105/AJPH.2009.175174

Matzo, M. L. (2004). Palliative care: Prognostication and the chronically ill: Methods you need to know as chronic disease progresses in older adults. *The American Journal of Nursing,* **104**, 40–49. doi:10.1097/00000446-200409000-00022

McKillop, M., & Boucher, A. (2018). *Aging prison populations drive up costs*. Pew Charitable Trusts. http://www.pewtrusts.org/en/research-and-analysis/analysis/2018/02/20/aging-prison-populations-drive-up-costs

New York Times. (2020). Coronavirus in the U.S.: Latest map and case count. *New York Times*. https://nyti.ms/39jvJEY

Ohio Department of Rehabilitation and Correction. (2020). *COVID-19 inmate testing*. https://coronavirus.ohio.gov/static/reports/DRCCOVID-19Information.pdf

Perissinotto, C. M., & Ritchie, C. (2014). Atypical presentations of illness in older adults. In B. A. Williams, A. Chang, C. Ahalt, H. Chen, R. Conant, C.S. Landefeld, C. Ritchie, M. Yukawa (Eds.), *Current diagnosis & treatment: Geriatrics* (2nd ed., pp 30–34). McGraw Hill.

Prost, S. G., Archuleta, A. J., & Golder, S. (2020). Older adults incarcerated in state prison: Health and quality of life disparities between age cohorts. *Aging & Mental Health*. Advance online publication. doi:10.1080/13607863.2019.1693976

Prost, S. G., & Williams, B. A. (2020). Strategies to optimize the use of compassionate release from US prisons. *American Journal of Public Health,* **110**, S25–S26. doi:10.2105/AJPH.2019.305434

Sanders, S., & Stensland, M. (2018). Preparing to die behind bars: The journey of male inmates with terminal health conditions. *Journal of Correctional Health Care*, **24**(3), 232–242. doi:10.1177/1078345818780686

Shapiro, J. (2020). *As COVID-19 spreads in prisons, lockdowns spark fear of more solitary confinement*. NPR. https://www.npr.org/2020/06/15/877457603/as-covid-spreads-in-u-s-prisons-lockdowns-spark-fear-of-more-solitary-confinemen

UCSF Health. (2020). *FAQ: Coronavirus and older adult patients*. https://www.ucsfhealth.org/education/faq-coronavirus-and-older-adult-patients

Volpenhein, S., & Candisky, C. (2020). Inmates, staff worry about care as Marion prison becomes one of largest outbreaks in

U.S. *Marion Star*. https://www.marionstar.com/story/news/local/2020/04/20/marion-county-ohio-coronavirus-prison-outbreak-largest-us/5166499002/

Williams, B. A., Ahalt, C., Cloud, D., Augustine, D., Rorvig, L., Sears, D., & Walter, L. C. (2020). Correctional facilities in the shadow of COVID-19: Unique challenges and proposed solutions. *Health Aff*. doi:10.1377/hblog20200324.784502

Williams, B. A., Goodwin, J. S., Baillargeon, J., Ahalt, C., & Walter, L. C. (2012). Addressing the aging crisis in U.S. criminal justice health care. *Journal of the American Geriatrics Society*, **60**(6), 1150–1156. doi:10.1111/j.1532-5415.2012.03962.x

World Prison Brief. (2020). *Highest to lowest—occupancy level*. https://www.prisonstudies.org/highest-to-lowest/occupancy-level?field_region_taxonomy_tid=All