Research Open

Ageing Science & Mental Health Studies

Volume 6 Issue 2

Short Article

Aging Offenders, Mental Health and Reentry Challenges

Kimberly A. Houser* and Christine A. Saum

Department of Law and Justice Studies, Rowan University, 201 Mullica Hill Road, Glassboro, NJ 08020, USA

Corresponding author: Kimberly A. Houser, Rowan University, 201 Mullica Hill Road, Glassboro, NJ 08020, USA; Tel: 856-256-3939; **Email:** houser@rowan.edu

Received: February 24, 2022; **Accepted:** March 04, 2022; **Published:** March 05, 2022

Introduction

Older prisoners represent one of the fastest growing demographics in correctional facilities. Indeed, the number of state inmates aged 55 and older tripled from 2001 to 2016 comprising 13% of the total United States (U.S.) prison population [1-3]. The graying of our nation's prisons is estimated to continue as experts project older inmates will constitute one-third (over 400,000) of the total prison population by 2030 [4]; a trend that goes beyond U.S. borders [5,6]. By way of example, the United Kingdom reported a 159% increase in prisoners aged 50 to 59 and a staggering 243% rise in prisoners aged 60 and above over the past two decades [7]. Many of these older inmates will be released to the community requiring support and assistance with immediate needs such as food, housing and transportation; often neglected, however, are linkages to mental health (MH) treatment and related services. This is especially important since it is not likely that the MH needs of inmates were adequately addressed prior to release, nor is it likely that sufficient plans, if any, were made to monitor these needs upon reentry. While scholars argue that the correlation between MH and criminal behavior is largely indirect [8], we know that the mentally ill (MI), are more likely to return to prison when their conditions are not addressed in the community [9-11].

Literature Review

Statistics demonstrate the scope of the problem: a national survey finds that over two-thirds (68%) of older prison inmates report having a history of a MH disorder and almost one-quarter (22.6%) report to have experienced serious psychological distress (SPD) [9]. In addition to this, over one-quarter of inmates 55 and older report having a drug abuse or dependence disorder with nearly one-fifth reporting drug use at the time of their offense [12]. Estimates suggest, however, that only 40% of state prisoners and 26% of federal prisoners who met the threshold for past 30-day SPD reported they were receiving treatment [13], with their likelihood of receiving treatment on release being even lower [14,15]. Moreover, despite the importance, most leave prison with only several weeks of prescription medications and no plan in place for acquiring refills [16,17]. A survey on the transitional health care of released offenders reported that 13 states provided 2 weeks or less of prescription medication to MI offenders, 11 states dispensed enough for 30-days, and one state gave out a 2-month supply [17]. This is disconcerting when we consider that untreated or unmedicated persons with MI are at greater odds of clinical decompensation affecting all areas of life [16,18]. Moreover, most MI offenders have no health insurance on release with more than half (60%) reporting no benefits 8 to 10 months following discharge [19], further negating their ability to receive needed treatment in the community.

The strong link between long-term MH and poor physical health [20,21] means that for older offenders with MI, their clinical conditions are often further compromised by chronic health problems as they age. Indeed, older offenders are more likely to suffer from a variety of chronic diseases and comorbid disorders such as hypertension, heart disease, cancer and diabetes, with more than half reporting a minimum of one disability [13,22-24]. Additionally, older inmates' psychopathology may be compromised by impaired cognitive function [25]; the clinical and symptomatic nature of which can be further exacerbated by the incarceration experience [26]. Thus, coupled with the challenges related to their MH and physical health needs on reentry, intellectual deterioration can further compromise the social and/or occupational functioning of older offenders [25,27], all of which can severely hinder their ability to successfully reintegrate into society.

A related reentry challenge for aging offenders is their greater likelihood of experiencing disengagement from family and friends, reducing vital social support networks [28,29]. In their study of recently released prisoners in Massachusetts, [29] found social support to be weakest among older releasees and those with a history of MI and addiction; 40% of older offenders and 30% with MI and addiction reported no family support on release. This is not unexpected given that older offenders, particularly those with MH and substance use disorders are more likely to have experienced conflict with family and friends or be estranged due to extended periods of separation [29,30].

It is clear then, that in addition to the more typical challenges of reentry, older offenders with MI have complex and special long-term needs which are further compounded by physical health issues and social functioning that often worsens with age. This is particularly salient among offender populations as they have been found to prematurely age; this is also referred to as "accelerated aging", which defines the "threshold for older adults in this population to begin at 50 or 55" or in some studies even younger [31]. High-risk lifestyles (e.g., drug use, crime), socio-economic disadvantage, lack of preventative health care, and stressors of the carceral environment are said to age offenders physiologically 10 to 15 years beyond their chronological age [32-34].

Due to myriad problems and extensive medical needs, older offenders are one of the most expensive populations to house in prison, and therefore, we should be exceedingly focused on their reentry success. Indeed, it is estimated that institutional healthcare costs of geriatric offenders are two to three times that of younger inmates [23]. The Pennsylvania Department of Corrections (PADOC), for example, reports medication costs at an astronomical rate of $3.2 million per month for inmates 50 and older independent of other healthcare costs, along with three long-term special care units at a cost of $500 per day per inmate [35]. Moreover, those with MIs are more likely to have disciplinary problems [36,37] with associated institutional expenses estimated to exceed 9 million dollars each year in the U.S. [38]; additionally, misconduct often leads to longer stays in prison [11], increasing overall housing costs.

Mental Health Court and Reentry

We suggest expanding the use of mental health courts (MHCs) in facilitating the reentry process to help fill the gap in providing support, structure and resources to this vulnerable population. Based on the drug court model which focuses on problem-solving in a non-adversarial setting, MHCs offer individualized treatment plans along with judicial supervision in a supportive environment. In our experience working with Strategies That Result In Developing Emotional Stability (STRIDES), a federal MHC program in the Eastern District of Pennsylvania, the participants were assisted in all areas of life that went beyond what is typically provided in drug and most specialty courts such as linkages to treatment, housing and work opportunities. STRIDES' participants received help with acquiring driver's and occupational licensing, clothing and groceries, and they were connected with agencies and volunteers to assist with parenting, financial literacy and ancillary legal needs. We observed older offenders, who with the help of the STRIDES Program, were able to stay productive and successfully navigate the many challenges faced during the transition to community supervision. Thus, MHC teams comprised of judges, attorneys, supervision and treatment agencies that collaborate to provide the best outcomes for their participants are uniquely positioned to help older offenders with their myriad complicated issues.

MHCs can be an excellent adjunct to reentry for inmates with further criminal justice monitoring as part of parole/mandatory release programs and special initiatives for older inmates such as medical or elderly release programs. In addition to providing the much-needed support and services, MHC participants could earn time off supervision for successful participation, therefore limiting further involvement in the criminal justice system and producing cost savings. Moreover, MHCs have overall been found to reduce recidivism [39-43], the primary goal of reentry, but they also demonstrate success in other important areas including reductions in hospitalizations, increased medication compliance, and other indicators of mental health recovery as well as the lessening of criminogenic needs (e.g., pro-criminal attitudes, antisocial patterns) [44-46].

We are cognizant that even though there are over 450 MHCs in 46 states (as of yearend 2020; [47]), the ability of these courts to handle the burgeoning population of older MI offenders isn't realistic, thus, it is essential that potential participants are carefully selected based on those who would most benefit from the available services. Consideration could also be given to the utilization of other types of specialty courts (e.g., reentry courts, veterans' courts) that are able to serve the complex treatment and other needs of the MI and provide the necessary interventions to improve their reentry process.

"Absent significant changes in sentencing and release policies, the number of aging and infirm men and women confined in US prisons will continue to grow. The rising tide of aging prisoners in the United States makes imperative renewed and careful thinking about how to protect the rights of the elderly while in prison" [30]. While we agree with the argument made by Human Rights Watch, we suggest that these protections must extend beyond the prison walls to include reentry, community supervision and the entire reintegration process. Moreover, aside from more principled considerations, a concerted effort must be established to assist those who are advanced in age and in poor mental health so that we can make a more sensible use of limited financial and human resources and allow these often-neglected offenders to become productive members of society in a more dignified manner.

References

1. Carson EA (2020) Prisoners in 2019 (NCJ-255115). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
2. Carson EA, Anderson E (2016) Prisoners in 2015 (NCJ 25022). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
3. Carson EA, Cowhig MP (2020) Mortality in State and Federal prisons, 2001-2016 – Statistical tables (NCJ 251920). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
4. American Civil Liberties Unions (2012). At America's expense: The mass incarceration of the elderly. New York, NY.
5. Seaward J, Wangmo T, Vogel T, Graf M, Egli-Alge M, et al. (2021) What characterizes a good mental health professional in court-mandated treatment settings?: Findings from a qualitative study with older patients with mental health care professionals. *BMC Psychology* 9: 121.
6. Sodhi-Berry N, Knuiman M, Alan J, Morgan VA, Preen DB (2015) Pre- and post-sentence mental health service use by a population cohort of older offenders (≥45 years) in Western Australia. *Social Psychiatry and Psychiatric Epidemiology* 50: 1097-1110. [crossref]
7. www.parliament.UK (2020). Aging prison population.
8. Skeem JL, Winter E, Kennealy PJ, Louden JE, Tatar JR II (2014) Offenders with mental illness have criminogenic needs too: Toward recidivism reduction. *Law and Human Behavior* 38: 212-224. [crossref]
9. Bronson J, Berzofsky M (2017) Indicators of Mental Health Problems Reported by Prisoners and Jail (NCJ-250612). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
10. Houser KA, Saum CA, Hiller ML (2019) Mental health, substance abuse, co-occurring disorders, and 3-year recidivism of felony parolees. *Criminal Justice & Behavior* 46: 1237-1254.
11. James DJ, Glaze LE (2006) Mental health problems of prison and jail inmates (NCJ 213600). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
12. Bronson J, Stroop J, Zimmer S, Berzofsky M (2017) Drug use, dependence, and abuse among state prisoners and jail inmates, 2007-2009 (NCJ-250546). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
13. Maruschak LM, Bronson J, Alper M (2021) Survey of prison inmates, 2016 disabilities reported by prisoners (NCJ 252642). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
14. Lurigio AJ (2001) Effective services for parolees with mental illness. *Crime & Delinquency* 47: 446-461.

15. Petersilia J (2003) When prisoners come home: Parole and prisoner reentry. New York, NY: Oxford University Press.
16. Binswanger IA, Nowels C, Corsi KF, Long J, Booth RE, et al. (2011) "From the prison door right to the sidewalk, everything went downhill," A qualitative study of the health experiences of recently released inmates. *International Journal of Law and Psychiatry* 34: 249-255. [crossref]
17. Flanagan NA (2006) Transitional health care for offenders being released from United States prisons. *Canadian Journal of Nursing Research Archive* 36: 38-58. [crossref]
18. Mayo Clinic (2020) Schizophrenia.
19. Baillargeon J, Hoge SK, Penn JV (2010) Addressing the challenges of community reentry among released inmates with serious mental illness. *American Journal of Community Psychology* 46: 361-375. [crossref]
20. Kendrick T (1996) Cardiovascular and respiratory risk factors and symptoms among general practice patients with long-term mental illness. *British Journal of Psychiatry* 169: 733-739. [crossref]
21. Osborn DPJ (2001) The poor physical health of people with mental illness. *The Western Journal of Medicine* 175: 329-332. [crossref]
22. Gates ML, Staples-Horne M, Walker V, Turney A (2017) Substance use disorders and related health problems in an aging offender population. *Journal of Health Care for the Poor and Underserved* 28: 132-154. [crossref]
23. Schlager M (2013) Rethinking the reentry paradigm: A blueprint for action. Durham N.C.: Carolina Academic Press.
24. Skarupski KA, Gross A, Schrack JA, Deal JA, Eber GB (2018) The health of America's aging prison population. *Epidemiologic Reviews* 40: 157-165. [crossref]
25. Calipari ES (2018) Boosting motivation and cognitive deficits in mental illness.
26. Baidawia S, Trottera, O'Connor DW (2016) An integrated exploration of factors associated with psychological distress among older prisoners. *The Journal of Forensic Psychiatry & Psychology* 27: 815-834.
27. Hugo J, Ganguli M (2014) Dementia and cognitive impairment: Epidemiology, diagnosis, and treatment. *Clinics in Geriatric Medicine* 30: 421-442. [crossref]
28. Wyse J (2018) Older men's social integration after prison. *International Journal of Offender Therapy and Comparative Criminology* 62: 2153-2173. [crossref]
29. Western B, Braga AA, Davis J, Sirois C (2015) Stress and hardship after prison. *American Journal of Sociology* 120: 1512-1547. [crossref]
30. Human Rights Watch (2012) Old behind bars: The aging prison population in the United States. Washington, DC.
31. Bryson WC, Cotton BP, Barry LC, Bruce ML, Piel J, et al. (2019) Mental health treatment among older adults with mental illness on parole or probation. *Health Justice* 7: 4.
32. Aday RH (2003) Aging prisoners: Crisis in American corrections. Westport, CT: Praeger.
33. Aday RH, Krabill JJ (2012) Older and geriatric offenders: Critical issues for the 21st century. In L. Gideon (Ed.), Special needs offenders in correctional institutions (pp. 203-232). Thousand Oaks, CA: Sage.
34. Wahidin A, Aday RH (2010) Later life and imprisonment. In D. Dannefer & C. Phillipson (Eds.), The SAGE handbook of social gerontology (pp. 587-596). Thousand Oaks, CA: Sage.
35. Pennsylvania Department of Corrections (2020-2021) FY 2020-2021 Budget.
36. Houser KA, Welsh W (2014) Examining the association between co-occurring disorders and seriousness of misconduct by female prison inmates. *Criminal Justice & Behavior* 41: 650-666.
37. Houser KA, Belenko S, Brennan PK (2012) The effects of mental health and substance abuse disorders on institutional misconduct among female inmates. *Justice Quarterly* 29: 799-828.
38. Lovell D, Jemelka R (1996) When inmates misbehave: The costs of discipline. *The Prison Journal* 76: 33-44.
39. Anestis JC, Carbonell JL (2014) Stopping the revolving door: Effectiveness of mental health court in reducing recidivism by mentally ill offenders. *Psychiatric Services* 65: 1105-1112. [crossref]
40. Costopoulos JS, Wellman BL (2017) The effectiveness of one mental health court: Overcoming criminal history. *Psychological Injury and Law* 10: 254-263.
41. Hiday VA, Ray B (2010) Arrests two years after exiting a well-established mental health court. *Psychiatric Services* 61: 463-468. [crossref]
42. Lowder EM, Desmarais SL, Baucom DJ (2016) Recidivism following mental health court exit: Between and within-group comparisons. *Law and Human Behavior* 40: 118-127. [crossref]
43. McNiel DE, Binder RL (2007) Effectiveness of a mental health court in reducing criminal recidivism and violence. *The American journal of psychiatry* 164: 1395-1403. [crossref]
44. Campbell MA, Canales DD, Wei R, Totten AE, MacAulay WAC, et al. (2015) Multidimensional evaluation of a mental health court: Adherence to the risk-need-responsivity model. *Law and Human Behavior* 39: 489-502. [crossref]
45. Han W, Redlich AD (2016) The impact of community treatment on recidivism among mental health court participants. *Psychiatric Services* 67: 384-390.
46. Wells BC (2015) Why a federal mental health court? The District of Utah's pioneering rise court. *The Judges' Journal* 54: 14-17.
47. National Drug Court Resource Center (2021).

Citation:

Houser KA, Saum CA (2022) Aging Offenders, Mental Health and Reentry Challenges. *Ageing Sci Ment Health Stud* Volume 6(2): 1-3.