

Chapter 13

Management and Care of Older Offenders with Mental Illness (OOMI) in the Criminal Justice System



Michele P. Bratina

Introduction

Over the past century, the US population has seen a remarkable increase in the average life span for adults (49 years in 1900 vs. 78+ years in 2012; Arias, Heron, & Xu, 2016). As a result, the proportion of the population of older adults aged 60 and over in 2015 is projected to double by the year 2050—from 12% or 900 million to 22% or two billion people (World Health Organization [WHO], 2016). Given intersecting relationships between the aging process and changes in socioeconomic status, physical health, mental health, and overall emotional well-being, there are a host of issues to consider as communities prepare to meet the needs of this growing demographic group. Such needs may challenge traditional resources and may include specialized housing, employment, transportation, public welfare (prolonged income and other benefits), and continuity as it relates to accessing physical and mental health-care treatment services over the extended life course (Aday & Krabill, 2006).

This chapter provides a framework for understanding issues and challenges as faced by older offenders with mental illness (OOMI). It summarizes the literature in relation to the prevalence of mental health and related problems among older adults—and, in particular, the mental health needs of the geriatric incarcerated population. It also examines the current response to these needs by the criminal justice system and offers suggestions for the implementation of effective services.

M. P. Bratina (✉)
West Chester University, West Chester, PA, USA
e-mail: mbratina@wcupa.edu

Prevalence of Mental Health, Substance Abuse, and Traumatization

While the majority of older adults have relatively good mental health, “Over 20% of adults aged 60 and over suffer from a mental or neurological disorder (excluding headache disorders)” (WHO, 2016, para. 3). There are also significant cumulative effects of the lived experience for aging adults that lead to an increased vulnerability for the late onset of psychological and neurological conditions (and physical health problems) of varying severity; such conditions present the need for specialized services in the community (Aday & Krabill, 2006). This is particularly true for older adults who have been exposed to a compilation of early adverse traumatic events but who were somehow overlooked, undiagnosed, and reluctant to engage in treatment for a variety of reasons, including perceived stigma as it pertains to mental illness (Seligowski, Spiro, & Chopra, 2016; Maschi, Sutfin, & O’Connell, 2012).

According to the World Health Organization, the most common neuropsychological disorders diagnosed in individuals over 60 include dementia and depression (WHO, 2016). Anxiety disorders affect about 3.8% of older adults, and approximately 1% are affected by substance use problems—substance abuse also being overlooked and misdiagnosed with this population. Moreover, individuals aged 60 and older account for approximately 25% of all self-harm-related deaths (WHO, 2016, para. 3), with older males having the highest rates for suicide of all age groups (Centers for Disease Control [CDC], 2008).

Oftentimes, symptoms of mental health and cognitive conditions (depression, in particular) may be attributed to frailty or physical disabilities, and therefore, older adults can suffer prolonged periods without proper treatment. Lack of treatment engagement is particularly concerning since depression has been noted to exacerbate physical health conditions often diagnosed in the aging population, such as heart disease, stroke, and diabetes (National Institute of Health [NIMH], 2016).

Some additional risk factors related to mental health and substance use-related disorders among the elderly at any point in time include limited mobility and the subsequent inability to live independently, having poor physical health and chronic pain, and current exposure or vulnerability to stressors such as bereavement and victimization (Beristianos, Maguen, Neylan, & Byers, 2016; CDC, 2008). There is a growing body of literature regarding trauma and polyvictimization¹ as experienced across the life course, and studies suggest that a sizeable proportion of older offenders have significant histories of multiple victimizations and resultant trauma (*see* Box 13.1) (Maschi, Zgoba, Gibson, & Morgen, 2011; Ramsey-Klawnsnik & Heisler, 2014). Furthermore, research on the geriatric population reveals that one in ten individuals has been exposed to some form of elder abuse, including emotional abuse, physical violence, abandonment, neglect, or exploitation (sexual or financial) (WHO, 2016).

Older adults who have experienced significant and frequent traumatizing events are especially likely to also experience economic hardship and obstacles to stable

¹A concept well-referenced in the field of child abuse which refers to a person who is exposed to and/or experiences multiple or varied forms of violence, crime, and abuse; multiple victimizations.

Box 13.1 Research on Posttraumatic Stress Disorder (PTSD)² among Older Adults in Community and Correctional Settings

Rates of PTSD in the General (Community) Population

- Between 1.5% and 4% of individuals aged 60 and older have reported *current* PTSD, and 8% reported *lifetime* prevalence, generally.
- In one study of older male combat veterans (median age = 71), findings indicated a *lifetime* prevalence rate of 53% and 29% for *current* PTSD.
- In one community-based study of older females (mean age = 70), 72% of respondents reported having experienced at least one type of interpersonal trauma throughout their lives.

Source: Kaiser, Wachen, Potter, Moye, and Davison (2017).

Rates of PTSD for Incarcerated Persons

- Approximately 48% of female inmates and 30% of male inmates report a *lifetime* prevalence of PTSD; data suggest that sexual assault is the type of experience most likely to result in PTSD for both men and women who are justice-involved

Source: Reichert & Bostwick (2010) and Wolff, Huening, Shi, and Frueh (2014).

housing, income, and overall well-being (Gross, 2007). For these reasons, it is increasingly important for the early identification of mental health and related social problems and needs among aging adults, so that treatment engagement can be encouraged and services can be rendered in the community setting, if at all possible.

Utilization of Mental Health Services/Treatment Engagement

For many individuals in both community and correctional settings, behavioral health treatment is one of the primary pieces in the recovery process and may include medication management, counseling or therapy, substance abuse services, case management, and a host of other educational and therapeutic interventions (Bratina, 2017; National Alliance on Mental Illness [NAMI], 2017a, 2017b).

As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), for adults (18 years of age or older), mental health service utilization is related to the receipt of treatment or counseling for any problem with emotions, nerves, or mental health that was not related to substance abuse; treatment may be

²The DSM-5 indicates that PTSD may be diagnosed when a person experiences debilitating fear, anxiety, or avoidance as related to situations (“triggers”) that remind the individual of a traumatic event. Projected lifetime risk for PTSD at age 75 is 8.7% in the U.S.

rendered in any inpatient or outpatient setting and may or may not involve the use of prescription medication. According to results of the 2013 National Survey on Drug Use and Health (NSDUH), the number of adults who received treatment or counseling for past-year (2012–2013) mental health issues was 34.6 million; counseling was 38.1—increasing to 45.0% for those who had a “severe impairment” (SAMHSA, 2014). The utilization of mental health services varied among adults in 2013. Adults who used mental health services the year under evaluation were more likely to have serious mental illness and engage in outpatient treatment and least likely to be hospitalized in an inpatient facility. There were also utilization differences by gender, with females being more likely to engage in services, regardless of type.

Depending on funding and resources available in the locale, mental health and related treatment programs have been perceived as barely adequate in their ability to respond to the complex needs of the population; this may be due to a number of unavoidable barriers, including cost, lack of communication between providers-agencies, training deficiencies, and the absence of structured programs, to name a few (Aday & Krabill, 2006; Gross, 2007). There is also the high likelihood that individuals with mental health issues will not actively seek out services due to symptoms that are characteristic of their illness, personal financial barriers, or restrictions or because they do not have the knowledge as to available services (Hartford, Carey, & Mendonca, 2006). Lack of treatment engagement for older adults has been attributed to reasons related to fear of stigma and ridicule (Kaiser et al., 2016). Unfortunately, older adults with untreated or undertreated mental health-related problems may find themselves in a state of crisis, which could place them at an increased risk for encounters with law enforcement and further engagement with the criminal justice system. The following fictional account (Box 13.2) is illustrative of this point.

Box 13.2 The Case of “Alice”

Alice, a 70-year-old woman, has been residing at a nursing home for the past 3 months since her husband of 45 years died of cancer. As a young adult, it was suspected that she might have *major depressive disorder* (MDD, major depression), but she has never been formally diagnosed nor treated for the disorder. Alice is presently showing early stages of *major neurocognitive disorder* (dementia)³ while also battling a recent diagnosis of heart disease. Her son, Alex (an only child), travels often for work and is unable to care for his mom at home—though he tries to visit her at least once every 2–3 weeks when he is in town. For the past month, and for periods of about 2–3 days, Alice has refused to leave her room—preferring to remain in bed mostly and barely eating the meals brought to her by staff. Recently, the staff at the nursing home had

(continued)

³In the most recent iteration of the Diagnostic Statistical Manual, the DSM-5, dementia has been categorized as a major neurocognitive disorder (NCD) that is characterized by an acquired cognitive decline in one or more of the following cognitive domains: Learning and memory; Language; Executive function; Complex attention; Perceptual-motor; or Social cognition. Prevalence rates of dementia rise steeply with age, ranging from affecting 5–10% of individuals in their 70s to proportions of at least 25% and greater of individuals in their 80s and beyond (American Psychiatric Association, 2013).

Box 13.2 (continued)

organized a card game for the residents, and Alice showed interest in playing. For luck, she carried to the table an old rabbit's foot keychain that her son had given her years ago. Throughout the course of the games, she kept the keychain on the table and grasped onto it periodically. About 2 h into the activity, Alice left for the restroom; when she returned, the keychain was gone. Visibly shaken, Alice promptly stood up from the folding card table and attempted to push it over, causing cards and other items to fall to the ground and some of the other residents to become frightened—especially the three who were at her table. She began to stare at another female resident who had been sitting across from her and admiring the keychain—at one point asking to hold it (to which Alice refused). Now, Alice was convinced this woman, Ruth, stole her keychain, and so she began screaming accusations and frantically pacing back and forth, becoming increasingly disruptive. Staff became extremely uncomfortable with this response, and, although they began to calm Alice down, a resident called 911 and told the dispatcher that someone “was being attacked.” Soon after, four police officers arrived and two attempted to convince Alice to move into another room so that they might talk with her; the other officers spoke with staff and a few residents. Alice would not comply with the verbal requests to follow the officers and, instead, began moving around the room screaming obscenities and flailing her arms, knocking into cabinets and other items, and, last, striking one of the police officers with the back of her hand.

Over objections from staff and Alice's son, who had just recently arrived and spoke with one of the officers about his mother's mental health status, the officers decided Alice posed a great enough risk to herself and the other residents. Consequently, after a brief struggle to get her to comply, the officers transported Alice to the local ER for an involuntary mental health evaluation and possible detainment for up to 72 h.⁴

The irony of Alice's story is that this encounter with police and subsequent detainment (involuntary commitment) at the hospital may lead to effective treatment and management of her mental health issues. In fact, police and other first responders have often referred to detainment of persons with psychiatric symptoms as *mercy bookings* (Reisig & Kane, 2014). This reality leads one to consider the following questions: Is Alice truly a criminal or a mentally ill individual who committed a criminal act (assault/battery) due to symptoms related to the nature of her illness? Should the police have taken her to jail for booking instead of the hospital for evaluation? How does the criminalization of mental illness further stigmatize this population? What kind of training to criminal justice actors need to more effectively respond to the specialized needs of this growing population of adults?

⁴While fictitious, Alice's story is based on a real event that was recently reported in the *New York Times*. In the *Times*' account of the facts, the woman was handcuffed and placed in a patrol car after the incident (an alleged attack on another resident at an assisted living facility), and was released from the hospital 7 h after she was initially detained for psychiatric evaluation.

Justice-Involved Offenders with Mental Illness (OOMI)

Alice's story represents one possible outcome of a crisis encounter involving an older adult with mental health-related issues whose behavior, most likely related to symptoms of their disorder(s), makes them especially likely to make contact with law enforcement. The truth is that many OOMI do not fare well during such encounters. In fact, recent arrest statistics suggest that, despite drops in overall arrest rates over a 10-year period (2002–2012), the proportion of arrests involving individuals aged 55 and over has actually *increased* by 23% and, for those 65 and older, by 28% (Span, 2017). The reasons for this trend are not clear, as research on offender age as it pertains to police arrest decision-making is limited. Nevertheless, available reports indicate that there are a number of offender and incident characteristics, aside from age, that might contribute to police use of discretion in the arrest decision, including gender and demeanor of the offender, nature/seriousness of the offense, and community priorities (Aday & Krabill, 2006). In some cases, police may view their role as protectors of those who appear unstable and unable to care for themselves. In this way, they might respond more leniently toward older adults with whom they encounter when the offense is viewed as less serious (e.g., vagrancy or public intoxication) (Aday & Krabill, 2006; Brown, 1998). Conversely, some police may treat older offenders more harshly even for behaviors that appear to be less serious—especially if the individual is a repeat offender who has become a nuisance to the police and threat to the community (Aday & Krabill, 2006; Span, 2017; Wilbanks, 1988).

In the narrative presented above, Alice is depicted as having some kind of support system in place (e.g., her son). Unfortunately, many older adults with behavioral health and cognitive disorders who become entwined in the criminal justice system are forced to navigate multiple systems of care on their own and without financial means or access to other resources and supports (Aday & Krabill, 2006). Furthermore, in some cases, police or other first responders lack the experience, training, and knowledge necessary to more safely respond to calls involving older citizens who may have a host of issues related to aging and behavioral disorders (Gross, 2007). In such cases, older adults may face an increased risk for the possibility of an arrest, injury, or even death during an encounter with law enforcement (e.g., Beaufrère, Belmenouar, & Chariot, 2014). The following sample of incidents involving police and aging persons was retrieved from the national news and illustrates the need for specialized training as related to assessment of the behavior and motivations of older offenders.

- A 66-year-old Deborah Danner of Bronx, New York, who suffered from schizophrenia (and who had previous encounters with police due to her illness), was shot and killed by police Sergeant Hugh Barry after an altercation in her NY apartment. Barry and other officers were responding to a 911 call from a neighbor who stated that Danner was acting erratically. When police arrived at her apartment, they reportedly found Danner in a state of agitation, first holding a pair of scissors then a baseball bat, which she swung at Barry before he shot her twice (Rosenberg & Cohen, 2017).

- A 91-year-old resident of an assisted living facility in Florida was tased by police when punching, biting, kicking, and screaming at staff while demanding to leave the facility. The man was suffering from dementia (“Punta Gorda officer”, 2017).
- An 87-year-old Oregon woman with heart disease (and a pacemaker) who was believed to be suffering from dementia was tased by police in an altercation on her property that ultimately involved a call to the police. After she refused to comply with a police order to put down a semiautomatic handgun, the woman was tased and subsequently died at the hospital (Bella, 2010).
- A 73-year-old unarmed man with early stages of dementia was shot and killed by police in California near his home. Police were responding to a 911 call that the elderly man had a gun and that he was standing in a neighbor’s driveway shortly after midnight. When the suspect did not respond to police orders to stop and remove his hands from his pockets, deadly force was employed. No gun was found on the scene, but instead, a wooden crucifix for which the deceased man had in his possession (Almasy & Cuevas, 2016).

Despite the egregious nature of these incidents, there are theoretical reasons and some research support which suggest that police have been traditionally lenient when dealing with aging offenders (Aday & Krabill, 2006; Miller, 2011; Sugie, 2017). Again, depending on several factors, including the demeanor of the offender and the nature of the offense, police in most locales have several available options in terms of disposing of or diverting a case where mental health or cognitive ability may be in question, including the option to transport someone to a psychiatric crisis unit (voluntarily or involuntarily, if certain criteria are met) for a mental health evaluation (Bratina, 2017). If it is decided that arrest is the preferred option, officers should still be cognizant of potential risks of injury or death associated with the initial period of custody and detainment for the aging offender, and if possible, consideration should be given to specific physical and mental health needs (Beaufrère et al., 2014).

OOMI Incarcerated

Representing almost 20% of state and federal inmates, the geriatric inmate population is currently two to three times greater than what it was a decade ago (Office of the Inspector General [OIG], 2016; Maschi & Aday, 2014). Some of the reasons for this steady increase have been previously stated, and include an increase in the average life expectancy and a diminishing access to financial and other resources (employment, health care, housing options) for this group, which may lead to isolation from the larger society and participation in crime as a means of necessity (Sugie, 2017). For some older offenders, their offending behavior may be the result of untreated (or undertreated) trauma and mental health-related issues that led to a crisis event (violent or non-violent) involving the police and the need for secure detainment. Moreover, for others, the passage of “tough-on-crime” policies and stricter sentencing practices of former decades has resulted in them serving maximum sentences, thereby aging in prison with no prospect of parole (Nellis, 2010).

Regardless of the pathway to incarceration, the broad array of needs specific to the geriatric inmate population require correctional administrators and staff to respond to unique challenges, including:

- Provision of and access to adequate health care during confinement (including medical and mental health treatment and medication)
- Provision of programming for older inmates with histories of trauma/substance abuse
- Provision of structural or environmental accommodations/needs (e.g., housing for persons with disabilities)
- Offending and victimization among inmates and staff
- Terminal illness, stressors related to death and dying, and related policy decision-making (e.g., compassionate release)

While all of these issues create the need for administrative policy, staff training, and the need for avenues of financial support and other resources to more effectively manage and rehabilitate geriatric offenders, the costs to address and maintain proper intervention are substantial. Consequently, due to creative but largely unsuccessful methods to save costs (e.g., outsourcing psychiatric and medical care, requiring geriatric inmates to go off-site for certain procedures), there are incredible wait lists for treatment and other services and a perception—held by inmates and some members of the general public—that correctional facilities are failing in their duty to address the needs of aging inmates (Office of the Inspector General, 2016).

Costs of Incarceration

The average cost of incarceration reported at the federal level for any inmate was approximately \$31,000 in 2015 (Department of Justice, 2015). By comparison, the annual cost of housing an elderly prisoner is approximately \$70,000 (Human Rights Watch, 2012). As previously stated, similar to differentials in the community setting, a primary reason for the disparity in prison expenditures relates to the increasing number of older inmates who are serving life sentences and unique needs of the aging population—in particular, complex physical and mental health needs and terminal diagnoses (Maschi, Viola, & Sun, 2013).

Physical and Mental Health Needs of an Aging Inmate Population

Overall, older inmates are far less healthy than their younger incarcerated counterparts and their peers in the community setting. In particular, deficits related to the normal process of aging—such as sensory impairment, decreases in agility, and a loss of stamina—make adjustments to extreme environmental changes (such as

those present upon initial confinement in a jail or prison) increasingly complex, if not dangerous. For example, a loss of balance and sight degeneration may lead to falls, increasing the risk for significant injuries (Gross, 2007). Furthermore, extreme temperatures have been noted in correctional settings throughout the states, often causing inmates to suffer serious harm and, in some cases, death due to conditions such as heatstroke or hyperthermia (Blinder, 2016; Burnett, 2016). Due to weakened immune systems, older inmates are also especially susceptible to chronic illness and communicable diseases during their incarceration. The most frequently cited health conditions found among them include cardiovascular, musculoskeletal, respiratory, and psychiatric disorders; diabetes and hepatitis C are also found to be prevalent (Hayes, Burns, Turnbull, & Shaw, 2012; Gross, 2007).

Compared with the non-incarcerated aging population, older inmates are more likely to have a mental health-related disorder, including mood disorder, anxiety disorder, psychotic disorder, major depressive disorder (MDD), and personality disorder, as well as co-occurring substance use disorders. Particularly, depending on the data source, estimates show up to 20% of jail inmates, and 24% of state prison inmates report recent histories of having a diagnosable mental health condition, figures that are higher than the general population, and may even be conservative estimates (NAMI, 2013). For example, in their study of federal, state, and jail correctional populations, James and Glaze (2006) collected data derived from offender mental health history information and clinical interviews. Their conceptualization of “mental illness” not only included recent history but also current symptoms experienced; as a result, their findings indicated that rates of mental illness were 64% in jails and 56% and 45% in state and federal prisons, respectively. Older inmates experience significant risk factors and have also been found to commit suicide at a slightly higher rate than their younger counterparts (Gal, 2003). *See* Box 13.3 for gender-specific factors among incarcerated OOMI.

Rates of dementia among geriatric inmates are also expected to be higher than in the community setting due to biological and physical health deterioration and an accelerated aging process that is argued to be resultant from the extreme psychological and environmental risks of confinement (Gross, 2007; Maschi, Kwak, Ko, & Morrissey, 2012). Though an understudied area, existing data indicates prevalence rates that range between 1% and 44%, depending on characteristics of the correctional setting (Maschi et al., 2012).

Box 13.3 Gender-Specific Issues

Some of the issues found in common among incarcerated older women include chronic health conditions, histories of frequent victimization and traumatic events (sexual and physical abuse), high rates of mental health issues, and problems negotiating health care. In terms of major health problems, a substantial number of females suffer from either high or severe levels of depression, anxiety, and interpersonal sensitivity (Covington, 2001). With multiple health problems, many elderly female inmates report an increased fear of victimization, and that they do not receive (or are discouraged from seeking) adequate medical care (Reviere & Young, 2004; Williams et al., 2006).

Service Engagement

Data derived from a survey of adult state and federal community and confinement-based correctional facilities in the United States in 2000 indicated that an estimated 191,000 of the inmates surveyed had self-reported some form of mental illness as of midyear. Among the 191,000, 1 in every eight was receiving some type of mental health service. The data were further broken down by type of treatment, and reports indicated that a total of 1.6% of inmates across reporting institutions ($n = 17,354$) had received 24-h mental health care, 12.8% ($n = 137,385$) received therapy or counseling, and 9.7% ($n = 105,336$) had received psychotropic medication for their mental health-related illness, compared with 5% of the non-incarcerated population of persons with mental illness (PwMI) (Beck & Maruschak, 2001).

For a variety of reasons, mental health programming and related reentry services have not been prioritized in jail and prison settings, and therefore, issues such as a high incidence of mental health disorders and significant histories of trauma that far surpass that of their non-incarcerated counterparts have further taxed resources that were already sparse. Moreover, research suggests that offenders with mental illness are quite difficult to treat (Morgan et al., 2012), if not resistant to treatment overall (Lamb & Weinberger, 1998). Based on this resistance, and coupled with unique criminal histories that indicate the potential for violence (James & Glaze, 2006; Lamb & Weinberger, 1998), mental health providers are often reluctant to treat them to begin with (Lamb, Weinberger, & Gross, 1999). As a result, a growing number of justice-involved persons with mental illness needing treatment have not been able to obtain it to the extent necessary—an outcome that reflects the non-institutionalized population experience.

In contrast to offending populations without mental illness, the lack of program and service engagement for this group is sometimes related to collateral consequences of their incarceration or other involvement in the criminal justice system, such as the loss of Medicare, Medicaid, or disability benefits (NAMI, 2017a, 2017b). Since research indicates that inmates who have mental health problems are likely to spend an average of 4 months longer incarcerated than those without (James & Glaze, 2006), the urgency of treatment becomes more imminent.

Furthermore, research has revealed an accelerated aging process among prisoners, which may be credited to high-risk personal histories and further aggravated by the conditions of confinement and lack of adequate health services (Courtney & Maschi, 2013). For example, like their younger counterparts, incarcerated OOMI are likely to encounter a break in the continuity of medical or mental health care they had received in the community and a weakening support system over the period of their incarceration. In relation to general day-to-day life in a correctional setting, older inmates who are particularly vulnerable (having physical or other disabilities) are oftentimes subjected to various forms of victimization and emotional distress (Aday & Krabill, 2006; Gross, 2007; Maschi et al., 2011). To exacerbate these conditions further, correctional staff are often inadequately trained in the context of addressing aging inmate needs, which results in increased costs due to unaddressed physical/medical services and physical accommodations (OIG, 2016).

Collaborative Research with Aging Inmates in Pennsylvania

In an attempt to extend the research base, this author and a colleague from the field of social work/gerontology, Dr. Charlene Lane, collaborated on a research project in 2015 with inmates in the state of Pennsylvania. In particular, we collected data from geriatric inmates (conceptualized as adults 55 and older) who were incarcerated at four prisons located in various parts of the state. These specific locations were selected for two primary reasons: (1) to collect data from equal proportions of male and female older offenders and (2) the selected facilities were reported to hold the largest proportion of inmates aged 55 and older due to available accommodations specific to this population. The primary purpose of the study was to explore perceptions of aging in prison among older inmates, with particular focus on the inmates' physical and mental health status, as well as their perceptions of available services in response to these issues. Specifically, we were interested in answering the following research questions:

1. How do older incarcerated adults feel about aging in prison?
2. Do older incarcerated adults perceive their physical health needs are being met?
3. Do older incarcerated adults perceive their mental health needs are being met?

Over a 6-month period between December of 2014 and March of 2015, the research team met with 91 inmates who volunteered to participate in the study. As anticipated, participants included a relatively equal distribution of males (42 or 47%) and females (48 or 53%) (Gender was missing in one case). Their average age was 63 years (one respondent was over the age of 80) and the majority (56%) identifying as non-Latino and Caucasian/white. To address the research questions, we designed a questionnaire which contained a mix of closed- and open-ended questions; semi-structured interviews were conducted by both researchers to clarify survey responses and to allow respondents at all four facilities the opportunity to share additional information.

Approximately 95% of the inmates who responded reported having one or more of the following medical conditions: heart disease (19%), high blood pressure (65%), diabetes (29%), glaucoma (8%), macular degeneration (9%), dizziness (22%), breathing problems (37% and 20% reported having bronchitis), diverticulosis (4%), arthritis (54%), stroke (8%), cancer (14%), and some other medical conditions (41%). Close to half of all respondents (48%) reported they had been diagnosed at some point in their lifetime with an emotional or mental health problem; in fact, 22% reported having been hospitalized for mental health-related problems, and almost 30% reported having received community mental health services prior to their most recent incarceration. Thirty-four percent indicated that they were currently experiencing depression and anxiety, and 76% of the inmates indicated they were currently taking medication for mental health-related issues. The majority of the inmates in our sample reported a history of drug usage (63%), and 34% indicated they had used for a period of over 15 years. The most popular drug of choice was alcohol (43%), followed by marijuana (23%), heroin (17%), prescription drugs (6%), hallucinogens (3%), and "other" drugs (9%).

A preliminary analysis of responses to additional questionnaire items revealed findings consistent with those reported in previous research with OOMI, including an array of issues that seem to revolve around the following three themes:

- Substantial history of co-occurring substance and mental health issues (sometimes undiagnosed) prior to incarceration
- Unmet medical needs/inadequate services while incarcerated
- Unmet mental health needs/inadequate services while incarcerated

Medical Needs

As it pertains to the participants' medical and physical needs, there were mixed feelings expressed. In this case, older adults interviewed perceived that they are a population forgotten by the larger society because of dual stigmatization related to their age and criminalization. They expressed frustration in relation to what they perceived as a long wait time to receive medical attention, and some attributed this to perceptions held by the individuals who provide services. For example, there were several participants who expressed the belief that their medical needs—such as the need for dentures and updated prescriptions for eyeglasses—were not being adequately met because of society's view of crime and criminals, for which they ascribed as demeaning and dismissive.

Mental Health Needs

A substantial number of inmates expressed the belief that they were appropriately medicated for psychiatric-related disorders while incarcerated; in fact, some revealed that their incarceration led to diagnoses and treatment they would not have otherwise received in a community setting. Nevertheless, they had concerns about therapeutic needs that were not being met, including a lack of available programs for which they were eligible to participate. Moreover, there was some concern about continuity of care beyond the prison for those who would be released. They also speculated as to whether more accessible and effective health care in the community with regard to medications, treatment, and other services might have prevented the behavior that led to the most recent incarceration. Many inmates with and without mental health concerns reported remorse as it pertains to "getting caught up in the wrong crowd."

During some of the discussions, participants revealed reasons for initial incarceration that differed across gender lines. For example, there was a larger percentage of female inmates who disclosed being victims of physical trauma (physical and sexual abuse), which they attributed to their involvement with the criminal justice system and subsequent incarceration. Conversely, their male counterparts were more

likely to attribute their incarceration to gang affiliations, murder, and other circumstances related to interpersonal violence. While further examination is certainly warranted for factors leading to incarceration for both males and females, the substantial proportion of incarcerated women who reported histories of abuse and trauma is especially troubling—in particular, since trauma-informed treatment is still lacking in correctional settings to a large extent (OIG, 2016). As will be revisited below in the chapter summary, further research is necessary to determine long-term effects of early trauma on older females who are incarcerated and the most effective response in terms of treatment and the provision of immediate needs and services.

Summary

A significant growth in the US population of older adults has resulted in a significant increase in the number of geriatric individuals who are entering the criminal justice system, through increasing numbers of arrests and, for some, incarceration (Aday & Krabill, 2006; Gross, 2007). As a result of this growth, the prison system is experiencing a huge strain in terms of its ability to provide necessary and adequate resources and related expenditures. In particular, compared with their younger counterparts, aging inmates are more costly to incarcerate due to increasingly complex medical needs—including physical and mental health-related conditions that are oftentimes co-occurring with substance abuse/addiction (OIG, 2016). Prior to incarceration, many geriatric inmates have very high rates of health risk factors, some of which are related to environmental stressors and adverse events including trauma and victimization that may have occurred early and persisted over the life course; due to lack of engagement in treatment in the community, many of these problems follow them into the criminal justice system (Maschi et al., 2011).

Sadly, the aging population in prisons and jails does not have access to adequate medical and mental health treatment and services because of the lack of financial support, space, or physical accommodations that would help make the facility conducive to the mobility needs of aging offenders. Furthermore, even if the resources were available, many facilities lack the institutional staff and/or staff lack the specialized training that is necessary to implement more effective methods of managing this unique population (OIG, 2016).

Policy Recommendations

Based on gaps and identified needs in the overall system of care as pertaining to responding to the needs of older offenders with mental illness (OOMI), the following section outlines three specific policy goals that should be incorporated into the development of a comprehensive system of care. This information, as presented, can be used to more effectively identify persistent goals, objectives, and strategies that are reflective of the prioritized needs of this population.

Compassionate Release Programs

One response to the growing geriatric population—in particular, those who exhibit serious health conditions—has been the implementation of policy that provides for what is referred to as *compassionate release*. Compassionate release allows for the furlough or early release of inmates diagnosed with terminal or chronic long-term illness, and reentry program changes to accommodate the needs of this group. Underlying reasons for the development and incorporation of such programs really relate to cost savings and more effective correctional management—in brief, reducing overcrowding (OIG, 2016).

Unfortunately, due to the adoption of a restrictive set of criteria that many potentially eligible inmates cannot meet (e.g., age limits, non-violent offense, served more than 50% of sentence), and confusion among staff as to eligibility requirements as a result, compassionate/early release programs have rarely been used. For example, as of 2013, the Federal Bureau of Prisons has released only about 3% of all eligible inmates who applied for the program, primarily due to concerns for public safety and recidivism and new provisions which included age and other restrictions (OIG, 2016).

On a positive note, developing research related to these programs has revealed minimal recidivism rates (in particular, with respect to aging offenders), substantial cost savings, and reductions in overcrowding that warrant consideration by correctional administrators. Further, recommendations have been made to expand these policies, reducing the restrictions that preclude eligibility for many older offenders (50+) and increasing the number of applications submitted (OIG, 2016).

Mental Health Training for Criminal Justice Practitioners

Public safety officials, including correctional staff, security agents and emergency medical personnel, firefighters, and law enforcement officers (LEOs), are often the first to respond when a person is experiencing a mental health crisis. Furthermore, unless reentry services are implemented during one's period of incarceration and treatment services are received soon after release (within 2 weeks), the same individuals who may have been stabilized while inside the institutional setting may quickly decompensate in the community, thereby becoming at risk for repeated encounters with justice and other systems of care (e.g., public welfare). Unfortunately, some first responders may feel ill-prepared to handle these types of encounters given a general lack of knowledge as to signs and symptoms of mental illness and a number of other factors that present themselves in a crisis situation. In fact, despite an increase in police encounters with persons in crisis, it appears that only minimal attention is directed in police training to dealing with individuals who might be experiencing mental health issues.

Two popular programs that have been used in the United States with reported success include Crisis Intervention Team (CIT) training and Mental Health First Aid (MHFA). CIT is delivered over the course of a 40-h week. Various training modules are facilitated and delivered by law enforcement personnel, community mental health professionals, family and consumer advocates, and experts in related fields and consist of a variety of topics including (a) signs and symptoms of mental illness, (b) types of psychotropic medications, (c) de-escalation techniques, and (d) interaction with PwMI who are not currently in crisis. The program is predominately used to train police and other traditional first responders, although a diverse group of police/correctional staff/mental health professionals have completed the course (Bratina, 2017). Mental Health First Aid (MHFA) is an 8–12-h training course on basic signs and symptoms of mental health problems. Specific training modules (topics) include anxiety, depression and mood disorders, psychosis, substance abuse disorders, and trauma (Bratina, 2017). While MHFA has been marketed generally to the public at large, although, specialized courses/modules have recently been developed for educators and public safety personnel. Although the length of the training program, the audience, and some of the content differ, both of these programs generally provide modules that cover topics central to more effectively responding to the needs of offenders with mental health problems; in fact, CIT programs have incorporated modules specific to crisis response involving older persons with cognitive impairments (Alzheimer's and dementia) (Bratina, 2017).

The viability of implementing programs such as CIT and MHFA will depend on available resources, extent of community support, and department or agency culture/philosophy. Given liability issues in relation to high-profile instances of alleged mistreatment of offenders with mental illness, administrators in some jurisdictions have explored mandated training of staff. For example, police and corrections officials in Rhode Island and Pennsylvania have required and administered versions of both CIT and MHFA to law enforcement and correctional staff with positive outcomes (Gourlay, 2016; Zoukis, 2017). Consideration should be given to the specific needs of staff in relation to more effectively responding to and managing of this population of offenders. To promote safe and effective management, diversion, and reentry of OOMI in any given environment, it is highly recommended that first responders become properly trained on the de-escalation of a crisis, the identification of the manifestation of psychiatric problems, the signs of age-related cognitive impairment and physical health conditions, and the proper utilization of less-than-lethal weapons.

Trauma-Informed Care

Research suggests that older incarcerated adults bring with them significant histories of trauma and polyvictimization that continues with incarceration. In particular, there is significant work that still needs to be done in reference to addressing the mental health needs of female inmates, many of whom disclosed being victims of

sexual abuse and domestic violence which can potentially lead to late life posttraumatic stress (Reichert & Bostwick, 2010). Without treatment, males and females with PTSD are at high risk of demonstrating violent behavior (Fournier, Hughes, Hurford, & Sainio, 2011). A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment (Bowen & Murshid, 2016). Trauma-informed care is conceptualized as an organizational change process which is grounded in four assumptions that are intended to promote healing and reduce the risk of re-traumatization for vulnerable individuals:

1. Realize the impact of trauma and also understand recovery.
2. Recognize symptoms in clients.
3. Respond to applying policy and procedure.
4. Resist the re-traumatizing of individuals (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016).

Within this framework, SAMHSA has outlined six core principles of a trauma-informed care approach to recovery, which include safety; trustworthiness and transparency; peer support; collaboration; empowerment, voice, and choice; and the intersectionality of identity issues (cultural, historical, and gender-based) (Bowen & Murshid, 2016). These core principles are briefly discussed below.

Safety refers to treatment programs designed to keep the consumer out of danger and to prevent further trauma from occurring.

Trust and transparency pertains to the extent to which the agency is transparent in its policies and procedures while maintaining the goal of building trust with staff, clients/consumers, and the community members.

Peer support involves the development of linkages between persons who have common lived experiences (e.g., histories of trauma and behavioral health problems) and the practice of sharing knowledge and experiences as part of treatment and recovery (Bratina, 2017).

Collaboration consists of staff viewing clients/consumers as active partners, which is often done through peer support, such as peer mentoring (Bowen & Murshid, 2016). *Empowerment* refers to the agency allowing the client/consumer to have a *voice* in the decision-making process.

Recognizing cultural differences, the last principle, has to deal with cultural differences that make each individual's treatment program unique. The key to treatment involves compassion and support, and effective approaches will be racially, ethnically, and spiritually relevant, as well as gender specific (Rosenberg, 2011).

In the context of responding to the needs of OOMI, a trauma-informed approach is highly recommended for several reasons, including to promote trust between offenders and criminal justice practitioners, to more openly and effectively determine the offender experience, and to determine if the use the offender has a history of trauma and abuse if so to use the information to help guide the treatment and to assure that the needs and services provided address the present issues. TIC also promotes staff well-being/well-care and the cumulative impact of trauma on the agency or organization (Bratina, 2017).

Conclusion

Given the growth of this segment of the population, generally, and all of these challenges/issues in the community and in correctional settings, a growing number of studies have been conducted exploring the experiences of older adults aging in the community or in the justice system. Still, there is a need for more criminal justice-focused work in this subfield, as well as the development of joint research and multidisciplinary work that involves academics in criminal justice/criminology, social work, gerontology, and other relevant fields. It is anticipated that researchers and various other professionals will use the information presented in this chapter as an opportunity to engage in further dialogue regarding opportunities for research, teaching, and practice and to encourage the development of academic-community-based partnerships and programs that will assist older adults with mental health problems.

Discussion Questions

1. In what ways can community-based services agencies accomplish more effective identification and intervention with older adults who have a history of mental health and/or substance abuse issues?
2. How might a caseworker or provider of services successfully overcome any obstacles to treatment engagement?
3. What are some of the challenges and needs of law enforcement officers who come into contact with OOMI who are experiencing a mental health-related crisis? What are some of the challenges and needs of OOMI who come into contact with law enforcement during a mental health crisis? Are these challenges and needs complementary or conflicting?
4. How might communities need to respond so that programs such as CIT and MHFA are successful at diverting OOMI from further penetration into the criminal justice system and maintaining safety for first responders, consumers, and community members?
5. What are some foreseeable challenges that could arise for correctional or mental health staff during the screening and assessment process for OOMI?
6. How might one's age and physical condition affect the classification process for department of corrections personnel?
7. Can you identify potential solutions to the challenges presented in the management and care of older incarcerated adults?
8. What are some of the possible arguments for the more frequent use of compassionate release programs with the geriatric inmate population? What might be some of the arguments against the practice? Which side do you most comfortably agree with, and why?

9. There are several challenges with regard to the training of police and other first responders (e.g., correctional staff) in mental health and substance abuse issues; based on your review of available resources, identify at least three of these challenges.
10. What solutions might you offer in overcoming the challenges you identified in the previous question?

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