

Chapter 12

Justice System Response to Elderly Criminality



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Introduction

The increase in the number of crimes committed by the elderly throughout the world is likely to continue for the majority of types of crimes. Kratcoski and Edelbacher (2016, p. 4) note,

As a result of improvements in health, communications, and education, changes in life styles, including the type of employment, and changes in social relationships, the life span of the populations of most countries of the world has increased. People are living longer, working longer, and in general have more formal and informal contact with people outside of their primary social relationships.

These factors, as well as others relating to the entitlements provided by the government to older persons, new policies and laws that affect the elderly, and technical tools used in data processing provide opportunities to engage in criminal acts. Kratcoski (2017, p. 13) states,

In addition to opportunity, the motivation to commit crimes must also be considered. For example, people who may have had a steady income during their productive years may not have had much motivation to steal, but in their older years, if they find themselves living on an income that is barely sufficient to cover the increasing cost of living and with no backup funds for emergencies, the motivation to fulfill their basic needs for food and shelter through stealing may increase.

The ability to commit the crimes may also be a factor in explaining why some types of crimes by the elderly are either increasing or decreasing. For example, violent crimes against persons by the elderly, such as homicide, might decline considerably in those countries where a small proportion of the citizenry owns firearms, because many older persons do not have the physical strength to be involved in violence. In other countries,

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including the United States, the rate of homicides may continue to increase, since easy accessibility to guns makes it easier for older persons to commit such crimes.

The criminal justice system's response to older persons who commit criminal acts due to circumstances, in contrast to those who have been habitual criminals for many years, must be considered in any analysis of the older criminal offender

Criminal Justice Response to Older Offenders

Criminal justice system functionalities dealing with older offenders must consider the prior criminal histories of older offenders in making decisions on how to process them. In addition, other factors such as the severity of the crime, the circumstances surrounding the criminal act, the laws pertaining to the crime existing in the jurisdiction in which the crime occurred, the likelihood of the desistance of criminal activity if the older offender is diverted, and the special needs of the offender, such as mental health treatment, must be taken into account in the disposition of cases of older criminal offenders. If the criminal code of the state or federal jurisdiction allows for considerable discretion on the part of the criminal justice officials, there may be considerable differences in the response to those charged and convicted of criminal offenses from jurisdiction to jurisdiction and even within the same jurisdiction. For example, within the same county court system, some judges may be known for their leniency in disposing of certain offenses, while other judges may have reputations for their severity in sentencing for the same offense.

With the exception of offenders defined as juveniles, the criminal codes do not specify age as a factor that calls for special consideration in the sentencing of convicted criminal offenders. What deference is given to the older offender will be based on either the policies of the criminal justice agency or the use of discretion on the part of the criminal justice agents. Research by Fattah and Sacco (1989) found that the police were generally sympathetic in response to the older offenders who were arrested for such offenses as shoplifting, vagrancy, public intoxication, and family violence. The police officers viewed most of the older offenders as being mentally confused and in need of assistance or supervision rather than harsh punishment. In contrast, other researchers (Aday & Krabill, 2006) found that some judges gave harsher sentences to older offenders than they gave to offenders in other age groups who were convicted of the same offense.

The specific offense may be a determinant on whether older offenders may be treated more severely in sentencing than younger offenders who are convicted of the same offense. Vinyard (2016), in a study of child pornography offenders who had been convicted under federal statutes, found that older age was a predictor of being given a harsh sentence and a longer period of post-release supervision. The Protect Act of 2003 (Vinyard, 2016, p. 47) was enacted by the US Congress to allow for harsher punishments for those convicted of violating federal laws pertaining to child pornography. In addition to provisions that would allow judges to give harsher sentences to those convicted of child pornography law violations, "... The Act length-

ened the supervised release term for child pornography offenders from a maximum of five years to a minimum of five years to life” (Shockley, 2010, p. 7). Vinyard’s research database consisted of 1770 males convicted of and sentenced for child pornography law violations in the federal courts. He found that older offenders (50 and above) convicted of an offense pertaining to child pornography were given significantly longer supervised release time than that given to younger offenders convicted of the same offense. Vinyard (2016, p. 51) concluded, “Of all the extra-legal factors considered in the study, age exerted a significant effect in predicting those child pornography offenders sentenced to a life term of supervised release. The result is contradictory to findings in the most recent extant sentencing literature on the effects of age and sentencing, which finds that the younger offenders are more likely than older offenders to be treated more harshly.” The author provides several speculations for the reasons for the older child pornography offenders to be treated more harshly than the younger offenders. He suggests that the older offender may be perceived as a greater threat to society by the sentencing judges. He states (p. 55), “The idea of an offender over age 50 receiving sexual gratification from images depicting the sexual assault of children under the age of twelve, including infants and toddlers, may be unsettling for judges.”

Application of the Sequential Intercept Model for Older Offenders

The Sequential Intercept Model (SIM) (Munetz & Griffin, 2006) was developed to set guidelines for those providing forensic mental health services for offenders in need of such services. The SIM identifies five intercept stages in the criminal justice process in which a violator of the criminal law might be diverted from deeper penetration into the justice system. The extent of penetration for an individual offender is determined by the severity of the offense, by the circumstances surrounding the offense, and by the community resources and linkages available to intercept the offender at various stages of the criminal justice process. Although the Sequential Intercept Model was specifically developed to provide a “systems mapping” plan for the treatment of law violators with mental health problems, the SIM is applicable to all criminal law violators, with the exception of those who are convicted of a criminal offense that requires a mandatory prison sentence. It is particularly useful with multiproblem offenders which is often the case with the older criminal. Research by Kratcoski and Dahlgren (2004) revealed that a large proportion of the older offenders participating in a drug court program as a result of substance abuse also had one or more problems in the areas of physical or mental health, housing, employment, and family relationships.

Bratina (2017, p. 60) notes “The SIM outlines five potential ‘intercept’ points in which personnel in multiple systems and at multiple points of processing could potentially divert persons with mental illness (PwMI) away from further justice involvement.” These five intercept points are:

- Law enforcement/emergency services (prebooking)
- Initial hearings and detention (post-arrest)
- Jails and courts
- Reentry
- Community corrections and community support services

The five intercept points listed above will be discussed later in the chapter with specific reference to the older offender. Bratina (2017, p. 67) notes that, although the research on the effectiveness of the SIM is limited, the SIM is useful as an organizational tool by the police and community corrections systems as a tool for multisystemic mapping of ways to respond to criminal offenders at each stage in the justice process.

Diversion of the Older Offender

Research on the characteristics of older criminal offenders suggests that a large proportion of the elderly have a problem or multiple problems that would tend to mitigate to some degree the culpability of the offense.

Bratina (2017, p. 55) states,

In fact, a significant proportion of offenders are frequent ‘cross-over’ clients in multiple systems of care (including criminal justice, mental health, public welfare, and substance abuse). To improve the systematic response to this population, there was a need for the development of a conceptualized model of diversion points by which to provide opportunities for treatment and prevent individuals from further penetration into the system of criminal justice.

The National Initiative to Reduce the Number of People with Mental Illnesses in Jails created by the Center for State Governments Justice Center (Center for State Governments, 2016, p. 1) has the specific purpose of using alternatives to handling those accused of a crime who have some form of mental illness, or an addiction to drugs or alcohol, and who would normally be held in jail. The alternative would consist of either hospitalization or referral to a treatment facility. Programs to divert the mentally ill from being held in jail pending a decision on the offense to which they were charged have been in operation for several decades throughout the United States. However, the police do not always have the opportunity to divert the mentally ill offender, and holding the person in jail may be the only option available. Kratcoski (2017, p. 2) notes,

The police working in many counties throughout the United States, particularly those counties that have relatively small populations, face a dilemma when they encounter a law violator whose behavior shows all of the signs of the individual being mentally ill. Although the police realize that arresting the person and transporting him/her to jail is not the ideal course of action to take, it may be the only option available, since the community does not have other means for dealing with such cases. Police officers also have to consider the potential for the mentally ill becoming violent and a danger to the community in making a decision to arrest or divert the mentally ill persons they encounter.

Scherer (2009) suggests the diversion of mentally ill criminal offenders from incarceration in jails requires cooperation and coordination of all of the justice agencies, including the municipal police, county sheriff, prosecuting attorneys, judges, and mental health officials. The procedures used may vary by the specific jurisdiction and can include the on-scene police officer making a referral to a mental health program, filing a charge or referral to a shelter for those who are at high risk of offending and those who have committed minor offenses, filing of charges with the prosecutor who makes a referral to a mental health facility, or taking the person into custody and, at the time of arraignment, having the judge offer the person an opportunity to engage in a mental health treatment program in lieu of being convicted of a criminal offense and the possibility of serving a sentence in jail. For those who have committed very serious offenses and for whom diversion is not possible, the options include the formal process of determining if the person was competent at the time the alleged crime was committed, if the accused is currently competent to stand trial, and if convicted what correctional facility is available to provide treatment for the mentally ill criminal offender.

Mental Health Courts

Following the lead of the Council of State Governments Justice Center's initiative in advocating the development of mental health courts for criminal offenders with mental health problems, including alcohol and drug addiction, Odegaard (2007) noted that the goals of mental health courts included providing criminal offenders who apparently have some form of a mental health problem with an opportunity to engage in a treatment program that will deal with the offender's problem. Hopefully, the intervention will lead to a better quality of life and an elimination or reduction of the person's criminal behavior. The US Congress signed into law the American Law Enforcement and Mental Health Project (2000, p. 1). This law provided funding for the development and implementation of 100 mental health courts for judicial jurisdictions located in various parts of the United States. Kratcoski (2017, p. 97) stated,

Mental health courts are community based and judicially administered and employ a team of court staff and mental health professionals to implement treatment plans for those mentally ill defendants placed under the drug court supervision. The treatment plan consists of providing incentives (often dropping or suspending the criminal charges), regular meetings before the mental health judge, and a type of graduation celebration in the court room for those who successfully complete the treatment program.

Mental health courts have been implemented in the legal jurisdictions throughout the United States. They are particularly effective for those older offenders who have multiple problems such as homelessness, isolation, poverty, a lack of a social support network, and drug or alcohol addiction.

Box 12.1 Summit County Day Court

The Summit County Probate Court's New Day Court has the goal of helping people with serious mental illnesses who are hospitalized or have been released from a mental hospital from potentially being a danger to themselves or others. Waresmith (2017, p. A1) states, "The goal is to get them stabilized, make sure they are following their treatment regimens and return them to their lives." The New Day Court was started by Probate Judge Elinore Marsh Stormer in 2016. Waresmith (2017, p. A1) states,

Stormer, who was elected probate judge in 2012, saw a need for another program to assist people who haven't been charged criminally but have been pink slipped or civilly committed for mental problems and hospitalization in a psychiatric facility—often repeated. She started the New Day Court in 2016, with the aim of providing clients with additional support so they don't get off of their medication and end up back in the hospital.

Waresmith (2017, p. A8) states,

Summit County clients do not enter Day Court willingly. The clients do so after a being forcibly hospitalized because of behavior deemed dangerous or an inability to meet the ordinary demands of life. They then are committed to the Summit County Alcohol, Drug Addiction & Mental Health Services Board for 90 days.

After being released from the hospital, the clients are paired with a caseworker from Community Support Services (CSS) and a psychiatrist. The caseworkers give them a ride to New Day Court, where they appear before Stormer for the length of their outpatient commitment. At the end of the 90 days, they may be released or their commitment may be extended for up to two years.

When viewed from a treatment as well as an economic perspective, the diversion of the older criminal offender from being locked up in jail or a prison makes sense. Bratina (2017, p. 176) discussing those inmates of jails and prisons states,

... a substantial number of inmates suffer from major depression, mood disorders, anxiety, and depression. For some, psychotic symptoms may also be observed, including delusions, disorganized thinking, hallucinations, and bizarre behaviors (some of which are the result of taking psychotropic medications). Moreover, other specialized populations (e.g., geriatric, females, or inmates with developmental disorders and/or substance abuse) may have mental health and multiple other medical issues, which results in the increased necessity for screening, diagnostic exams, and follow-up services.

Kratcoski (2017, p. 109) notes, "In addition to the factors of age, health, type of crime committed, and the character of the older offender that a judge must consider when sentencing an older offender, the matter of the difficulties a jail or prison" sentence creates for those who administrate jail or prison facilities must be taken into consideration. For example, elderly offenders may suffer from chronic physical and mental health problems, may be in need of special diets or unable to participate in the normal activities required of someone incarcerated in a jail or prison.

Drug Courts

One provision of the Violent Crime Control and Law Enforcement Act of 1994 was to provide funding to local political jurisdictions to establish specialized court dockets (referred to as drug courts) that allowed criminal offenders charged with a drug-related offense to participate in a supervision and treatment program specifically focused on the needs of the drug and alcohol abusers. The courts established in jurisdictions throughout the United States varied in size, structure, and criteria for eligibility for the program. However, they tended to have common characteristics. According to Kratcoski (2017, p. 98),

These included that, to be eligible for the drug court, the offense must be drug related. Participation was voluntary, that is, the defendant had the option of being tried in the drug court or in the regular criminal court. For those who chose the drug court, the determination of guilt or innocence would be deferred, and, if the person successfully completed the program, the charges might be dropped. The presiding judge of the drug court had wide discretion in deciding who was eligible for the court (generally violent offenders were excluded) and the types of sanctions and treatment programs in which the defendants were required to be involved. The treatment programs were staffed by both court officials (probation officers) and professionals such as psychologists, counselors, and social workers.

The only age requirement for eligibility for participation in a drug court program is that the defendant be charged in a criminal court. Many of the juvenile courts throughout the United States have developed specialized dockets for drug offenders, and the programs for the juvenile offenders are specifically designed for the age group under the court's jurisdiction. In regard to older offenders, although the drug court programs do not specifically focus on the problems and needs of older offenders, each individual accepted into the program will be supervised and provided with treatment according to the case management plan developed during the initial period of participation. For example, an evaluation of the CHANCE Drug Court program (Kratcoski & Dahlgren, 2004, p. 600) found that the drug court participants had one or more chronic or minor problems relating to alcohol abuse, drug abuse, mental health, family disruption, physical health, employment, or education. The older offenders when compared with younger offenders tended to have fewer problems with employment, family disruption, and education than the younger participants, but are more likely to have more severe problems with physical health, mental health, and housing. This observation was confirmed through an interview with Alison Jacob, director of the Day Reporting Program, Stark County Common Pleas Court, Ohio (Interview completed on August 1, 2017).

Box 12.2

Q:PK: What percent of the total number of Day Reporting participants currently active in the Day Reporting Program and age 60 or older?

A:AJ: Three percent of the active clients are over 60 years of age. Only 1% of the total number of participants are age 65 or older.

(continued)

Box 12.2 (continued)

Q: PK: What is the gender distribution of the Day Reporting participants?

A: AJ: There are 308 active clients, 231 (75%) are male and 77 (25%) are female.

Q: PK: What is the gender distribution of the older clients?

A: AJ: All of the clients age 60 and above are males.

Q: PK: Provide information for the number of clients and the number of older persons in the following Day Reporting Programs:

A: AJ:	Total participants	Older participants
Drug/alcohol counseling	76	3
Mental health counseling	65	1
Anger management counseling	28	3
Multiproblem counseling	Unknown	2

Q: PK: What are the most difficult problems the Day Reporting Staff encounters with the older clients?

A: AJ: Most of the treatment we provide is in a group setting. The older adults have told us that they have difficulty relating to the younger individuals in the group.

Five out of the nine individuals over 60 have been to prison on prior charges and were not given the opportunity for community control in the past. Some of them are conditioned by their prison experience, and they do not understand that Day Reporting Staff is trying to help them stay out of prison. These individuals can be resistant to programming in the beginning. After they are engaged in treatment for a period of time, they tend to be more compliant with requirements than the younger participants and are more successful at completing community service and other requirements of probation.

Often times older adults in substance abuse counseling can identify the consequences of drug and alcohol use and verbalize a desire to make a change as far as their using drugs and alcohol, but find it difficult to change old habits.

Q: PK: Please give the most common characteristics (profile) of older participants in the Day Reporting Program.

A: AJ: I don't know if there is a common characteristic among all of the older participants. The majority have a substance abuse problem and a high percentage are violent offenders. Five out of the nine participants over 60 years old have done prison time, three have no prior criminal record and all of the first time offenders were charged with either violent or sex offenses. The majority are unemployed and not seeking employment. Most of the older participants are receiving SSI or Disability. Those who have no prior felony records tend to have been employed in the past and are now retired or still employed.

The Day Reporting Staff all agree that older adults tend to be the most compliant with adhering to the requirements of the court and the program.

Criminal Justice Response to Older Drug Offenders

The heroin and opiate crisis that is affecting most cities throughout the United States has the justice agencies adopting new measures to deal with the crisis. For example, in Buffalo, New York, Thompson (2017, p. A6) stated that the opioid crisis in Buffalo is so drastic and unique that the current drug court in that city could not handle the problem. Thompson states, “Now the city is experimenting with the nation’s first opioid crisis intervention court, which can get users into treatment within hours of their arrest instead of days, requires them to check in with a judge every day for a month instead of once a week, and puts them on strict curfews. Administering justice takes a back seat to the overarching goal of simply keeping them alive.” If the offender agrees to participate, “Acceptance into opioid crisis court means detox inpatient or outpatient care, 8 p.m. curfews, and at least 30 consecutive days of in-person meetings with the judge.” To date, none of the 80 persons who participated in the program had overdosed.

Community Courts

Statistics on the arrests of older offenders reveal that a large proportion of all arrests for those age 65 and older in 2016 (Federal Bureau of Investigation, 2016) were for minor offenses. In 2015, the number of arrests of persons 60 and older for

Box 12.3 Turning Point: Summit County Ohio Drug Court

Warsmith (2017, p. A1) stated, “Summit County’s (Ohio) drug court has gotten so large that the county wants to start a second program.” The program, titled Turning Point, served 225 participants in 2014 and 366 in 2016, a more than 69% increase. The drastic increase in opiate users in Summit County created the need for a second drug court. Warsmith (2017, p. A6) states, “Summit County’s drug court program is offered to offenders who struggle with drug or alcohol addiction. Participants are regularly and randomly tested for drug use, required to appear frequently in court for a review of their progress, rewarded for doing well, and sanctioned for not following requirements.”

Recently, Summit County received a grant from the United States Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration. The funds will be used to provide for additional crisis intervention counselors, caseworkers, recovery coaches, and researchers needed for the second drug court.

Currently, the drug court docket, Turning Point, is presided over by Summit County Common Pleas Judge Oldfield. The second drug court docket will be administered by Common Pleas Judge Christine Croce.

property offenses, including burglary, larceny theft, motor vehicle theft, and arson, was 140,187; arrests for assault was 22,560; arrests for drunkenness was 14,415; arrests for buying, receiving, and possessing stolen property was 687; arrests for offenses against family, including children, was 1271; arrests for driving under the influence was 38,826; arrests for disorderly conduct was 8664; arrests for drug abuse violations was 8629; and arrests of those 60 years old and older for vagrancy was 1402.

Some of these offenses committed by the elderly, including the offenses against persons, were serious enough that, if convicted, a sentence of either community corrections or imprisonment was warranted. However, a large number of the offenses, such as the public order crimes of drunkenness, disturbing the peace, vagrancy, and drug abuse, perhaps can be handled either through diversion or through a special problem court.

Unlike special problem courts, community courts do not focus on one specific problem of the offenders such as drug abuse, mental health matters, or family matters. Kratcoski (2017, p. 104) notes that, while the goals of community courts may be similar to those of other special courts, the main goal is to process low-level misdemeanor offenders as quickly as possible and to provide the assistance the offenders need to function successfully in their lives, family, and the community. To achieve these goals, there must be cooperation between the officials of the justice agencies, social service agencies, and the community. Lee et al. (2009) list the aims of community courts as individualized justice; discretionary options for judges to vary sentences of convicted offenders depending on circumstances; varying sentence lengths, again depending on circumstances; holding offenders accountable for their offenses even though circumstances may mitigate somewhat the offenders liability; and involving the community in determining the problem areas and developing solutions.

Given our knowledge of the characteristics of the majority of older offenders and the factors that lead them to crime, the community court appears to be a viable means for addressing the interrelated legal, residential, health, and relational problems many older offenders face. For example, a sizable number of older people live in substandard housing, have an income below the poverty level, have physical and mental health problems, face social isolation, and have diminished mental capacity. Older offenders are found in all categories of criminal offenses. Their criminal acts are concentrated in property crimes, such as petty theft, trespassing and property destruction, public order crimes such as disturbing the peace, and public intoxication. The large majority of crimes against person committed by the elderly consist of simple assault, with the victims being family members, friends, and acquaintances. An approach that combines the justice system and public health concerns appears to be reasonable and likely to benefit the community as well as the older offenders.

Effectiveness of Special Problem Courts

Rowland (2016) completed an assessment of the “problem-solving” courts operating in the federal judicial system as well as within the various jurisdictions of the state systems. Rowland (2016, p. 4) notes,

The problem-solving court model calls for the formation of a team led by a judge and joined by the prosecutor and defense attorney, a probation officer, and usually a treatment provider. The judge and attorneys are asked to transcend their traditional roles and broaden their normal objectives in a criminal case. Specifically, judges and attorneys are tasked with working collaboratively to help justice-involved persons remain law-abiding.

After an extensive review of the research on the effectiveness of problem-solving courts (the large majority of the research cited focused on drug courts), Rowland (2016, p. 12) concluded, “There is ongoing debate about whether problem-solving courts achieve their goal of reducing recidivism and keeping communities safer. Studies of federal problem-solving courts have been mixed. Adding to the equation is that operation of problem-solving courts has generated some policy, ethical, and even pragmatic questions.” The author continues by noting that even with the mixed results of the research on the effectiveness of the problem-solving courts, problem-solving courts hold great potential for the treatment of multiproblem criminal offenders. Rowland (2016, p. 12) states, “Specifically, many problem-solving courts help participants manage and overcome ‘collateral consequences’ to their criminal activity, prosecution, and sentence. In doing so, the courts address “responsivity issues” that could interfere with a successful reintegration into society, and impact important life skills that assist program participants in moving forward.”

As previously mentioned, the vast majority of the research on the effectiveness of special problem courts, such as drug courts, mental health courts, and family courts, does not focus on the older offender. Occasionally we get a glimpse of the likely effect when age is included as a variable in the research design. Without having much factual data to assess the effectiveness of the specialty courts with older offenders, one can only surmise that the influence of the supervision and programming provided by the courts to participants of other age groups will be the same for the older participants.

If one bases the determination of being effective solely on recidivism or relapse as in the drug courts, the problem-solving courts may not show results different from those that of the traditional courts. During the course of completing research on a specific drug court, the author had observed a number of participants who relapsed, violated the conditions of their supervision, and had been sanctioned by the judge, with a reduction of privileges, an extension of required time in the program, and even given the extreme sanction of jail time. However, they were not terminated from the program and, at the time of their graduation from the drug court program, appeared to be making a satisfactory adjustment in the community and in their personal lives (Kratcoski & Dahlgren, 2004).

Community-Based Programming for Special Needs Offenders

Assessment of Risks and Needs

Traditionally, the assessment of a convicted criminal offender for potential risk of committing additional crimes and risk of harming the community was the responsibility of the court in which the offender was convicted. The assessment, referred to as a *presentence investigation*, was completed by a member of the probation department attached to the court. The typical presentence report focused on many of the same items included in the risk and needs assessments currently being used in the majority of the states and the federal probation services. These included age at first offense, prior convictions, drug and alcohol abuse, family matters, and matters pertaining to employment, family, and the community. In addition, the report contained information on the individual's attitudes, cooperativeness, and likelihood of recidivating if placed on community supervision. In those cases for which the sentencing judge had an option of committing to prison or placing the defendant on probation, the presentence report and the recommendation of the officer who completed the report were the major factors used to assist the judge in making a decision on the appropriate disposition. In some cases, the specific age at the time of committing the offense and the circumstances surrounding the offense could serve as mitigating circumstances that would work in favor of granting an older offender a less severe sentence. For example, if it was determined that the offender stole food from a grocery store as a result of not having sufficient funds to buy food, committed fraud in order to have money to buy medicine or pay the rent, or was suffering from some form of mental illness, such factors would no doubt be considered in the sentencing judge's decision.

Statewide risk and needs classification systems were first developed in the late 1970s, with Wisconsin being the first state to adopt a statewide system. In 1982, the National Institute of Corrections (Clements, McKee, & Jones, 2010) provided grants to states who submitted proposals to develop and implement a standardized probation and parole assessment instrument that would be suitable for use throughout the state. Risk-needs assessment instruments were eventually developed and implemented in all of the states and in the federal pretrial and probation system. They tended to replace or modify the assessment and case management systems in use that were based on the presentence investigation or a model that was not evidence based. While the presentence investigation was not discarded, it tended to be used less frequently and only with the more difficult cases. Kratcoski (2017, p. 117) noted,

The vision of NIC was that the statewide classification systems would be useful tools for probation and parole officers, who would have objective criteria to assist them in making decisions on case management plans. Also, it was hoped that with the use of standardized instruments throughout the state the likelihood of officers' prejudices being a factor in the decisions would be reduced.

The large majority of the statewide classification systems adopted by the states, referred to as *evidence-based classification models*, are based on essentially the three principles of risk, needs, and receptivity. The items on the risk assessment instruments have been set up, based on research findings on their predictability of recidivism. Typically, prior felony convictions, number of prior arrests and convictions, employment status, alcohol and drug abuse problems, number of times on probation/parole supervision, number of prior incarcerations in a prison, and number of revocations of probation or parole are included on the risk instruments. The items are weighted according to their importance in predicting recidivism, and, if the offender was placed on probation or granted parole, the level of supervision (maximum, medium, minimum) is determined by the score the person assessed obtained. The individualized case management plan adopted for each offender placed in the system is based on the dynamic risk factors and the needs assessment. The PEW Center of the States (2011, p. 3) notes, "Research has identified both changeable (dynamic) and unchangeable (static) risk factors associated with criminal conduct. The seven dynamic risk factors closely associated with criminal conduct that can be assessed and altered through effective intervention are: Antisocial personality patterns, pro-criminal attitudes, social support for crime, substance abuse, poor family and or marital relationships, school or work failure, and lack of prosocial recreational activities."

Those states that use a needs assessment instrument in their probation and parole classification system include many of the items found on the risk assessment instrument on the needs assessment instrument. For example, such items as associations, drug use, alcohol use, employment status, and attitudes and functioning in the family are included in the needs assessment. However, since the main function of the needs assessment is to determine the strategies and types of programming that will be the most conducive to bringing about desired changes in behavior, several of the items generally included on the needs assessment instrument, in addition to those mentioned, pertain to emotional and mental stability, financial management, vocational or educational training needs, problems with health or residency, sexual behavior, and mental abilities (intelligence, reasoning powers). For the older offender, the needs assessments are likely to be the most important part of the case management plan, since the older offender may have a number of needs to be addressed, including those relating to health, housing, finances, isolation from family, and even mental functioning. For those older offenders who have been assessed as having multiple problems and needs, their case management plans are likely to be complex and require the involvement of a number of service provider agencies as well as health and mental health agencies.

Older Offenders on Probation

A Bureau of Justice Statistics report (Kaeble & Bonczar, 2016, p. 1) stated that more than four and a half million adults were under some form of community corrections supervision at the end of 2015. Almost four million of the adults in

Box 12.4

Woodrow (known as Woody) was arrested for theft and assault by the _____ Police Department. Woody, age 81, had worked in the tire and rubber industry for 40 years, most of his adult life. After graduation from high school, Woody enlisted in the United States Army and obtained the rank of Sergeant before his enlistment was up after 3 years of service. He obtained a position in a factory that made automobile tires and held various positions within the factory. On his retirement he was the foreman of the afternoon shift. Woody married shortly after leaving the military. He and his wife had been married for more than 50 years when his wife died suddenly. Woody and his wife never had children. However, they had engaged in a wide range of community activities and had a considerable number of friends, and both of them were involved in religious and social activities associated with their church. He was a member of the bowling team and would occasionally attend sporting events with some of his fellow factory workers.

After his wife's death, Woody tended to withdraw from social interaction. He stopped going to church services and would generally find some way to avoid his friends. On those occasions when they did meet to have a beer or two at the local tavern, his friends noticed that he seemed withdrawn and depressed. They also noticed that he would become intoxicated long before the group separated and departed for home. In the past, Woody could be described as a moderate "beer drinker." Now he could be described as a "heavy whiskey drinker." In addition to his heavy drinking, Woody would often become very loud and argumentative after having several drinks of alcohol. He would order the bartender to bring him his drink immediately and often complain and cursed at the bartender and his friends when they tried to persuade him to "calm down." One night, when he accused the bartender of shorting him on the amount of liquor in his drink, the bartender ordered him to leave the tavern and never come back. After several nasty comments, Woody left the bar.

As the months passed, Woody became more isolated and depressed. Living alone, he would sit for hours doing nothing except drinking and occasionally fixing some food for himself. He lost all interest in community or national affairs and had no desire to interact with people.

He located another bar that did not seem to be frequented by any of his former friends. When not home alone drinking, he would go to a new bar and sit at the bar for hours. He would complain about how rotten the world has treated him and that he deserved better. Generally there was no one at the bar to hear him except the bartender. As Woody tended to become more depressed and difficult, none of his former friends wanted to interact with him.

Woody's situation came to a head on the night he was arrested for theft and assault. Woody was living on his retirement income and social security. Under normal circumstances, the income would have been enough to pay the bills,

(continued)

Box 12.4 (continued)

but the cost of purchasing the liquor he drank and his bar bills was cutting into his monthly income. The bartender at the new bar he frequented was willing to run a “tab,” but insisted the entire bill had to be paid at the end of each month, or else Woody’s drinks would be cut off.

On the evening of his arrest, Woody had run out of money and was trying to figure out a way to purchase another drink. There was no one at the bar except Woody. The bartender asked Woody if he was ok with his drink, and when Woody said “yes,” the bartender said that he was going in the kitchen to clean up and to get ready for the happy hour crowd that would soon be coming into the bar. When the bartender left the room, Woody walked behind the bar and quietly opened the cash register. He took several 20 dollar bills and a 50 dollar bill from under the register drawer. He had noticed that the bartender hid the larger bills there. He walked back to the other side of the bar and sat down.

When the bartender came back, Woody ordered another drink. The bartender asked if he had any money, reminding Woody that his tab had been stopped. Woody threw out a 50 dollar bill. The bartender made the drink, and when he went to the cash register to make change, he noticed that the 50 dollar bill that was under the register drawer was gone. He had jotted a few numbers on the bill to be able to identify the bill in case it was stolen, and he immediately recognized that the 50 dollar bill given to him by Woody was the one from the cash register. The bartender also noticed that other money was missing.

He approached Woody and told him to give back the money he had stolen and leave and never come back, and that if Woody refused, he was going to call the police. Woody became very angry and threatened the bartender. The bartender stated he had one last chance to give the money back before he called the police. Woody started swearing and kept denying that he had taken the money. At that point the bartender picked up the phone to call the police, and Woody ran to the bartender and tried to grab the phone. He was swinging his fists and punching the bartender.

The police soon arrived and, given the fact that Woody was in a violent mood, he was arrested on charges of theft and assault and driven to the county jail where he was booked.

His case was reviewed by the prosecutor, and Woody appeared to be eligible for diversion in one of several of the special dockets of the county courts. The risks and needs assessments revealed that Woody had multiple problems that need to be addressed. He could benefit from participation in the drug court program to get treatment for his alcohol problem, and he appeared to be eligible for the mental health docket as a result of his depression, isolation, and anger outbursts. Since he as a veteran, the Veterans’ Court was also a possibility.

Woody was accepted in the drug court. Based on the outcome of the needs-risk assessments, the judge ordered that Woody be placed in a community residential treatment facility. Woody was required to participate in the treatment programs designed to address his problems.

community corrections were on probation (3,789,800), and the remainder (870,500) were on parole.

It is not known what proportion of the close to five million convicted criminal offenders under some form of community-based supervision in any given year are age 65 or older and have special needs. Estimates of the proportion of probationer and parolees who may have some form of mental illness range from five to fifteen percent. The proportion of convicted offenders, as well as those offenders who have been diverted from the justice system who have been placed under some specialized community-based treatment program for drug and alcohol treatment, is not known.

A special report on trends in the correctional populations in the United States (Kaeble, Glaze, Tsoutis, & Minton, 2015, p. 1) indicates that the corrections population in 2014 had steadily declined from its peak year, 7,339,600 in 2007 to 6,851,000 in 2014. Kaeble and Bonczar (2016, p. 5) show that in 2007, 80.3% of the corrections population was under non-secure community supervision, either probation or parole. The remainder was either in prisons or local jails. In 2014, the percentage was almost the same as in 2007, with 79.2% under probation or parole supervision. The report does not provide information on the number of persons under probation or other forms of community supervision who were age 65 or older. However, given the fact that more than half of all of those who are under correctional supervision are on probation and that the large proportion of older offenders are convicted of either property crimes, public order crimes, or simple assault, it is safe to assume that the large majority of older offenders not diverted from official processing are placed on probation or some other types of community corrections status such as referral to a community treatment center.

The proportion of these older offenders under community supervision who are in need of special treatment for drug abuse, alcohol abuse, or mental health problems is not known. Research findings on the effectiveness of programs for those with special needs will generally include age as one of the variables in the research design, and one can obtain detailed information on the importance of the age factors in the analysis of the effectiveness of the treatment modalities used in these programs for special needs offenders. Reports on several of the community-based programs for special needs offenders are presented later in this chapter.

Bratina (2017, p. 241) suggests that a large proportion of the special needs offenders placed under community supervision may recidivate as a result of having multiple problems that the community programs are not equipped to handle because of lack of personnel or programs needed for their treatment. Research by Hartwell et al. (2013) indicated that as many as 70% of those offenders with serious mental health problems may also have serious substance abuse problems. In addition, many are homeless and have serious physical health problems. In addition to the fact that many communities do not have the programs to treat the special needs offenders, particularly those with multiple problems, Bratina (2017, p. 244) states, "Also there is a lack of knowledge with respect to services available for persons with mental illness. Thus, although research has shown that parole and probation supervision does reduce recidivism, specialized mental health and substance abuse training would further increase the number who are successful released into the community."

Ostermann and Matejowkowski (2014) report that resource guides have been designed and used in some communities and made available to individuals working in multiple, but integrated, systems of care. In some jurisdictions, specialized programs were created for probationers with mental health problems and offenders who were released on parole or post-release supervision who have been identified as having mental health or substance abuse problems. In addition, specialized training programs for community correctional personnel have been implemented in some jurisdictions.

Community Residential Treatment of the Older Offender

Community residential facilities that housed convicted criminal offenders were established in New York in the mid-nineteen century under the auspicious of the Society of Friends (Quakers) and the Volunteers of America (Ohio Division of Parole and Community Services, 1974, p. 6). The movement continued to expand, with new facilities established in the larger cities until the 1930s. Since almost all of the community residential facilities were under private auspicious, the majority being nonprofit organizations administered by religious or volunteer organizations and depending largely on donations, many were forced to close during the 1930s. At that time, many of the charitable and service agencies were forced to discontinue their work due to the great economic depression. However, there was a resurgence of the use of community residential facilities in the 1950s. Since state and federal criminal justice agencies are generally supportive of community treatment and were willing to provide funding for community residential facilities, the number of facilities has been increasing. Kratcoski (2017, p. 162) noted,

The first halfway houses were established to house and provide treatment to a variety of criminal offenders. The programs were quite general in programming and focused on providing a stable environment and preparing the residents for their transition to independent living in the community. If the residents needed specialized treatment for substance abuse or mental health matters, they were referred to therapists who were employed by private and public agencies in the community, or even transferred to another facility that provided the type of treatment needed.

Box 12.5 Older Residents at Oriana House

Oriana House, Inc., consists of 34 residential and nonresidential facilities located in several sections of Ohio. Oriana House offers a wide variety of programs for the residents. These include counseling on family matters; a motivation for success treatment program; substance abuse treatment; recovery coaching; counseling on housing, health, and employment matters; distorted thinking group therapy; anger management counseling; and other

(continued)

Box 12.5 (continued)

programs designed to address specific problems of the residents (Kratcoski, 2017, pp. 167–175).

The following information was supplied by Alex Boros, who works in the research division, and other staff members on matters pertaining to older Oriana House residents. The statistics were compiled on August 20, 2017.

- The number of older participants (age 60 and above) in the Oriana House programs is 100. This constitutes less than 1% of the total Oriana House population.
- More than three fourths (77%) of the older participants are male.
- The distribution of the participants age 65 and above is 91% male and 9% female.
- Thirty-five percent of all of the Oriana House clients are housed in the residential facilities. Less than 1% of those housed in any of the residential facilities are age 65 or older.
- A large majority of the older residents, age 65 and above, participate in the drug and alcohol abuse programs.

Statistics are not available on the number of older residents at Oriana House who are participating in some type of mental health counseling. Often, residents are required to participate in a program ordered by the courts as a condition of probation. These programs are not under the auspicious of Oriana House.

Oriana House does not have a special residential facility for older residents. The older residents are assigned to living quarters on the basis of several criteria, including a need for special accommodations on the basis of having physical disabilities, the amount of security required, and the types of programs for which participation is required.

When a staff member was asked to give the general characteristics of the typical older Oriana House resident, the reply was, “With less than 1% of our residents being over the age of 65, it is difficult to generalize a profile. Older inmates in the prison system tend to be returned directly to the community via a compassion release or at the completion of their sentences, so they are not included in our Halfway House population among our other reentry clients. For offenders sentenced directly to Oriana House residential programs, the low risk level of the elderly offender population makes it better suited to non-residential options where they can access generic focused community programming.”

When asked what about the most difficult problems faced in providing residential treatment to older offenders, the response was, “The problems facing older offenders tend to be the same types of problems facing the elderly in general. Their financial resources are often more of a concern if they do not

(continued)

Box 12.5 (continued)

have a community support system. Medical issues are more problematic in the older population, and medical needs are often neglected. From a programming standpoint, many behavioral treatment curriculums are geared for clients starting out in careers, parenting, finding employment, education, and such. We also have to address physical accommodation challenges and must train staff on how to handle specific issues pertaining to the elderly they might have to address during the course of completing their duties.”

Currently, community residential facilities housing those who are under supervision of criminal justice agencies can be found in varying sized communities throughout the United States. Some of these are administered by private profit-making organizations, others by private nonprofit organizations, and still others by a public municipal, county, state, or federal criminal justice agency. Generally, programs offered in these residential facilities continue to focus on many of the goals of the early houses, such as preparing the residents for their transition to independent living in their community, but have broadened their missions and programs to include many other goals. Some community residential organizations consist of one facility, in which the treatment is specialized and focused on one type of offender, such as substance abusers, while other organizations serve several types of offenders and offer a variety of programs. For example, Oriana House (Oriana House Home Page 2016), headquartered in Akron, Ohio, has several buildings located in Akron and other Ohio cities and provides residency and treatment for a variety of criminal offenders. These include:

- Special category offenders (drug, alcohol abuse) who have been diverted from the justice system
- Convicted offenders who have not been sentenced and who are housed in a residential facility during the time a presentence investigation is being completed
- Low-risk offenders placed on probation, but who are in need of some structure in their lives
- Probationers who are under intensive supervision
- Inmates of a correctional facility who are on pre-release status
- Probationers with alcohol, drug addiction, or mental health problems who are required to receive treatment for their problem/s as a condition of their probation

Each of the categories of offenders listed above will be housed in either a separate Oriana House facility or a separate section of a facility. The specific treatment programs followed differ, depending on the needs and problems of the residents housed in the facility. The type of staff training and experience needed to provide the treatment will also vary, depending on the specific type of offender housed in the unit.

As mentioned in the statements given above, the residents of Oriana House, Inc., who are elderly are dispersed throughout the residential and nonresidential pro-

grams of the organization. They include both men and women, but predominately men, as is the case with the distribution of those under justice agency supervision throughout the criminal justice system. Although not all clients are charged and convicted of a drug- or alcohol-related offense, 90% or more of the residents have either alcohol, drug abuse, or mental health problems. Health-related matters are also a major concern for the elderly residents of Oriana House. A considerable number of the older residents have multiple physical and mental health problems. These health problems of the elderly residents are often related to their drug and alcohol use, and providing the appropriate medical care needed is a considerable problem for the administration. In regard to this problem, James Lawrence, President and CEO of Oriana House, Inc., remarked (Kratcoski, 2017, p. 174),

Most of the concerns in the day to day operations center around having qualified staff to fill the huge need and lack of appropriate funding to cover the increasing cost of operating the organization. For example, there are just not enough people who are qualified in the AOD field to fulfill the demand. The Affordable Care Act makes many substance abuse offenders eligible for treatment, but we have to put them on a waiting list to get into our program.

Secure Community Residential Facilities

A secure community residential facility can best be described as a facility designed for convicted offenders who are in need of a more secure living situation than can be provided by probation supervision or a typical halfway house, but who are not in need of the high security found in the local jails and the secure correctional facilities under state administration. In addition to security matters, the typical offenders committed to such facilities, particularly the older offenders, have multiple issues that need to be addressed, such as substance abuse problems, health problems, and employment problems, and a community setting where the offenders live in or near their homes and where medical and service providers are most likely to be available is the type of environment that will be conducive to producing the changes desired.

Carlson (2015, p. 2) reported that the total number of prisoners under the jurisdiction of state or federal correctional authorities on December 31, 2014, was 1,561,525. The distribution of prisoners consisted of 13.5% federal and 86.5% state prisoners. The prisoner population consisted of 92.7% men and 7.3% women. The number of prisoners decreased by 1% from the previous year. Carlson (2015, p. 2) contends,

The decrease observed in 2014 was the second largest decline in the number of prisoners in more than 35 years. The decline of 28,600 prisoners from 2011 to 2012 coincided with the enactment of California's Public Safety Realignment Policy, which diverted newly sentenced nonviolent non-serious, non-sex offenders from state prison to serve time in local jails and under community supervision.

The substantial decrease in the number of federal prisoners was a second reason for the decrease in the prisoner population in 2014. The number of older inmates in state facilities is not known. In June, 2017, there were 11,078 inmates 60 years of age and older under Federal Bureau of Prisons (BOP). These constituted 5.3% of the total BOP population (Bureau of Prisons, 2017, p. 1).

The number of older inmates housed in state and federal correctional facilities in the United States is expected to increase drastically in the future, even though there has been a trend toward reduction of the number of prisoners in state and federal facilities. “The number of federal and state prisoners who are age 65 or older grew an astonishing 94 times faster than the total sentenced prisoner population between 2007 and 2010. The older prisoner population increased 63.5% while the prison population grew by 0.7% during the same time period.” This increase of older persons in the prison population is predominately due to two factors. First, the determinate sentencing codes of the federal government and the majority of the states require or required long-term sentences for a large range of offenses. As a result, it is not uncommon for many criminal offenders sentenced under these laws to enter prison during their middle age, but essentially grow old in prison. The second factor pertaining to the increase in the number of older persons in the prison population is related to the larger number of the older population convicted of a crime and given a prison sentence. For example, the Ohio Department of Rehabilitation and Corrections is completing a movement of the death row inmates from the prison where they are currently housed to another prison that has better facilities for older inmates. Seewer (2017) states,

State prison officials said last fall they would move death row from Chillicothe in southern Ohio to the Toledo Correctional Institution because of the growing number of aging inmates serving death sentences. Toledo’s prison is newer and designed to handle inmates with physical and mobility limitations, including those in wheelchairs, the state said. There are about 140 inmates on death row and the average age is around 50.

Research (Krstcoski, 2004; Vito & Wilson, 1985; Kratcoski & Pownall, 1989; Bratina, 2017) supports the claim that most correctional facilities do not have the proper programs or sufficiently trained staff to handle the diverse physical health, mental health, recreational, and social programming needs of a large majority of the older inmates housed there.

Judges charged with the task of sentencing older offenders may be cognizant of the limitations of the programming for older offenders with special needs in most correctional facilities and perhaps would prefer to pronounce a community-based sentence rather than a prison sentence for those older offenders who are not considered a serious threat to the community. However, the judges’ ability to follow this inclination is hampered by either the sentencing guidelines of the criminal code under which they must abide or the lack of community-based programs or facilities designed to treat the older offender.

Special Problem Older Inmates

Bronson and Maruschak (2015, p. 1), in a study of disabilities among prison and jail inmates, report, “An estimated 32% of prisoners and 40% of jail inmates reported having at least one disability. About 2 in 10 prisoners and 3 in 10 jail inmates reported having a cognitive disability, the most common reported

disability in each population.” Other disabilities consisted of hearing, vision, ambulatory, self-care, and independent living. The most common disabilities among those age 50 and above were ambulatory, closely followed by cognitive (Bronson and Maruschak, 2015, p. 4).

For some older inmates, mental illness, dementia, or physical conditions such as loss of hearing, poor eyesight, or loss of physical strength, if not recognized by the prison staff, may result in unwarranted punishments for being considered insubordinate or defiant. In some cases, the inmate may be placed in solitary confinement. Correctional officers who interact with the inmates on a daily basis, if not properly trained, may not recognize that the bizarre behavior of some inmates is a result of mental illness and may become frustrated when the mentally ill inmates do not respond properly to commands or are disruptive.

Inquiries into cases of mentally ill persons convicted of a criminal act who end up in prison rather than being given the care and treatment needed to address their mental health problems have resulted in court decisions favorable to the mentally ill prisoners. Mental Health America (MHA) (2015) is an organization that has a goal of assuring that the rights granted under the Eighth Amendment of the US Constitution to mentally ill persons incarcerated in correctional facilities will be adhered to by correctional administrators. In a position statement, MHA cites the US Supreme Court’s *Brown v. Plata* decision, in which the Court ordered more than 40,000 prisoners with serious mental health problems released from California correctional facilities because they were not receiving the “basic human rights” and minimum level of care guaranteed under the Eight Amendment that prohibits cruel and unusual punishment.

The 2015 MHA call for action (MHA, p. 3) states,

MHA and its affiliates should work to inform members of law enforcement and correctional groups, judges and attorneys, mental health professionals and advocates, prisoners and their families, the community, and the media about the excessive number of persons with mental illnesses and addictive disorders in prison and jails and the inherent difficulties involved in providing decent and humane care to such persons in these settings, and should develop and advocate for effective strategies addressing these problems.

Carlson (2011) notes that some correctional jurisdictions have established separate facilities for criminal offenders who have been diagnosed as having mental problems. For example, the Larned Correctional Mental Health Facility (LCMHF) of Kansas houses the severely mentally ill inmates of the Kansas Department of Corrections. Cadue (2016, p. 1) writes,

LCMHF consists of a maximum-security central unit with 150 beds and a minimum-security Unit with 288 work detail beds. The facility’s Central Unit serves as a transitional unit for inmates who are not able to function in the general population of a traditional correctional institution for mental health reasons, but are not in need of psychiatric hospitalization. Inmates are assigned to this facility by mental health staff at other correctional institutions.

The inmates at LCMHF are provided with counseling and mental healthcare and treatment with the purpose of preparing the inmates to reenter their community on

release or in some cases to ready them for return to a traditional correctional facility. The Michigan Department of Corrections (2017, p. 1) reports that “approximately 20% of Michigan’s prisoners population is enrolled in a mental health program operated by MHS (Mental Health Services), ranging from brief counseling to inpatient residential placements.” Mental Health Services provides mental healthcare to eligible prisoners based on their needs. The programs consist of an Adaptive Skills Residential Program, Counseling Services and Intervention, a Crisis Stabilization Program, Acute Care, Rehabilitative Treatment Services, a Residential Treatment Program, and Outpatient Services.

It is difficult to ascertain what portion of the inmates of state and federal correctional facilities with physical health, mental health, addiction, or other problems are older inmates. However, unless they are incarcerated in a facility especially designed and programed for older inmates, the decisions on classification for living quarters, participation in special programs for the mentally ill, and other matters pertaining to their daily routine will be made by the administration, using the same criteria for decision-making that is used for all other inmates of all age groups.

Special Facilities for Older Inmates

Research on older inmates (Kratcoski, 1994) focused on the satisfaction of older men and women incarcerated in state and federal correctional facilities. The state and federal correctional facilities in the study were selected on the basis of security level and the size of the inmate population. Inmates housed in facilities for women, as well as facilities for men, were included in the study. A total of 482 inmates and 62 corrections officers, supervisors, and administrators completed the questionnaire or were interviewed.

An analysis of the ways correctional administrators responded to the older inmate situation revealed:

- Correctional administrators did not change policies and operating procedures in any way to accommodate the older inmates. Their reasoning was that 90% or more of the inmates were of a younger age, and thus the limited resources of the facility should be directed toward programming for the general population.
- A few of the state legislatures authorized the construction of new correctional facilities or the conversion of existing facilities into institutions that would provide the special housing and programming for older inmates who had one or several handicaps, either physical or mental.
- Correctional administrators followed the standard procedures of integrating the older inmates with the general population, their housing units and programming being determined by the classification system used.
- A specialized unit was established within the larger unit. This approach was generally used in newly constructed facilities. The older inmates interacted with

other inmates in work, educational and recreational programs, as well as during meals (Kratcoski, 1994, pp. 508–509).

A comparison of responses of older inmates housed in special facilities or units and those housed in the general population on several questions (Kratcoski, 1994, pp. 509–510) revealed:

- The large majority of inmates in both types of institutions claimed that they got along well with other inmates and were never threatened or victimized by the other inmates. However a larger proportion of those housed in the general population units stated that the younger inmates were more aggressive and violent.
- A significantly larger proportion of those housed in the special institutions or units for the older inmates claimed to be in poor health and that their health had deteriorated since they came to the prison.
- Those who were institutionalized for the first time had more adjustment problems than those who had been previously institutionalized, regardless of the type of institution in which they were housed.
- Older men housed in specialized units or facilities were more satisfied with their living quarters, work assignments, programming, and the recreational activities than were older men housed in the general population.
- Older women (none were in special units or facilities) were generally dissatisfied with their living quarters, recreational activities, programming, and relationships with their fellow inmates. They cited insufficient space, poor ventilation, excessive noise, lack of privacy, and the hostility of younger inmates as major reasons for their dissatisfaction.

The Federal Bureau of Prisons (FBP) and state corrections departments have established correctional facilities that are designed to house inmates with physical health problems. For example, the FBP has six comprehensive health facilities (CHU) located throughout the United States. The Fort Worth, Texas, CHU (FBP, 2017, p. 1), a co-institutional facility, is designed to house inmates with ongoing medical health problems for which their medical care needs exceed what can be provided in a regular FBP correctional facility. The inmates at the Fort Worth facility are able to attend to their own needs such as personal hygiene, eating, and dressing and even are able to complete limited work assignments. However, they have one or more handicaps, such as those related to walking, hearing, seeing, and internal problems that require 24-h medical coverage provided by the staff or outpatient healthcare providers.

The Federal Medical Center, located in Lexington, Kentucky (FMC Lexington, p. 1), houses 1356 inmates at the main facility and 305 at the camp. FMC Lexington houses both men and women inmates. Similar to other Bureau of Prisons medical centers, the operations of the facilities are similar to those of other federal correctional facilities. The inmates who are able to work have work assignments, there is an extensive educational program for those who would benefit by furthering their education, treatment programs for special needs are offered, and there are a number

of recreational programs. Work and recreational programs are designed to encourage the participation of all inmates, even those with physical handicaps. Similar to other BOP Federal Medical Centers, 24-h medical service is available, and extensive cooperative agreements with medical and healthcare agencies located in the community have been made to provide outpatient care for the inmates who are in need of more extensive medical care than that provided at FMC Lexington.

Summary

Although the proportion of the total crimes committed by older persons has increased significantly during the past several decades, old age has not been a key factor in determining the response of justice agencies. Research on sentencing of those older offenders convicted of a crime reveals that the sentence received corresponds to the type and severity of the offense. In cases in which the offense is minor, such as petty theft, and mitigating circumstances are considered, the older offenders might receive a less harsh sentence than those in other age categories who were convicted of the same offense. On the other hand, some research would suggest that the older offender is given a harsher sentence for some offenses, such as child molestation, than the sentence given to younger offenders who have been convicted of the same offense.

Information on the characteristics of the older offender suggest that the typical older offender will have more problems with such matters as physical health, mental health, alcohol and drug addiction, employment, and housing when compared with the criminal offender in other age groupings. Such programs as diversion from jail and participation in a drug court or a mental health court, community correctional programs such as probation, and placement in a community correctional facility rather than being sentenced to prison are likely to be quite beneficial for the older offender. Such programs were not specifically created for the older offender. A large proportion of older offenders have many problems that must be addressed, and the services needed must be provided by agencies other than justice agencies, because the personnel and resources needed to address the problems can best be found in a community setting rather than an institutional setting.

In some cases the older offender is sentenced to prison as a result of laws that require a prison term for specified offenses, or in some cases, an institutional setting is the best alternative. For example, for protection of the community, those older criminal offenders who have very serious mental health problems are likely to be sentenced to a mental facility that houses criminal offenders. Typically, while in prison, the older offender will be housed with inmates of all age groups and participate in the same activities as inmates in other age groups. However, there are examples of correctional facilities designed and administered specifically for the needs of older inmates.

Discussion Questions

1. What are the major reasons for the increase of older criminal offenders in the criminal justice system?
2. Discuss the reasons why a public health approach to dealing with older offenders with mental health problems makes more sense than a criminal justice approach.
3. Briefly describe the stages of the Sequential Intercept Model. From which stage in the intercept process would the majority of older offenders be most likely to benefit?
4. What are the major benefits to the community and the offenders whose offenses are related to drug or alcohol abuse if they are to supervised and treated in a community residential facility such as Oriana House?
5. What are the major differences between community correctional facilities and facilities such as halfway houses?
6. What are some of the pros and cons for establishing correctional facilities exclusively for older inmates?
7. Based on the research cited in this chapter, what effect does the age of the offender have on the sentencing decisions of judges who sentence older persons convicted of crimes?
8. Describe the typical characteristics and the process followed for those offenders referred to drug courts.
9. Describe the typical process followed in “problem-solving courts.” Based on the research cited in the this chapter, list some of the major benefits of problem-solving courts (drug, mental health courts) and some of the major problems associated with such courts. Would it make sense to establish special courts for older offenders?
10. Discuss the benefits of using a statewide risk-needs classification and case management system in the supervision and treatment of criminal offenders placed on probation or parole (post-release supervision). Are there disadvantages of using the same standardized model in all of the political jurisdictions throughout the state?

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