In Prison

SPECIAL POPULATIONS
Dear Readers:

This info-mag is a compilation of short articles written by Master of Science in Criminal Justice students at Bowling Green State University who were enrolled in CRJU 6200 Seminar in Contemporary Corrections spring semester 2016. For their major course project, students were divided into groups to examine two growing special offender populations in our nation’s correctional institutions: the elderly and inmates with mental illnesses. U.S. prisons have experienced unprecedented growth over the last 30 plus years that has resulted in more and more offenders being incarcerated for longer periods of time due, in large part, to mandatory minimum sentencing practices and the war on drugs. As the net widened for offenders who normally would have been placed on probation or other community corrections alternatives prior to the late 1980s, our jail and prison populations expanded, particularly for drug offenders who often serve longer sentences than some offenders convicted of more serious crimes such as murder.

Assuming we are alive, people age, and inmates are no different. On this journey, we experience a range of changes in our bodies, minds, and emotional well-being. Most prisons were not built to accommodate an aging inmate population, nor were they designed to house and treat the influx of offenders with mental illnesses. Sometimes the two populations overlap, thereby further complicating the management and administration of our prisons. When state psychiatric facilities began closing in the 1960s, the criminal justice system became the unofficial entity (after all, what else is available 24-7 to deal with crises) to keep the mentally ill off the streets, out of trouble, and some would argue, out of sight. Our prisons (and jails) have become the new mental health hospitals.

Fortunately, policy makers, police, prosecutors, judges, and corrections officials are starting to speak out against this practice in recognition that the criminal justice system cannot provide the services and programs necessary to appropriately treat persons with mental illnesses in the long-run. This acknowledgement is especially salient considering approximately 95% of the offenders who are sentenced to prison will be released back into society at some point, persons of all ages. It is incumbent that our correctional system (and the police, courts, and communities) more adequately plan for the release and reentry of a sizable percentage of the prison population who needed or will need targeted services treatment before, during, and after their entry into secure custody.

I hope you enjoy this info-mag and that you find something insightful to share with others about these two special offender populations. A very special thank you goes to Joelle Bridges for designing and incorporating the content for this info-mag.

Best,

Melissa W. Burek, Ph.D.
Associate Professor of Criminal Justice
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Factors Affecting the Growth of Aging Inmates

By Rachel Fettinger

Aging Inmate Population Rising
Many are aware of the steady increase in the number of aging inmates in US prisons, but what is not part of the conversation is how this is happening. We know the baby boomers are aging, but other factors may be able to explain the “graying” of our prisons.

Historical Context
In the years prior to the Vietnam War, correctional policy was based on the rehabilitation model. This model wanted to help treat the offenders because criminal behavior was seen more as a sickness (Rikard and Rosenberg, 2007). The 1960s marked a period of significant social change, and offenders were no longer seen as “sick,” but as untreated. This began the shift toward incapacitation. Through the 1980s and until more recent years, the incapacitation model influenced many policy decisions. From this model, we see “three strikes” programs and “get tough” policies (Rikard and Rosenberg, 2007). The shift in America’s criminal justice philosophies has not only contributed to the general growth of the prison population, but the aging inmate population as well.

Population Growth
The United States saw a spike in population rates after World War II and the children born during that time were referred to as the “baby boomers.” The “baby boom” cohort was famously large and when members of that generation were young adults, a larger number of them were likely to become criminals in comparison to other generations. This cohort has contributed to half of the observed increase in the aging inmate population (Luallen and Cutler, 2015). While Luallen and Cutler (2015) found support for the effect population aging has had on the inmate population, results of crime policies cannot be ignored.

Products of Tough Policies
A factor contributing to the “graying” of prisons that holds the most weight is the increasing admission age of offenders entering prison. More older adults are
committing more crimes, and it is possible that sentencing policies are less lenient for older criminals (Luallen and Kling, 2014). When looking at the aging inmate population, it is important to notice social and political growths. For example, currently in the United States we are seeing a slight increase in arrest rates. With a higher percentage of citizens being arrested, it makes it probable that there will be more convictions. Mandatory sentencing and truth in sentencing policies requiring inmates to serve at least 85% of their sentence, paired with an increase in harsher sentences, leads to more inmates being imprisoned for a longer period of time. Surprisingly, prior research suggests sentencing severity is not the biggest contributing factor, but its implications should not be ignored (Luallen and Kling, 2014).

**Medical and Technological Factors**

In the late 1900s, older inmates would have likely died in their sixties, but in the 2000s more people, including the incarcerated, were living until their late seventies. In addition to the increase in life expectancies, advances in medical technology are another reason for the increased number of aging inmates (Rikard and Rosenberg, 2007). Not only are people living longer, but also advances in medicine to keep people alive longer. For example, the advent of cholesterol lowering drugs and other preventive medications that target the precursors to cardiovascular diseases help to extend time to mortality. In addition, screening and diagnostic tools aid in disease prevention and health monitoring. Even our cell phones and smart watches can monitor our heart rates and track our steps, thereby providing our physicians with valuable data to help increase our longevity.

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**Life expectancy reaches all-time high**

Declines in death rates from most major causes have pushed Americans’ life expectancy to a record 77.6 years.

**Estimated life expectancy, 1943-2003**

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<tr>
<th>Year</th>
<th>Female</th>
<th>Male</th>
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<tr>
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<td>63.3</td>
<td>61.9</td>
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<td>1955</td>
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<td>2003</td>
<td>77.6</td>
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**By race and gender, 2003**

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<td>Black</td>
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**SOURCE:** Centers for Disease Control and Prevention

Retrieved from Life expectancy in U.S. hits record high (2005, February 28)
Demographics, Needs, and Challenges of Aging Inmates

By Paige Crawford

Overall U.S. Statistics and Aging Inmates

Bill is 57 and has been in prison for the past 15 years. He has developed high blood pressure problems and has trouble moving around the facility due to arthritis. Bill is not a rare example. There are many Bills in our nation’s prisons. The stressors of the prison environment and inadequate healthcare accelerate the aging process of prisoners so that they are physically older than average individuals. The National Institute of Corrections and a majority of criminologists agree that 50 years of age is when an inmate is considered to be “elderly” (Reimer, 2008). Thus, while an inmate may be considered elderly at 50 years in prison, the United States marks the elderly population at 65 years of age.

Statistics show that there has been an overwhelming growth in the number of older prisoners in the U.S. Fellner & Vinck (2012) present data from the Bureau of Justice Statistics to support this claim. These data show that in 2007 there were 16,000 state and federal prisoners age 65 and older, and increased to 26,200 by 2010 (Fellner & Vinck, 2012). If we use the age of 55 and older, closer to the accepted “elderly” inmate classification, in 2010, the number was close to 125,000 inmates (Chettiar et al., 2012). It is predicted that by 2020, 400,000 prisoners will be 55 or older, a growth rate of over 300% (Chettiar et al., 2012).

Demographics

Demographics of America’s aging inmates have been recorded and research has found that America’s elderly prisoners are overwhelmingly male. Women only comprise about 6% of aging prisoners (Chettiar et al., 2012). In terms of race, White prisoners make up the largest portion of aging prisoners (42%). However, while Blacks and Hispanics make up lower percentages of the population, they make up higher percentages of the aging prisoner population (Chettiar et al., 2012).

Types of Elderly Inmates

An increasing number of the elderly prison population is comprised of individuals sentenced to prison for long periods of time (20 years or more) and gradually remain in prison into their later years (Chettiar et al., 2012). For example, the percentage of aging prisoners falling into this category is currently 19% in Ohio (Chettiar et al., 2012). The majority of aging prisoners are not incarcerated for violent crimes, but instead are in prison for low-level crimes. In fact, most are incarcerated for non-violent crimes such as drug crimes, property crimes, burglary, and other non-violent and public order violations (Chettiar et al., 2012).

Although we cannot determine the exact reason for the aggregate growth of aging inmates in U.S. prisons, several factors have played a major role. Criminologists have recognized four major ideas that seem to attest for some of the reason for the increasing populations (Fellner & Vinck, 2012):

1. Long sentences
2. Life sentences
3. Older age of offenders
4. Early release
Where Does Ohio fall?

Ohio also shows clear trends of increasing aging populations. Fellner & Vinck (2012) present statistics on the growth of inmates age 50 and older in Ohio. The authors say that in 2001, the percentage of inmates 50 and older was only 9.5 percent of the total prison population as compared to 14.5 percent in 2010. In addition, between the years 1997 and 2010, the number of inmates (age 50 and older) increased by 126.2 percent (Fellner & Vinck, 2012).

To address the increasing numbers of older prisoners, Ohio has one state prison that is used primarily to safely incarcerate elderly inmates. Hocking Correctional Institution located in Nelsonville, Ohio, houses mainly level 1 and 2 (minimum and medium) security inmates. The 2010 Hocking Correctional Facility Inspection Brief provided statistics about the institution, some of which include: it is an all-male facility, 483 inmates with the majority being White, and 152 staff members (Correctional Institution Inspection Committee, 2010).

Challenges in Prison and Post-Release

If federal and state prison policies continue on the same path, the number of older inmates will continue to require additional funding to pay for the medical needs and costs of housing these inmates. For example, it costs around $35,000 to house a non-elderly inmate, but these costs increase two-fold for inmates over the age of 50 (Chettiari et al., 2012). Indeed, health care providers in correctional facilities have become more concerned with the challenges involved with dealing with the increasing elderly population. Some medical services needed for elderly inmates include a 24-hour nursing staff and physician availability and a pharmacy and laboratory (Rikard & Rosenberg, 2007, p. 152), which are extremely costly services in an already strained budget environment. Due to these high costs of housing inmates, state and federal authorities have been in a controversial debate over what to do with these inmates. Policies and programs such as “compassionate” release (medical parole), or early parole are ideas offered to decrease some of the costs the aging inmates pose on prisons (Rikard & Rosenberg, 2007).

There are other unique challenges to housing older inmates, such as prison facility design and management. Prison officials have had a hard time deciding whether to separate the elderly from the rest of the prison population. On one hand, if officials decide to keep the elderly with the general population, they may be at risk of harassment from the younger inmates, or the older and wiser inmates may teach the younger inmates bad habits. On the other hand, if the elderly are segregated, this may restrict and even change the social behaviors of the inmates, because they will be confined to close quarters with only other elderly people. The above limitations clearly demonstrate that elderly inmates have different needs than other inmates in the prison system and pose unique challenges to correctional officers and policy makers.

Conclusion

In sum, increases in the proportion of elderly inmates is having widespread effects on the criminal justice system. The statistics show that the number of aging prisoners will continue to grow unless changes are made to the U.S. justice policies such as “tough on crime,” and long mandatory sentences practices. Policy makers should focus on training their correctional officers within the prison to teach them to better identify and meet the needs of the elderly inmate.
Practices and Approaches

By Joelle Bridges

One of the major problems facing our prisons today is the increasing number of elderly inmates. In fact, in 2014 it was reported that from 1999 to 2012, the number of elderly inmates (55 or older) in state and federal prisons increased by 204 percent (U.S. Department of Justice, 2015). Unfortunately, this trend does not appear to be slowing down. According to a report by the Osborne Association (2014), it is predicted that by 2030, those 55 years and older will account for one-third of the U.S. prison population. In other words, in a fifty-year span the elderly inmate population will have grown 4,400 percent (Osborne Association, 2014). Thus, the federal government and a few states have begun taking steps to deal with this unique population of inmates. However, the practices and approaches used by these governmental entities are not uniform; states and the federal government tackle the issue in very different ways. This article will identify practices and approaches the federal government and some states are doing to address the elderly inmate population.

Ohio is one of the most accommodating states when it comes to policy on elderly inmates (Rikard & Rosenberg, 2007). First, the state has a geriatric conditional release law that allows elderly inmates to be considered for early release (FSU Project on Accountable Justice, 2015). However, the state’s most noteworthy approach attempts to deal with inmates

"In a fifty-year span the elderly inmate population will have grown 4,400 percent."

while they are in prison. Six correctional facilities house elderly inmates (Rikard & Rosenberg, 2007). The most prominent example is the Hocking Correctional Facility, which has created chronic disease and diabetes self-management programs (Osborne Association, 2014). Other states and the federal government, however, are taking different approaches to deal with this population.

The Federal Bureau of Prisons (BOP) has not been seen as a leader and innovator when it comes to elderly inmates. In fact, the U.S. Department of Justice (2015) released a report on the BOP and elderly inmates. They found that the BOP lacked appropriate staffing and training to deal with this population (U.S. Department of Justice, 2015). They also found that their prisons could not adequately house elderly inmates because of their physical infrastructure (U.S. Department of Justice, 2015). Lastly, they found that the BOP does not have any program opportunities specifically for addressing elderly inmate needs (U.S. Department of Justice, 2015). However, in 2013 the BOP did take one progressive move when it revised its policy on compassionate release in three distinct ways (U.S. Department of Justice, 2015).

1. Extended the period a person can seek release from 12 months to 18 months
2. Allows anyone over 65 who has served at least half of their sentence apply for release if they have a chronic or serious medical condition
3. If a person does not have a serious medical condition, they can still apply as long as they are over 65 and have served 75% of their sentence.

In the state of New York, 17 percent of
The number of state and federal prisoners age 55 and older increased by 204%, 1999-2012. Percentage change in sentenced prison populations by age group.

<table>
<thead>
<tr>
<th>Year</th>
<th>Prisoners under age 55</th>
<th>Prisoners 55 and older</th>
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their total prison population is comprised of elderly inmates (Osborne Association, 2014). New York has contributed to this large increase by harsh sentencing policies and the underuse of release options (parole, clemency, and medical release) (The Center for Justice at Columbia University, 2015). The state has begun to make strides towards addressing these issues. For instance, the state has proposed the Safe and Fair Evaluation (SAFE) Parole Act, which would eliminate the ability of parole boards to use the nature of the inmate’s original crime as a reason for denying parole in cases where the inmate has already served his/her minimum sentence (The Center for Justice at Columbia University, 2015). This would hopefully increase the number of individuals released on parole. Additionally, a Compassionate Release Program allows for the release of certain prisoners suffering from debilitating medical conditions (The Center for Justice at Columbia University, 2015). In coordination with that, New York has implemented practices aimed at helping and initiating Medicaid applications for individuals prior to release (The Center for Justice at Columbia University, 2015). Once released, inmates are eligible to be placed in one of the state’s adult care facilities that provide temporary or permanent care for individuals who cannot care for themselves (Osborne Association, 2014). In terms of care within the correctional setting, prisons in New York are attempting to deal with the elderly inmate population by creating specialty units. For instance, the Fishkill Correctional Facility has a cognitive impairment unit for individuals with dementia that provides an array of services from professional caregivers (Osborne Association, 2014).

In Florida, the number of elderly inmates has quadrupled in the last 15 years; meaning that the state currently estimates that it houses 20,753 inmates over the age of 50 (FSU Project on Accountable Justice, 2015). One method the state has used to address this problem is that it does not use age-specific policies and procedures (FSU Project on Accountable Justice, 2015). In other words, the state evaluates individuals overall medical classification and do not rely on age as an indication of need. This is beneficial because some inmates may not meet the standards to be considered elderly (50 and over) but still may require some of the medical services. Additionally, the state has six correctional institutions designated for elderly and sick inmates (FSU Project on Accountable Justice, 2015). For instance, the Lowell Correctional Institution, which houses female inmates, opened a dorm specifically for inmates with medical needs (FSU Project on Accountable Justice, 2015). This unit houses elderly inmates with complex needs that require constant attention.

A few other states have been innovators when it comes to dealing with elderly inmates. For instance, Nevada has implemented a True Grit program that provides many services, such as physical therapy, group counseling, musical groups, and craft making for elderly inmates (Osborne Association, 2014). The program appears to have decreased the number of doctor visits and medications used by inmates (Osborne Association, 2014). Additionally, California trained inmates to become “Gold Coats” by the Alzheimer’s Association (Osborne Association, 2014). The prison lets these trained inmates help care for the needs of their fellow elderly inmates. Lastly, Virginia offers assisted living services and programs to elderly inmates in their Deerfield Correctional Center (Osborne Association, 2014).

Despite these examples of states that have started taking steps towards managing this population, according to the Osborne Association (2014), only 5 percent of state correctional institutions had any type of geriatric-specific services of elderly inmates. This is alarming considering the growing number of elderly inmates in U.S. prisons and jails. Additionally, the techniques and approaches used by these different facilities are not standardized. Thus, states are forced to come up with their own programs and solutions because of the lack of guidance over the appropriate approaches to take. However, as the elderly inmate population continues to grow, more states will be forced to take action to address this special population. Other states should look at places like Ohio, New York, and Florida to get an indication on where to start in their own state.
THE COST OF PROVIDING CARE FOR AGING INMATES

By Marvin Paul

INTRODUCTION
In a 2012 report, the ACLU confirmed what many prison administrators and staff already knew by experience – aging adults were increasingly sentenced to prison and offenders punished when they were younger were starting to age in an environment not designed for elderly inmates. The limited number of resources used to assist with the care of an aging inmate population should be reexamined. Ohio Department of Corrections Deputy Director of Health care and Fiscal Operations Stuart Hudson stated that “With aging prisoners come medical issues and climbing costs to pay for them. Since 2012, the state spent $33 million in healthcare just for inmates age 50 and older” (Lander, 2015, para 4). The average cost to house an inmate with no medical issues in the United States is between $20,000 and $40,000 annually. With a prison population of 1.56 million at yearend 2013, the annual cost per year tops in the billions quickly. Splitting the inmate population into two groups will shed light as to why the cost of an inmate is so expensive. On one hand, there is the average inmate who is, for the most part, healthy and able to care for his or herself. On the other hand, you have an inmate who is 50 or older and has developing medical issues; this group (aging prison population) in particular would have hire medical expenditures thereby increasing their annual costs. “Adjusting for inflation, 44 states spent over $6 billion dollars on inmate healthcare in 2008, which was $2.3 billion dollars more than they spend in 2001 (Vestal, 2013).” Ohio is no exception to the trend. JoEllen Smith, a spokesperson for the Department of Rehabilitation and Correction, said state institutions have 6,847 inmates 50 or older; the oldest is 90. Inmates in that age group account for 15 percent of the overall prison population, up from 14 percent a year ago, she said” (Johnson, 2012, para. 5).

DISCUSSION
According to the Ohio Department of Rehabilitation and Correction (ODRC) website, the average daily cost to house an inmate in 2015 is estimated to be $67.31, and annual figures are $24,568 for one healthy prison inmate. The cost of an aging inmate is three times that amount. “Like the population on the outside, elderly prisoners are more likely to have chronic medical and mental conditions that require expensive treatments. The health care costs for inmates age 55 and older with a chronic illness is on average two to three times that of the cost for other inmates, according to the study” (Vestal, 2013, para. 7).

There are many costs associated with the aging population, “Ohio’s prison system spends $222.8 million a year on medical care for its approximately 51,000 inmates, including $28 million for prescription medications” (Bischoff, 2011, para. 4). Looking at Ohio specifically, the cost of an aging inmate is double the costs of their younger counterparts. What contributes the most to the high cost of aging inmates are the medical aides and resources necessary for the care of these inmates, such as canes, wheelchairs, walkers, and prescriptions.

Although the aging inmate population makes up a small percentage of the population, they make up a huge part of the budget for the ODRC. “Elderly prisoners are very expensive. Today, the U.S. spends about $16 billion annually locking up aging prisoners; in 1988, we spent about $11 billion on the entire corrections system. It costs $34,135 per year to house an average prisoner, but $68,270 annually to house a prisoner 50 and older...Releasing elderly inmates would save an average..."
of $66,294 per year” (ACLU, 2012, p. ii).

With the aging inmate population placing high costs on the ODRC’s overall budget, there are many things to acknowledge when considering possible solutions. There are other costs associated with the care of the aging inmate population outside of a cane or walker. This figure extends to urgent care, daily care, and managing chronic illnesses. “The state prison medical system is both expensive and expansive. Each year, it provides 6,000 video consults, dispenses 1.4 million prescriptions, manages 18,300 inmates with chronic conditions such as diabetes, asthma, hepatitis and heart disease, covers 2,250 local emergency room visits, runs a hospital lab that processes 3.5 million tests, and tends to 309 broken jaws and 260 broken hands” (Bischoff, 2011, para. 28).

The cost for Ohio’s state prisons, when speaking of the aging inmate population, falls in the middle at $4,300 compared to a few other states. States like California spends somewhere around $14,000 annually per aging inmate and Texas spends slightly under $3,000. These numbers reflect the resources and costs in annual figures per inmate.

**Cutting Costs**

Cutting costs to not only the Ohio aging inmate population, but also the nation’s aging inmate population should be a goal that most, if not all state legislators are tackling or trying to tackle. Some state departments of corrections are trying to save money by making use of telemedicine and outsourcing medical services (Vestal, 2013). The charts above show how the national graying inmate population and although the graying inmate population number is a lot smaller than the inmate population under 55, they cost the department of corrections the most money. One promising cost-saving measure is expanding eligibility for Medicaid to adults making $11,490 or less, which for those states that implement such measures, substantial cost savings are probable. To illustrate, “In Ohio, where Republican Gov. John Kasich recently circumvented the GOP-led legislature to approve the expansion, the state estimates it will save $273 million in prison health care costs in the first eight years” (Vestal, 2013, para. 13).

Another possible avenue to is to hand over the responsibility of caring for aging inmates to government-funded state and local nursing home facilities and other health facilities that are designed to deal with these types of 24-7 issues. Some argue that state department of corrections would be doing the general inmate population a favor by creating more room and taxpayers a favor by using the money saved to fund other areas.
Resources for the elderly inmate population are very scarce. Not many states implement programs that are aimed to help deal with this inmate population, but there is growing interest and need to do so. More states are seeing the issues related to the elderly inmate population and are trying to implement different resources and programs to benefit the inmates and the criminal justice system. Some states implement special housing facilities for elderly inmates, specialized programs for elder inmates, and in very rare cases, geriatric and medical releases. The most beneficial of all resources provided for the elderly population are special housing units to cater the needs of this population. Elderly inmates require special needs that most prison institutions cannot accommodate. Some aging prisoners need special medical care, wheelchair and disabilities accessibility, special food accommodations, and low bunking options. The majority of institutions provide basic medical care, but lack the proper resources to address the elderly population. Facility structures, such as lower bunks and wheelchair accessibility, are not always available. Some facilities have lower bunk options for aging inmates, but based on the increased number of these inmates in the prison, they are not always option for everyone who needs the accommodation. Table 1 provides a list of the different states in the United States that offer special housing options/facilities for elderly inmates.

In addition to having housing that is more accommodating and providing appropriate care options, some states offer specialized programs to provide more services for the elderly inmate population. Minnesota has a facility that has a 100-bed special needs unit. Offenders that are under 55 are required to participate in facility programs, whereas those over 55 can retire and relax. The facility also offers religious, social, and veteran groups (Price, 2014). Pennsylvania has a program called S.T.E.P that is implemented in multiple facilities in the states. It offers services to elderly prisoners, which include leisure activities, skill development, pre-release planning, and parole planning (Price, 2014). Oklahoma provides care for terminally ill inmates who are not eligible for medical parole. Lastly, Utah provides special housing for elderly inmates in wheelchairs and on oxygen. In this setting, elderly inmates are also paired with another inmate who is “passive” and they help each other with their daily chores, replacement of oxygen, and movement around the facility (Price, 2014).

As noted earlier, there are only a few states providing special housing and care options for elderly, and even fewer states provide special programs for those with special needs. The state of Ohio offers the most options for the elderly population and has more than 20 programs to assist these inmates.

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<th>Table 1. Special Housing Options By State</th>
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<td>Don't Forget!</td>
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<td>Medication Education</td>
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<td>Fifty Plus and Aging</td>
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<td>Grandparenting</td>
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<td>Healthy, Well and Wise, Personal Development for Elderly Inmates: A Way Out; and Eye on the Future</td>
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<td>Aerobic Exercise Program</td>
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<td>Older Resourceful Women</td>
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<td>Huggy Bear</td>
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<td>Recreation</td>
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<td>Forty-fives and Over Intramural Basketball League</td>
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<td>Arts with the Aged and Third Age Arts and Crafts Programs</td>
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<td>Days Gone By</td>
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<td>ACT (Action, Communication and Tolerance)</td>
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Ohio offers aging inmates a wide variety of different programs, and each Ohio prison has a designated administrator for the older population. Special programs addressing the elderly population are important to have. Elderly inmates cost the most money, need the most help, and have difficulties surviving without the support of others upon release. Ohio’s targeted programs aim to address all three of these issues. They make it possible to release the older population and provide them with the resources to make sure they can function outside of prison. One of the most beneficial programs is reentry programs. These programs are widespread across the United States and have proven most effective in decreasing recidivism. Aging inmates pose a bigger challenge than younger individuals when re-entering into society. They face homelessness, fragmented community and family ties, medical conditions and limited ways to support themselves (Osborne Association, 2014). Today, many institutions do not have reentry programs designed specifically for older inmates, but those that do have implemented such programs have seen good results. Below is a list of five of the reentry programs in the United States that are community based and aid in the reentry process for elderly offenders.

Offender reentry has a significant impact on the criminal justice system, society, and the individuals transitioning from incarceration to the community. When released, it is a big struggle, but even more of a struggle for the elderly population. They require more care than younger inmates do, they have extensive medical issues, most cannot work, and some have nowhere to live. Giving them the proper knowledge and/or programming to help with the reentry process can make a large difference.

Figure 1. Reentry Programs in the U.S.

Ohio’s Hocking Correctional Facility
Has a one-stop pre-release program providing older individuals with appropriate information on housing, employment and job trainings, self-care, and benefits. The staff is trained to address the issues affecting this population to ensure that they have the right support and resources to be successful.

Colorado’s Sterling Correctional Facility
The LTOP program was created in 2011 to assist parole-eligible individuals serving long sentences to transition to the community through peer support and restorative justice. The parolees are released to a nursing home or halfway houses where they are supported by counselors and peers through the reentry process.

The Transitions Clinic at Montefiore Medical Center
Provides primary care, HIV care, and mental health treatment, and addiction treatment services for those recently released. The clinic is run by professionals who understand the reentry process so they can gain a unique relationship to help each patient.

Rocky Hill Nursing Home in Connecticut
It is privately run facility. There have been issues because inmates are seen as residents rather than prisoners. This raises the question of whether they are actually incarceration. The point of the nursing home is to transfer the costs of care from corrections to Medicaid to save money.

Senior Ex-Offender Program in San Francisco
This is the first reentry program in the U.S. that exclusively focuses on the aging population. It includes transitional housing, case management, pre and post release counseling, transitional support groups, health and mental health services, access to a certified addiction specialist, and useful provisions such as clothing and hygiene products.

Retrieved from Osborne Association (2014)
Innovative Approaches for Dealing with Elderly Inmates

By Alexis Schmidt

The unique issues that accompany the elderly inmate population can be viewed in several different ways. It can be seen as a monetary urgency, a public health crisis, a violation of human rights, or simply as an outcome of the shortcomings of our criminal justice system (U.S. Department of Justice, 2015). Most would say that issues arose due to the increase in costs because of health issues, accommodation issues, and the specific needs of these elderly inmates. Not all of these issues brought forth by the elderly population are need-specific problems, but are often due to the lack of resources available in the prison setting.

One major issue is the increase in costs associated with the incarceration of elderly population. More specifically, the large costs to address their health conditions and the costs to accommodate the special needs of the elderly population. Elderly inmates may not only be in need of current health issues, but future problems may arise that will need assistance. Some inmates may have disabilities, impaired movement, mental illness, risk of major diseases, and require assistance with daily activities (Chiu, 2010). The inmates rely on the correctional staff for assistance and when they cannot help, more outside visits to medical clinics for assistance may become necessary. Aging inmates may also need special living accommodations and institutions often cannot adequately provide housing to address their needs (U.S. Department of Justice, 2015). These issues make it costlier to incarcerate elderly offenders. The US spends approximately $16 billion a year on offenders 50 years and older (Osborne Association, 2014). The amount of money it costs to incarcerate an individual offender varies by age. Inmates that are between the ages of 18 to 24 cost an average of $18,505, and offender 80 and older cost $30,609 each (U.S. Department of Justice, 2015).

Other issues associated with the elderly inmate population come from the lack of resources for these inmates. Institutions find it difficult to provide the appropriate care for these inmates because they often do not have the appropriate staffing levels to address their (U.S. Department of Justice, 2015). Many facilities do not have medical personnel available at all times, which leads to limited access and delays for medical care. Not only can prisons lack staffing, but also the existing staff at facilities often lack the appropriate training to assist the elderly inmates (U.S. Department of Justice, 2015). Facilities also lack programming opportunities for elderly inmates. Many elderly inmates do not need educational help, job help, or other skilled help that institutions provide. The institutions also lack reentry programs that are geared for geriatric offenders as they re-enter society (U.S. Department of Justice, 2015). There is momentum in some states to address these gaps. There are 15 facilities across the US that offer housing for elderly inmates that have special medical needs.

Above is a list of the 20 states that provide specialized medical care for elderly inmates. The most common approaches used to provide these medical care options include chronic care clinics, preventive care, and frequent physical examinations (U.S. Department of Justice, 1997).
Despite these advances, many facilities do not have the properly trained staff to care for people with medical issues. A big reason is the costs associated with employing the proper staff and providing medical supplies and services to support aging inmates. The use of special housing options for the elderly population is beneficial for the inmates, but could also be beneficial for the states, saving added costs of transport and hospital bills. Below is a chart of the states that offer geriatric housing for inmates.

Particularly timely, the majority of these states offer more than just living options. They offer programs that focus on addressing multiple needs of the elderly inmate population. These options are not necessarily an approach to help save time and money for the criminal justice system, but are aimed at help accommodate the needs of elderly inmates. One of these facilities is the Ohio Hocking Correctional Facility. The facility only houses geriatric inmates and provides an array of different programs to help the elderly population. In fact, the state of Ohio provides the most available options for the aging inmate population. The Ohio Hocking Correctional Facility has programs that help with chronic disease and diabetes self-management and offers an extensive reentry program (U.S. Department of Justice, 1997). The facility also offers the proper resources to make sure elders get the proper care they need.

In the state of Nevada, they offer the True Grit program that is all volunteer-based and is meant only for geriatric inmates. This program provides daily structured living activities that address physical, mental, spiritual, and emotional needs, and well-being of the elderly population. The elderly inmates engage in activities and services that has shown that the program decreases doctors’ visits, medication intake and the well-being of the inmates. Some of the activities include counseling, therapy dogs, musical groups, and physical therapy (U.S. Department of Justice, 1997). Other state programs that assist the elderly population include (U.S. Department of Justice, 1997):

1. Virginia’s Deerfield Correctional Center, which provides assisted living services and programming that is designed to slow the onset of osteoarthritis.

2. California’s Men’s Colony and Fishkill Correctional Facility focus on providing services to elders with dementia.

3. Angola State Prison, which has a hospice program to help care for those who are dying being bars.

Finally, there are geriatric release options in some states. This option is beneficial to the criminal justice system as once the incarcerated geriatric population decreases, there should be a large savings in medical costs, special facility costs, specialized programing costs, and predicted lower recidivism rates. There are 15 states and the District of Columbia that have releasing options for elderly inmates. These options range from parole, medical or compassionate releases. Below is a chart of all the states and their requirements to be considered for geriatric release.

Not all elderly inmates are considered for these geriatric release options. There are specific requirements and procedures that take place in order to decide whether each individual elder is eligible for one of these early release routes. An inmate has to meet the basic age and time served requirements. Consideration is also taken relevant to the types of crimes an inmate was convicted of to determine whether they can apply for release. After applying, state representatives do an evaluation of the individuals, look at the conditions of release, and finally the revocations (Chiu, 2010). There are many different approaches available to address the issues associated with the elderly population. Elderly inmates often require special care and need different accommodations compared to younger inmates. Some of these programs are aimed at addressing the needs of the inmates, while others are implemented to benefit the criminal justice system.

<table>
<thead>
<tr>
<th>State</th>
<th>Statutory/ Administrative Provision</th>
<th>Minimum Age</th>
<th>Eligible Applicants</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL</td>
<td>Ala. Code §§ 14-14-1 to 14-14-7</td>
<td>55</td>
<td>Must be 55 years or older and suffer from a chronic life-threatening illness, life-threatening illness, or chronic debilitating disease related to aging.</td>
</tr>
<tr>
<td>CO</td>
<td>Colo. Rev. Stat. §§ 17-1-102, 17-23-503.5</td>
<td>65</td>
<td>Must be 65, incapacitated, incapable of earning a living, not a threat to society, not likely to re-offend, and not convicted of certain felonies.</td>
</tr>
<tr>
<td>CT</td>
<td>Conn. Gen. Stat. § 54-131t</td>
<td>-</td>
<td>Must be physically or mentally disabled from age or illness incapable of being a threat to society, and have served half of their sentence.</td>
</tr>
<tr>
<td>DC</td>
<td>D.C. Code § 26-465</td>
<td>65</td>
<td>Must be 65 and have a chronic, age-related problem that arose after sentencing.</td>
</tr>
<tr>
<td>MO</td>
<td>Mo. Code Ann., Crim. Law § 14-1013g</td>
<td>65</td>
<td>Must be 65 and have served at least 15 years of a sentence for a crime of violence.</td>
</tr>
<tr>
<td>MO</td>
<td>Mo. Rev. Stat. § 217.250</td>
<td>-</td>
<td>Must be advanced in age to the point of needing long-term nursing home care.</td>
</tr>
<tr>
<td>NC</td>
<td>N.C. Gen. Stat. §§ 15A-1369.5 to 1369.5</td>
<td>65</td>
<td>Must be 65 or older and suffer from chronic illness, or disease related to aging, and incapacitated to the extent that they do not pose a public safety risk.</td>
</tr>
<tr>
<td>NM</td>
<td>N.Mex. Stat. §§ 31-21-25.1</td>
<td>65</td>
<td>Must be 65, have chronic illness/infirmity/disease related to aging, and must not be a danger to themselves or society.</td>
</tr>
<tr>
<td>OK</td>
<td>Okla. Tit. 17, § 332.7</td>
<td>60</td>
<td>Must have committed their crime before 3/1/1998, be 60 years of age, and have served at least 50% of a sentence imposed under applicable truth-in-sentencing guidelines.</td>
</tr>
<tr>
<td>OR</td>
<td>Ore. Rev. Stat. § 144.122(10)</td>
<td>-</td>
<td>Must be elderly and permanently incapacitated in such a manner that they are unable to move from place to place without assistance of another person.</td>
</tr>
<tr>
<td>TX</td>
<td>Tex. Gov’t. Code § 508.146</td>
<td>-</td>
<td>Elderly, physically disabled, mentally ill, terminally ill, or mentally retarded individuals or those who have a condition requiring long-term care, and are not a threat to public safety based on their condition and a medical evaluation.</td>
</tr>
<tr>
<td>WI</td>
<td>Va. Code Ann. § 53.1-43.01</td>
<td>60 or 65</td>
<td>People age 60 who have served 10 years or those who are age 65 and have served 15 years.</td>
</tr>
<tr>
<td>WA</td>
<td>Wash. Rev. Code § 9.96A.728</td>
<td>-</td>
<td>Have a serious medical condition that is expected to require costly care or treatment and are physically incapacitated due to age or medical condition or expected to be so at the time of release.</td>
</tr>
<tr>
<td>WI</td>
<td>Wis. Stat. § 302.1135</td>
<td>60 or 65</td>
<td>Must be age 60 and have served 10 years or age 65 and have served 5 years, may seek petition for release to extended supervision.</td>
</tr>
<tr>
<td>WY</td>
<td>Wyo. Stat. Ann. § 7-1-424</td>
<td>60 or 65</td>
<td>Must be incapacitated by age to the extent that deteriorating physical or mental health substantially diminishes their self-care within a correctional facility.</td>
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Recommendations

By Joelle Bridges, Paige Crawford, Rachel Fettinger, Marvin Paul, and Alexis Schmidt

Photo by Ron Levine/Prisoners of Age
Increase the Use of Release Mechanisms
One recommendation that would provide effective management of the aging population is to increase the use of release mechanisms. States and the federal government should move towards utilizing and expanding its use of parole for older inmates. One change that could help achieve this goal is to increase the use of compassionate release and medical parole (Osborne, 2014). This would be beneficial because the state could save money on medical expenses by releasing individuals who pose very little threat. Many states have such policies but are often underused. Additionally, states and the federal government should consider implementing similar laws to the New York State Safe and Fair Evaluation (SAFE) Parole Act 9. These laws no longer allow parole boards to use an inmate’s original crime as a basis for parole denial after the minimum sentence has been served (The Center for Justice at Columbia University, 2015). This law provides a mechanism for more inmates to be released on parole and thus, lowering the number of individuals aging behind bars. Lastly, states that decide to increase release mechanism should also consider and develop plans for post-release services for this population. In other words, states should ensure that their communities have infrastructures that are capable of receiving and caring for these individuals (The Center for Justice at Columbia University, 2015).

More Specialized Geriatric Units
With prison overcrowding, there is concern on how to handle the aging population since that prison demographic is growing. Some alternatives suggest housing the aging inmates in other facilities in the community, but there are some inmates that may not be seen as safe to be released into the public. To solve this issue, more prisons should have specialized geriatric units. The aging population has a different set of needs, and often prisons do not have the technology or staff to address these needs. Creating specialized geriatric units would provide a location to house these inmates, as well as providing better care.

Improve Reentry Efforts
The availability of program opportunities for the aging inmate population are lacking in many aspects. The biggest issue would be the lack of reentry services geared for this population. More specifically, states could do more to help with the continuity of care for the elderly inmates and help them make connections to health insurance and nursing homes (Osborne Association, 2014). States could also develop more efficient infrastructures in the community that are specifically aimed at providing care and opportunities for the elderly population returning to society (Osborne Association, 2014). A final recommendation would be to do further research to identify the concerns of reentry of the aging population to establish a better understanding of what needs to be done to improve outcomes for reentry success (Osborne Association, 2014). Reentry is one of the biggest challenges in corrections, for both the younger population and the elderly population. In order to be successful, adequate and effective programs are needed. To do so, we must have a thorough understanding of the specific needs and concerns of the different populations and what approaches work best for successful reentry.

Correctional Officer Training
Due to the presented challenges of the elderly population and others found in many studies, researchers and criminologists have provided recommendations in order to reduce the costs and numbers of these inmates in prison. Institutions should provide mandatory training to their correctional officers on the elderly (e.g., identifying needs of the elderly, hire more social workers). Though this recommendation will not totally fix the issues explored in this publication, it will alleviate some of the issues found with this population in prison. It correctional officers are required to do training, they will better understand the needs of the aging population, and overcome some of the challenges.

Increase Use of Private Facilities
The inmates with chronic illnesses should be released or pardoned due to their condition, and then transferred to the nearest facility that supports the inmate’s condition. As a few of the articles pointed out, if the medical care responsibility is outsourced to a facility that supports these types of conditions and are also federally funded, this would alleviate state funding and reduce prison crowding. As Governor Kasich pointed out, having the inmates with these conditions moved to a facility that is supportive will save the state of Ohio millions overtime.
Factors Affecting the Growth of Mentally Ill Inmates

The U.S. has approximately 356,000 inmates with some type of serious mental illness who are currently serving their sentences in jails and state prisons. Of particular concern is that figure is 10 times more than the approximately 35,000 individuals who are being treated for a serious mental illness in state hospitals. One quarter of the correctional population, (i.e., prisoners, jail inmates, and probationers) have been diagnosed with a severe mental illness (Kim, Becker-Cohen, & Serakos, 2015). Studies have shown that mental health issues are more commonly found among the white, young, female inmates in comparison to other demographics (Kim et al., 2015). In addition, female inmates also experience higher rates of mental health problems than their male counterparts do. In state prisons, the percentage of females experiencing mental health problems were 73 percent and males hovered around 55 percent (Kim et al., 2015). Similar proportions are found for females and males with mental illnesses in federal prisons and jail. However, funding and/or grants for treatment are often scare, making mental health issues a growing challenge for all in the U.S. correctional system.

The rate of mental disorders varies with age of inmates. Inmates who were under the age of 24 had the highest rate of mental health problems and those over 55 had the lowest rate (James & Glaze, 2006). We are seeing an extensive amount of mental illness among our inmate populations that would indicate there is a much greater need for mental health treatment within our correction system. In the U.S., the largest jails and prisons house more individuals with mental illnesses and co-occurring substance use disorders than many psychiatric institutions (Kim et al., 2015). Indeed, treating someone who is suffering from a mental illness within the corrections system has become a much larger problem now with the closing of large state mental institutions.

As is supported by the data, persons with mental illnesses represent a significant number of the correctional population. The care, or in many cases, the lack of care, that individuals with mental disorders receive has been shown to be inadequate. According to James and Glaze (2006), only one in three state prisoners and one in six jail inmates has received any type of mental health treatment since their admission. According to various reports, the aging inmate(s) and those suffering from mental disorder(s) will continue to be a growing part of the inmate population. The rise in the number of mentally ill inmate/ex-offender(s) has increasingly put a big strain on the correctional systems.

As with any inmate within the criminal justice system, there will be a number of challenges they face. However, when it comes to working with mentally ill offenders, their circumstances and needs quickly change. The mental health prison system that we currently work under addresses the need(s) of the current situation and/or provides that quick fix; however, it is not equipped to react to the long-term effect(s) of prison. Sometimes we release inmates without the proper care being put in place to ensure their success. A follow-up assessment prior to and then after release rarely takes place, leaving the ex-offender on his/her own. The vicious cycle then just continues, most times either back on drugs/alcohol or landing the ex-offender back into custody.

While incarcerated, mental health problems can contribute to an inmate’s behavior. Considering a large proportion of people in prison (including those on remand) suffer from one or more mental illness, a focus on treatment could result in big savings for those who choose to use it. It has been shown that therapy/treatment, when given early on does have a positive effect on recidivism rates. Properly assessing, formulating a treatment plan, and following through to aftercare does indeed make a difference. Not only do they get inmates get help, they are given tools/life skills, which many may have lacked.
illness cost approximately $50-60 more to house in comparison to an inmate without a mental illness. This difference is often due to the costs associated with the initial assessment, treatment, and/or medication that may be needed by inmates with mental disorders. The fact is, inmates who suffer from mental illness require much more in terms of care, and the cost of providing this care can affect the budget of any correction system. Various research studies have shown, not only is there an effect on the health care cost(s), but they also suggested that prison misconduct and recidivism occur at much higher rates with the mentally ill inmates (Kim et al., 2015).

Several factors or events affected the large growth in the percentage of the correctional population suffering from mental illness. There are social economic, environmental/sociocultural, individual attributes, risk vulnerabilities, some of which have already been addressed above. There are also risks that can present themselves at any given point in our lives; any one of those can impact our mental health. Some researchers found this could occur depending on the broader sociocultural and geopolitical context.

One of the major changes that occurred that led to an increase in the number of persons with mental illnesses in the criminal justice system were a result of a change in the mental health policies such as deinstitutionalization. Deinstitutionalization led to the increase of the number of people in the community with serious mental illness who lacks appropriate care for their disorders by releasing individuals from mental hospitals who were no longer considered a threat (MacKenzie, 2001). As it would turn out, mentally ill ex-hospital patients were not always able to function in society and had trouble obeying the law. Arrests of this population became more frequent and some of these individuals ended up in the correctional system. The prisons have now become our new mental illness asylums. In fact, researchers have found that in every county in the US that has both a county jail and a county psychiatric facility, the jail now houses more of the seriously mentally ill individuals.

Researchers such as Cloyes et al. (2010) have stated that other factors such as experienced homelessness, prior incarceration, and substance abuse and dependence may also have contributed to the increasing numbers of mentally ill in the criminal justice system. Available data show that jail inmates had the highest rate of symptoms for any mental health disorder (64%), followed by state (56%), and federal prisoners (45%) (James & Glaze, 2006). Prison overcrowding further complicates this situation. In the past 25 years, the US prison population has quadrupled and correctional institutions are now responsible for meeting the health care needs of approximately 2.3 million U.S. inmates.

Correction officers and others will also be affected due to lack of professional staff that should be there to help with the mentally ill inmates. According to Kim et al., (2015, p. 11), "in addition, to direct mental health care costs, mentally ill prisoners have higher rates of misconduct and accidents in prisons," which also increases costs. There is also the issue of fear of victimization, which affects the older prisoners (Kim et al., 2015). "Older prisoners generally have higher rates of mental illness than their younger peers do, and the present 'graying' of the prison population has recently become well documented" (Kim et al., 2015, p. 10). To complicate matters, reports of inmates who had been physically or sexually abused in the past are 24%, in comparison to eight percent of those inmates without mental disorders. In order to protect and treat inmates who are suffering from a mental health related illness additional funding is needed. A treatment plan must be unique in its own terms; mental health and the way we treat it has to be tailored to the client/inmate needs. Project(s) and/or program(s) such as these are not widely available in prison due to the limited funding.

In sum, studies have concluded, as the inmate population grows older, the percentage of mentally ill inmates will also continue to rise (Kim et al., 2015). Management of the mentally ill has become particularly challenging for corrections officials (Mackenzie, 2001). It has been shown that prison conditions actually can exacerbate a preexisting mental illness. Increasing health care costs, staff expense(s), lack of qualified health care professionals, proper leadership, and the increasing litigation cost, many of states have now opted for privatized mental health and medical services. Finally, each mentally ill offender brings with him/her a a unique set of conditions that could be their level of criminal responsibility into question (Kim et al., 2015). As such, states and their respective courts are left to decide if offenders with a mental disorder should be held liable for their crimes. Specific methods to determine if a person was insane at the time of the offense are in place in most jurisdictions, such as the M’Naghten Rule, the Model Penal Code Rule, or the Durham Rule. Found guilty or not, offenders with mental illnesses need access to treatment to address their needs, preferably before individuals become law violators.
Demographics

The estimated number of inmates with severe mental illness in 2005 was 319,918 (James and Glaze, 2006). This number rose to 356,268 in 2012 (Torrey et al., 2014). Looking to Table 3 from James and Glaze (2006), the majority of those inmates are found in local jails, making up about 64% of the population, followed by state prisons making up about 56% of the population, and federal prisons making up about 45% of the population (James and Glaze, 2006). As for sex, women have the highest rates of severe mental illness in prisons and jails. In local jails, women make up about 75%, in state prisons they make up about 73%, and in federal prisons they make up about 61% (James and Glaze, 2006). Whites also have the highest rates of severe mental illness in state prisons (62%) and local jails (71%), but are passed in federal prisons (50%) by persons identified as “other,” or American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and inmates who specified more than one race (James and Glaze, 2006). Characteristics of the typical offender with mental illness in our nation’s correctional institutions are those who are younger, Whites, and females.

Table 4 presents a picture of the history of these inmates with severe mental illness. The table from James and Glaze (2006) outlines other factors facing these individuals adding to their likelihood of ending up in the criminal justice system, such as substance abuse, family history, employment history, homelessness, history of abuse, and current and past criminal record (James and Glaze, 2006). Mentally inmates are very different from the average inmate. They require specific care and can sometimes become violent and unpredictable, requiring officers to be trained to deal with these sensitive situations properly.

Needs

Adams and Ferrandino (2008) discuss the different needs and challenges presented to mentally ill inmates and the criminal justice system. They address that those who have severe mental illness need to have more extensive assessment upon intake and require more risk management. Those who suffer from mental illness can also be a threat to themselves and others, meaning they need more specific care. Along with that, mentally ill inmates require more intensive supervision to combat these risks.

Mentally ill inmates also require more specialized staff. Correctional officers need more specific training in crisis situations to properly discipline mentally ill inmates without causing a potentially violent reaction. Concentrated planning also needs to be taken for suicide watches, protecting inmates from harming themselves and others, and knowing how to diffuse situations before they become problematic. (Adams and Ferrandino, 2008). Mentally ill inmates also require...
specialized clinical staff as well. They need clinicians to prescribe and dispense medications, monitor their medications and intake for possible reaction. Counselors should be on hand for possible crisis situations, and to evaluate progress (Adams and Ferrandino, 2008). Lastly, mentally ill inmates require more specialized programming for their treatment. One type of programming that ties into medical personnel is medication. These inmates need to take different types of medications, such as anti-depressants, anti-anxiety, and anti-psychotics to help them stay stable (Adams and Ferrandino, 2008). Counseling programs are also necessary. These programs can include sessions such as group therapy, substance abuse programs like Alcoholics Anonymous (AA), behavioral therapy, and anger management (Adams and Ferrandino, 2008).

Challenges

Challenges that face mentally ill inmates in and out of prison include their vulnerability, programming issues, and their higher rates of recidivism. Adams and Ferrandino (2008) note that mentally ill inmates are more likely to be victimized by other inmates and staff while incarcerated because they are less able to defend themselves against assault, rape, and other forms of sexual assault (Adams and Ferrandino, 2008). Another issue they face is the need for programs. Due to the large number of inmates suffering from mental illness, there is a high demand and need for treatment, but some prison programs can only take on so many inmates at a time. There is also an issue of funding opportunities for these programs. Prisons that do not have high levels of funding may not be able to offer the types of programs these inmates need, making their path to treatment very difficult (Adams and Ferrandino, 2008).

Lastly, Adams and Ferrandino (2008) point out that these inmates also have higher levels of recidivism compared to inmates without mental illness. Problems that can arise for these inmates upon release that can lead to increased recidivism are: being unable to get the medication they need, being unable to hold a job, and being unable to get affordable housing (Adams and Ferrandino, 2008). A lot of inmates with mental illness have substance abuse problems, so if they are unable to receive the medication they need, they are more likely to self-medicate with illicit drugs. Having a criminal record can make it difficult for anyone to get a job, but those with mental illnesses face an even harder time than others. Along with that, if they are self-medicating with illicit drugs, that can make it that much harder to hold a steady job. If they have no family to live with, they must try to rent/buy housing. As with finding a job, it is difficult to find affordable housing with a criminal record. If they lose their job due to self-medicating with illicit drugs, they have no income, so they cannot afford a home, making them homeless. Homelessness is high among mentally ill individuals. These are all violations of parole, which can lead them to being placed back in prison (Adams and Ferrandino, 2008). It can become a vicious cycle.
Introduction
With the number of mentally ill offenders being incarcerated increasing alongside the total incarceration rate, the criminal justice system is challenged to supervise a group of offenders for which training and preparedness is minimally existent. Mentally ill offenders do not only pose a threat to correctional officers, but they can also pose a threat to the correctional facility as a whole. Incarcerating mentally ill offenders does not treat the underlying disorder that likely brought them to the criminal justice system. Actually, in some cases, incarceration may be doing more harm than good. A good number of mentally ill offenders do not need to punished or isolated, they need proper and effective treatment that targets their individual issues. While there are a variety of approaches, this article will discuss three of the most popular practices that states have taken to address the issue of mentally ill offenders starting with community to residential options.

Approach One
The first approach is an approach Ken Kerle addresses in his article “The Mentally Ill and Crisis Intervention Teams: Reflections on Jails and the U.S. Mental Health Challenge” (2016). The approach of Crisis Intervention Teams (CIT) originated in Memphis, Tennessee, in 1987 after an officer had shot and killed a mentally ill individual. In this article, Ken discusses the growth of crisis intervention teams and how they can be a valuable tool for diverting the mentally ill from correctional to mental health settings (2016, p. 153). CIT started off with putting more focus on law enforcement, meaning training officers on how to appropriately deal and handle mentally ill offenders since they often the first line of contact when it comes to the mentally ill. For example, if a mentally ill offender is having a manic episode at a public place, law enforcement is the first to be called. If officers are better trained to know what these episodes look like and what to do, they can prevent mentally ill offenders from going through the criminal justice system. Instead, they can refer them to mental health settings, where they will receive the necessary treatment.

For CIT to be effective, there would need to be help and cooperation from all components of the criminal justice system. However, Karle states, “The Memphis CIT training ultimately resulted in a decline in the use of deadly force and resultant reduction in injuries for the mentally ill (40%) and officers (85%)” (2016, p.156). With declining numbers like that, it is no wonder why CITs are becoming popular. In conjunction with CIT, the National Institute of Mental Health emphasized five goals that would also work to divert mentally ill offenders from the criminal
ill offenders from the criminal justice system (2016, p. 156):

(1) Training of police and sheriffs’ departments on mental illness and appropriate management of the mentally ill;
(2) Obtaining a commitment to implement alternatives to incarceration;
(3) Willingness of mental health and corrections personal to work together;
(4) Training mandated for suicide prevention and treatment; and
(5) Developing in-jail mental health treatment programs.

Ultimately, proper training is the technique that is required bolster the effectiveness of this approach.

**Approach Two**

The second approach comes from Lucas B. Shaw and Robert D. Morgan in their article “Inmate Attitudes Toward Treatment: Mental Health Service Utilization and Treatment Effects” (2010). Shaw and Morgan discuss the idea of actually educating offenders on mental health treatment. This approach comes from a study done with the Kansas Department of Corrections. Educating the mentally ill on the resources available and the benefits of treatment allows the offender to gain a better understanding of what he or she may be feeling mentally and how to seek help, without the fear of being judged or punished.

The approach of educating offenders on mental health requires that the treatment be educationally focused. The first step is offering information to inmates regarding mental health. This information is given during new inmate orientation for all inmates, which can provide accurate information on mental health, mental health treatments, and when to seek treatment for anyone in the prison population. While some inmates know what is wrong and going on within themselves, most do not, and often go into prison with mental health issues and come out the same or worse, which leads to a repeated cycle of recidivism. This is not the case for all inmates, but with this approach it gives the opportunity to help those who are willing. Overall, this study found the approach of educating offenders on mental health beneficial. Inmates gained more positive attitudes towards seeking mental health help and overcoming treatment fears (2010, p.259).

**Conclusion**

In closing, with the growth of mentally ill offenders going through the criminal justice system, there needs to be some type of action taken. Incarceration is seen as a form of punishment for individuals who have willingly broken the law and must “pay their debt to society.” However, for the mentally ill prison is not the ideal setting or best approach to deal with these offenders. Kerle mentions that “Locking up mentally ill law violators has proved to be extremely expensive. It makes political sense to divert the non-violent mentally ill charged with misdemeanors out of the criminal justice system and into the community for care” (2016, p. 159). Diverting mentally ill offenders with one of the three approaches mentioned throughout this article will cut down the cost and difficulty of housing mentally ill inmates.
The Cost of Mental Health in Prisons

By Christopher Holbrook

Photo by Barbara Davidson/Los Angeles Times
Mental illness such as schizophrenia or other psychotic disorders is three to five times greater at generating greater healthcare costs for prisons. Some experts believe that the mentally ill should be in a hospital environment not prison because it is a healthcare concern not a criminal justice concern. Roughly 3.9% of inmates in state prisons had schizophrenia or another psychotic disorder (Kosak, 2005). Roughly 13.1 to 18.6% of state inmates suffer from major depression and between 22 and 30% of all state prisoners suffer from some form of anxiety disorder (Henrichson & Delaney, 2012). Incarcerating individuals with severe psychiatric disorders costs twice as much as community treatment programs. The average prison cost for all states reporting for general healthcare is 37% (Chang & Klein, 2014). While mental healthcare and substance abuse treatment, which often go hand in hand, totals 19% of the entire budget (The PEW Charitable Trusts, 2014).

One of the biggest spending drivers for state prisons is mental healthcare costs. In most states reporting a large portion of the costs for inmate hospital care relating to mental health is funded outside the corrections department budget by grants. The full cost to taxpayers including costs outside the corrections budget is $39 billion, which is $5.4 billion more than the states corrections department spending budget (Henrichson & Delaney, 2014). Hence, it has to be funded outside of the corrections budget using a variety of tools including grants. Mental illness healthcare cost is 19% of that figure, which turns out to be $7.4 billion out of the $39 billion (Henrichson & Delaney, 2014).

A few points on the human cost of mental illness with inmates are that among inmates, 2.1% were missing data on their prescriptions and 2.8% had prior diagnosis of PTSD (Wilper et al., 2009). This makes it more difficult to stay out of trouble in prison and it sometimes leads to time in solitary confinement, which, in turn, makes their symptoms of mental illness worse (Daniel, 2007).

On average, in state prisons, the typical prisoner costs states about $22,000 a year but prisoners with mental illness range from $30,000 to $50,000 a year (Treatment Advocacy Center, 2014). The human cost is a revolving door of psychiatric mentally ill prisoners, who in Palm Beach county Florida are required to have a psychiatric exam with each exam costing $2,000 each. In a 40-year period, one inmate with mental illness was in and out of jail so much that the cost of the exams totaled $98,000 (Treatment Advocacy Center, n.d.). This is a viscous cycle. There is also the cost of lawsuits brought by family members of mentally ill prisoners. An example of this is in 2006 the family of a 65-year-old mentally ill stockbroker who was stomped to death in the Camden County Jail (Treatment Advocacy Center, n.d.). Mentally ill inmates are more likely to be victimized than other inmates, contributes to the human cost (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010).

Mentally ill inmates also tend to stay longer than the average stay for all inmates. In New York’s Riker’s Island, the average stay is 42 days. For mentally ill inmates it is 215 days, so there is a significantly greater cost associated with that (Treatment Advocacy Center, n.d.). Mentally ill inmates also present administration and management problems and end up in segregation. In Wisconsin, state prisons find that between 55 and 76% of inmates held in segregation are mentally ill (Treatment Advocacy Center, n.d.). Further, mentally ill inmates are more likely to commit suicide. To alleviate this problem, one option would be to set up mental health courts to get these mentally ill offenders healthcare instead of prison.
Available Resources for Mentally Ill Inmates

By Eric Nelson
In 1955, shortly before the process of deinstitutionalization began, there were roughly 558,239 public psychiatric beds available, representing 340 beds per 100,000 U.S. residents. In 2005, that number had been reduced to approximately 52,539, leaving only 17 beds available per 100,000 (Baillargeon, Hoge, & Penn, 2010).

The deinstitutionalization of the mentally ill has had profound effects on incarceration rates of individuals with substance abuse or mental health issues. While mental health services do exist in prisons, treatment decisions depend entirely on limited available resources to the facility, public support of correctional treatment and procedures, and correctional management decision-making (Gonzales & Connell, 2014). Limited resources have left 43 percent of mentally ill inmates waiting for diagnosis and treatment services. Many of which are scheduled to leave within a few months (Baillargeon, Hoge, & Penn, 2010).

Correctional facilities are now recognized as one of the largest providers for mental health services (Warrilow, 2011). Although statistics represent a lack of resources and treatment available, facilities and state legislatures are beginning to understand the importance of accessible health services.

For many institutions, standard mental health screening at intake is required for accreditation by the American Correctional Association and the National Commission on Correctional Health Services (Warrilow, 2011). These screenings are vital to ensure a proper diagnosis that leads to appropriate intervention. After assessments, optimal correctional systems offer a continuum of inpatient and outpatient treatment services. Many institutions have developed mental health in-reach teams that carefully monitor an offender's progress in these programs and offer insight to future needs. Without these services, it makes it difficult to implement an effective aftercare or transition program (Baillargeon, Hoge, & Penn, 2010).

"Limited resources have left 43 percent of mentally ill inmates waiting for diagnosis and treatment services."

Treatment services have also begun to include crisis intervention specialists who are on-call 24 hours a day. Well-trained and dedicated mental health personnel are available to offer suicide prevention strategies and specialized evaluation services to gain more understanding on certain individual needs. If more intervention is needed, psychotherapy groups, medication, and substance abuse programs are available to help remedy any situation. Transfer abilities to local hospitals have also been made available if an individual needs more focused treatment or intervention (Warrilow, 2011).

The importance of providing quality treatment for severely mentally ill prisoners during incarceration will increase the likelihood of a successful transition back into society (Oxelson, 2009). However, the extent to which correctional mental health services are provided varies substantially across the United States. All of these resources mentioned either are offered in prisons currently, or in many cases, have been known to be very limited in availability to offenders with mental health issues (Warrilow, 2011).
Innovative Approaches for Dealing with Mentally Ill Inmates

By Johnson Ekhator

The graph below shows the percentages of inmates diagnosed with specific mental illnesses in correctional institutions. This article explores several innovative approaches for dealing with the unique issues brought forth by the increasing numbers of individuals entering secure correctional facilities with mental health illnesses.

![Graph showing percentages of mental illnesses among inmates.]

**SCREENING AND ASSESSMENT:**

The key to identifying mental health problems in prison inmates begins at intake through effective mental, medical, and psychological screening and assessment. Statistical reports compiled by the Bureau of Justice Statistics show that in 2000, approximately 70% of state prisons used psychiatric screening approaches to assess inmates’ mental health problems at intake (Beck & Maruschak, 2001). Over time, screening tools such as clinical interviews and evaluations and actuarial or statistical approaches were utilized in numerous prisons and continue to be used today. Screening and assessment approaches have aided in pinpointing inmates’ mental health problems, effective evaluation, and offering of necessary and adequate treatments (Adams & Fernandino, 2008).

Similarly, numerous correctional facilities across the United States are currently utilizing risk assessment models to assess mentally ill inmates’ substance abuse, treatment needs, and potential for recidivism. Taxman, Cropsey, Young, and Wexler (2007) examined the risk assessment models at multiple correctional institutions and found that 58.2% of them utilize standard substance screening tools, and 34.2% used actuarial risk tools for determination of risk.

**SPECIALIZED HOUSING UNITS:**

The majority of prisons have established specialized mental health units for inmates who are unable to mentally function well and partake in routine daily programming with the general prison population due to their mental illness (Wilkinson, 2000). One effective approach that has been used is the intermediate care program units for inmates that are psychiatrically disordered. These units enable inmates who need outpatient services to receive clinical and rehabilitative services such as milieu, individual, and group therapy. The programs also help to reduce suicide attempts, seclusion, and hospitalization (Condelli, Dvoskin, and Holanchock, 1994).
However, concerns and pertinent questions have been raised about the use of specialized housing units for mentally ill inmates. In 2003, a Human Rights Watch report contended that specialized housing units intended to segregate, seclude, and isolate inmates increased suicide risk for mentally ill inmates. Despite these concerns, correctional facilities continue to use specialized secure housing units to manage mentally ill inmates for a variety of reasons, such as protection of staff and other inmates from destructive and assaultive behaviors. These units can also provide protection for the mentally ill inmates from victimization and self-harm, and help maintain order in correctional facilities (Adams & Fernandino, 2008).

EXTRA MEDICAL CARE AND HIGHER STAFFING RATIO:
Inmates with mental illness often need extra medical attention, treatment, and medication. In addition, providing effective care, management, and supervision of mentally ill inmates’ disorderly behavior requires extra and adequate staffing. Therefore, most prisons are now increasing the staffing ratio for inmates with mental illness in order to treat, control, and serve their medical and psychologically dependent needs effectively (Hills, et al., 2004).

AVOIDING OR MINIMIZING PUNISHMENT:
Due to their mental illness and the coercive nature of prison environment (i.e., structure, routine, and subculture), mentally ill inmates have faced significant challenges adapting to prison life and socializing with other inmates. In addition, because they are unable to exercise good judgement about which behaviors are tolerable and accepted in prison due to their diminished mental capacity, they tend to violate prison rules frequently and are difficult to supervise and manage. One of the most effective means many prisons have used to respond to this type of unique issue is by avoiding or minimizing punishment of inmates for behavior that emanate from their mental disorder (Jemelka, Trupin, and Childes, 1989).
References

Factors Affecting the Growth of Aging Inmates


Demographics, Needs and Challenges of Aging Inmates


Practices and Approaches


The Cost of Providing Care for Aging Inmates


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Innovative Approaches for Dealing with Elderly Inmates


Recommendations


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Innovative Approaches for Dealing with Mentally Ill Inmates


Cover

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