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TREATMENT, RELEASE AND REINTEGRATION OF ELDERLY IN PRISON - PROBLEMS AND CHALLENGES IN PRACTICE**

Older prisoners are the fastest growing incarcerated sub-group. They have more complex health and social care needs than both younger prisoners and their agematched peers living in the community. Convicts who are in prison, and the elderly who will soon be released are at increased risk for their physical and mental health. The treatment in the prison is also not adapted to the population of older convicts. This population, due to their age, disability or inability to work, are often not employed in prison. Opportunities to use sports facilities are also limited for older convicts. In this work, the author tries to answer the question of what are the key health and social needs of elderly convicts and how the treatment and its contents can be adapted to this population. Furthermore, a special challenge is the planning of reintegration into the social environment, after release from prison. Consequently, there is a need for timely and multi-disciplinary release planning.

Keywords: *older prisoners, health of convicts, social needs, treatment, prison system, social reintegration*

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Introduction

With the aging of the population, the number of elderly people in prison is increasing (Hayes et al. 2013). Although the number of elderly convicts is growing, all over the world, it seems that the needs of this population remain invisible.

Researchers, policymakers and corrections administrators have yet to reach a consensus as to what constitutes an 'older offender'[1] and definitions vary substantially, ranging from 45 years and above to 65 years and above (Stojkovic, 2007; Yorston, Taylor, 2006).

The issue of definition is essential for comparative research and a lack of consensus can impede the development of a sound evidence base concerning older prisoners and related issues, such as offence types, recidivism rates, health concerns and prison management issues (Badawai, et al., 2011). Heckenberg (2006) suggests that any functional definition must also avoid bundling 'older prisoners' together as a homogenous group and in doing so, neglecting individual characteristics and needs. Defining old age does not have only academic relevance, since different definitions of old age have different impacts on the way in which the society perceives and treats elderly persons, as well as on creation of public policies in the area of social welfare and health protection of the elderly (Petrušić, Todorović, Vračević, 2015: 27 according to Batrićević, 2022: 464).

Public support for 'tough on crime' or 'law and order' policy approaches remains popular in most countries, while the rehabilitative function of prison has steadily eroded over the last half-century. This trend mirrors the advancement of neoliberal welfare retrenchment outside prisons, and the worsening of conditions inside prisons, from overcrowding and violence to the catastrophe of the COVID-19 pandemic (Danely, 2022: 59). Conditions in prison are so poor that prison health researchers have long considered incarcerated people to reach 'old age' (in biophysical and emotional terms), at around, on average, ten years earlier than non-incarcerated people (Aday, 2003). Because of this accelerated aging, 'time served' is much longer than the length of sentence would seem to indicate (Danely, 2022).

This increase in the number of older prisoners around the world is not merely a reflection of aging populations, nor is it likely that the current generation of older people are somehow more prone to criminal behavior than they were in the past. Yet, if we look for answers to the puzzle of the global increase of older people in prison on an institutional level, it becomes difficult to draw strong conclusions.

[1] Despite the variability of definition, many writers and researchers have adopted a functional definition of 'older prisoners' as being those who are 50 years of age and over (Kerbs, Jolley 2007).

Cross-national comparisons are complicated by differences in laws, police enforcement, sentencing, parole and other elements that make up the criminal justice system. Cultural models of aging and access to social welfare support also vary widely across national contexts (Danely, 2022).

In the USA, the number of older prisoners increased by 181% between 2000 and 2010, in contrast to the overall prison population which increased by only 17% (Bureau of Justice Statistics, 2011 according to Milićević, Ilijić, 2022). It is estimated that by 2030 one-third of all prisoners in the USA will be over 50, equating to a 4,400 per cent increase from 1980 (American Civil Liberties Union, 2012). There has also been a sizeable increase in the number of older prisoners in England and Wales (Forsyth, 2014). At the end of 2012 there were 9,880 prisoners aged 50 and over in England and Wales; this figure incorporates 3,377 prisoners aged 60 and over and equates to 12 per cent of the total prison population. It also includes a small but important group of 413 older women (Ministry of Justice, 2013). In Serbia, official statistics show that convicted persons aged over 50 accounted for 14.7% of the total number of convicts admitted to serving their sentences in 1999, 18.8% in 2006, 19.1% in 2015 and 20.1% in 2020, which represents an empirical increase in their percentage representation (Statistical Office of the Republic of Serbia, 2004, 2011, 2016, 2022 according to Milićević, Ilijić, 2022: 504).

While the reasons for the increase in older prisoners vary considerably across societies, prisoners' experiences of growing older, being abused or neglected, and finding ways to care or be cared for in prison, seem to resonate across cultural contexts (Danely, 2022: 59).

In this article, author trying to answer the question of what are the key health and social needs of elderly convicts, and how treatment and facilities can be adapted to this population, and what are the key obstacles that hinder the social reintegration of this population in society.

2. Issues in the management of older prisoners

The rising number and proportion of older prisoners (Forsyth et al., 2014) has implications for planning, policy and service delivery across the correctional system. Older inmates are characterised by different issues and present unique challenges across a number of domains, including physical and mental health needs, costs associated with incarceration, vulnerability to victimisation, prison environment, service delivery and release planning (Baidawi, et al. 2011).

By reviewing international literature we can see the key observation that the treatment of older adults in prison is predicated on broader social beliefs about not only criminality and justice but also age (Maschi, Morgan, 2020; Humbert, 2021).

Ageism, as a modern (negative) stereotype of the elderly, reflects the attitude that this category cannot take care of itself, due to old age, which is associated with the decline of cognitive functions and weakening of physical and mental health. For them, social care represents an unnecessary social cost, an investment that does not return (Ljubičić, 2021: 526).

As Daneley (2022) notes there is a persistent tension, for example between assumptions about age-related vulnerability and the image of the dangerous criminal, or between the recognition of differences in care needs of frail older people and the routines and uniformity of prison institutions. These contradictions are the main topic of two significant studies on the elderly prison population: *Aging behind prison walls* by Tina Maschi and Keith Morgen (2020) and *The older prisoner* by Dieta Humblet's (2021). While it has been recognized for decades that inequalities based on race, class, and citizenship are reflected in and perpetuated by criminal justice and penal systems (Wacquant, 2009), these books are two of the most significant works to extend the argument to age and disability (Daneley, 2022).

In *Aging behind prison walls*, Tina Maschi and Keith Morgen (2020) offer a data-driven and compassionate analysis of the lives of incarcerated older people. They explore the transferable resiliencies and coping strategies used by incarcerated aging adults to make meaning of their lives before, during, and after imprisonment. The autors argue that older prisoners' lives are marked by cumulative disadvantages and a lifetime of traumatic experiences. Despite the demographic heterogeneity of older adults sampled for their research, nearly three-quarters of those surveyed had three or more incidences of trauma, such as abuse or assault, in their life histories. Based on the data, Maschi and Morgen (2020) present a solution-focused caring-justice framework in order to understand and transform the individual - and community-level structural factors that have led to and perpetuate the aging-in-prison crisis. They offer concrete proposals - at the community and national policy levels - to address the pressing issues of incarcerated elders.

Analyzing *Aging behind prison walls*, Daneley (2022) makes the boldest claim from the aforementioned study - that "it was the aging prisoner who awakened the general public to the possibility of a form of justice that cares" (Maschi, Morgen, 2021: 5). The authors introduce the term "caring justice", which means a response to the neglect of elderly prisoners and arises on an institutional and collective level as a result of indi-

vidual improvement under the slogan *if I care, my community will care, and judicial institutions will care* (Maschi, Morgen, 2021).

In other words, by gaining a "new place of awareness and inner knowing" regarding both the traumas and the resilience of aging prisoners, society will no longer be able to stand aside and will be compelled to act. Resilience, or "adaptive coping," is an ability to bounce back from negative experiences, and in some cases, to find opportunities for "biopsychosocial spiritual" development. Examples of resilience create hope for change, allowing the reader to see older prisoners as more than just passive victims of oppression, incapable of ever having healthy relationships or controlling their actions and emotions (Daneley, 2022: 61).

The development of geriatric services, specific to older adults is important, because they have a potential for improving the lives of older adults both inside prison and in the community, including developing better policies, community services and greater public awareness.

In *Older prisoner* (Humblet, 2021) author examines the construction of 'the older prisoner' that is accompanied with distinct characteristics and specific knowledge determining the way we think about, scientifically approach, and respond to this category. The starting point is that the older prisoner is conceived as a social problem that must be managed. The idea of managing social problems through segmentation is not a novel one yet is here once more applied to the older prisoner who is placed in separate locations.

In this landmark study, the author critically analyzes the notions of "prison harm" and "accelerated aging" that result from the prison environment, picking apart assumptions about the "older prisoner" as a subject in a way that reveals that their special treatment or marginalization is rooted in ageist assumptions.

Prisons, much more so than other places in society, demand order and conformity, severely restricting prisoners' capacities to have their individual needs recognized, let alone to create a space for personal expression and meaning. This is a technology of control necessary for a small number of staff to keep order in the prison environment, but for frail and disabled older prisoners, this 'management' easily crosses a threshold into punishment (Daneley, 2022: 62). Humblet reveals a predominant ethos of what British Criminologist Elaine Crawley and Richard Sparks (2005) calls "institutional thoughtlessness", that is "rooted and sustained by the prison praxis" (Humblet, 2021: 137). Crawley and Sparks introduced the concept of 'institutional thoughtlessness' whereby prison staff, through attempting to retain consistency in their treatment of all prisoners, do not recognise the additional needs of older prisoners and expect them to behave in the same way and to conduct their activities at the same speed as everybody

else. This resulted in everyday 'hidden injuries' which were unnoticed by staff and unacknowledged by prisoners (Hayes et al., 2013: 590).

3. Needs of elderly convicts and treatment in prison

Older inmates are characterised by different issues and present unique challenges across a number of domains, including physical and mental health needs, costs associated with incarceration, vulnerability to victimisation, prison environment, service delivery and release planning (Baidawi et al., 2011: 4).

It is widely reported that prisoners and ex-prisoners experience considerably worse levels of health and wellbeing than the general population in relation to suicide risk, mental illness, substance misuse and physical mobility (Forsyth, et al., 2014). The health of older prisoners is a matter of concern – research indicates that you age 10 years faster in prison (Uzoaba, 1998) which can compound the problems that may be associated with ageing. The provision of health and social care do not match those for older people outside of the prison system (Williams, 2010). Similarly, older prisoners present with the highest rates of many disorders in comparison

to the overall prison population (Fazel, Baillargeon, 2011) and have more complex health needs than their aged-matched counterparts in the community, with approximately 85 per cent of older prisoners having one or more major illnesses (Fazel et al., 2001). Fazel et al. (2001) demonstrated increased physical and mental health problems among prisoners aged 60 and over in particular chronic illness and depressive disorder. The same researchers state that 9% of older convicts need additional help with daily activities, most often due to impaired mobility.

Correctional environments are designed for younger prisoners (Williams, 2010; Baidawi et al., 2011) and they are not adapted for elderly with diverse and specific needs (Milićević, Ilijić, 2022; Jovanić, 2014). Daily activities, programs of treatment, work and leisure activities, are not adapted to the population of older convicts.

Many researchers have argued that older prisoners' health concerns are exacerbated by many prison environments and regimes (Aday, 2006; Carlisle, 2006). Stairs, crowd and architectural barriers create additional problems for residence of elderly in prison (Jovanić, 2014). In general, the older a prisoner, the more barriers there were to active life, the greater their mental and physical health needs, and the less likely it was that they would be able to live and function in dignity (Her Majesty's Inspectorate of Prisons, 2004).

Research findings support this and suggest that prison environments and regimes poorly cater for the needs of older prisoners with physical disabilities, such as

limited mobility (eg requiring the use of ramps, wheelchairs, walking frames or sticks), hearing or vision impairments, infirmity or incontinency (Aday, 2003; Carlisle, 2006; Kerbs, Jolley, 2009; LeMesurier et al. 2010). Qualitative studies have found that older prisoners having limited contact with friends and family found it much more difficult to cope with prison (Hayes, et al., 2013).

The first step in ensuring an adequate approach to the treatment of elderly convicts in prison is the identification of their individual characteristics and needs (medical, physical, psychological).

Certain strategies that were developed in the United States of America and United Kingdom, at the local level, implemented with the aim of providing adequate assistance to older convicts.

Such initiatives have utilised assessment, collaboration with community agencies, case management, mentoring and advocacy to identify and address issues affecting older prisoners; for example, developing more appropriate exercise and day programs and coordinating transitional support (Evans, 2005).

In the United Kingdom, strategies have included developing an elderly register, training and employing prisoners as carers for other prisoners or using older inmates as advisors on aging issues within prisons (HMPS, 2009). In Meryland, the social work department in the Division of Corrections is responsible for keeping a database of elderly prisoners, ensuring regular physical and mental examinations and monitoring the need to apply for medical parole if necessary (Gaseau, 2004).

4. Release from prison and reintegration into community

Release from prison is just the first step in the longer process of prisoner reentry, which is composed both of desistance from crime and community reintegration (Visher, Travis, 2003).

While it has been established that older offenders recidivate at a lower rate than younger offenders (Cooper, Durose, Snyder, 2014), it remains largely unknown how older offenders fare in processes of social reintegration more generally (Williams, Stern, Mellow, Safer, Greifinger, 2012).

This topic is significant both because of the scope of the problem, and because social integration has important implications for individuals' long-term health and well-being (Carson, Golinelli, 2013).

Building on the multidimensional concept of reintegration put forth by Visher and Travis (2003), successful social (re)integration is defined as encompassing (a) resource factors, such as the attainment of stable housing, benefits and employment, (b)

network factors, such as the (re) establishment of social relationships and roles and (c) psychosocial factors, such as feelings of "mattering" or being valued within these relationships and roles.

In other words, successful reintegration following prison entails securing the material resources, social connections and psychological grounding necessary for positive social functioning (Wyse, 2018).

The researchers point to the existence of numerous difficulties, both in terms of planning the release of older convicts from prison, and in terms of their reintegration into the social community.

The causes underlying this shortcoming include a lack of coordination (eg. funding, resources and service provision) between prisons, community correctional services and community agencies (Ahmed, 2008), priority being provided to younger inmates (either due to higher perceived risk of reoffending or higher perceived chances of successful rehabilitation and re-integration) and a lack of strategies to address the needs of older prisoners, combined with restrictive criteria for the early medical release of terminally or chronically ill prisoners (Rikard, Rosenberg, 2007 according to Baidawi et al., 2011).

Prior studies of prisoner reentry into community (which generally focus on "average" - i.e., younger former prisoners) have documented the challenges they face in securing or maintaining necessary resources and valued social roles, including employment, housing, public benefits, and relationships with family (Travis, 2015).

There is also evidence that incarceration significantly harms familial bonds, by breaking up intact families and diminishing post-incarceration marital prospects and relationships with children (Lopoo, Western, 2005).

Older former prisoners' reentry into community is likely distinct from reentry into community of younger ex prisoners - in many important ways.

Previous researchers state the data the older offenders' ties to family may be frayed following years of criminal involvement and drug abuse, or simply weakened following a lengthy prison sentence. Jobs may be even more challenging to obtain as older men face both the barriers posed by a criminal record as well as those of advanced age (Wyse, 2018).

Researchers state the data that older prisoners due for release often have intense anxieties about, and an inadequate understanding of, the resettlement process (Crawley, 2004). What seems to give older prisoners the most concern is the lack of clarity / or assist from prison staff as to where they are going to live, how they are going to get there (with limited money and poor mobility) and whom they will be living with. In the main, only prisoners with a supportive wife and / or family were hopeful and

enthusiastic about resettlement. For these men, release means being with family again and regaining the freedom to structure their own days and choose their own activities and company. Importantly, for those whose wives were infirm, release also provides the opportunity to resume the protector role which they had been forced to leave behind. Most of the older men who do not have marital or familial ties, however, are unsure how they will fare when released (Crawley, 2004: 34).

Researchers sugested that family relationships with parents and siblings were a key social role and source of emotional support for men exiting prison (Wyse, 2018).

Men also return to particular neighborhood contexts that may have important implications for their reintegration processes. Prior research has found that former offenders are more likely to recidivate when they return to their pre-prison neighborhood, or to a neighborhood populated by higher concentrations of ex-offenders (Stahler et al., 2013). In these cases, recidivism may be facilitated by interaction with criminally-engaged friends and neighbors, and / or exposure to environmental "triggers" for substance use that encourage relapse (Kirk, 2012).

According to the report of Prison reform trust (2003) in elderly convicts who have cronic diseases, the fear of not being able to access health care is often one of central concerns. This category of convicts, while in prison, relied on formal health care as well as informal assistance. They often received a certain type of help in terms of performing daily activities and meeting hygiene needs from other convicts (such as dressing, bringing food or maintaining hygiene in the cell) (Jamieson, Crawley, Noble, Grounds, 2002).

Understanding the social integration processes of older offenders is particularly important given the established relationship between social ties and support and positive physical and mental health outcomes.

The positive implications for health of social connectivity include lower overall mortality, improved immune and cardiovascular functioning and lower rates of depression (Seeman, 1996).

Social integration also protects against feelings of loneliness, promotes life satisfaction, and is an important element in successful aging (Rowe, Kahn, 1997). Given the documented high burden of disease and illness borne by aging former prisoners, social integration may help stave off further mental and physical decline (Aday, 2003; Human Rights Watch, 2012).

Conclusion

Further research should be systematic and focus on characterization of the population of older prisoner cohort in terms of its size and the particular issues and challenges faced by corrections services, including corrections, health and pre-and post-release services, in the management of this prisoner group. Older inmates are characterised by different issues and present unique challenges across a number of domains, including physical and mental health needs, costs associated with incarceration, vulnerability to victimisation, prison environment, service delivery and release planning

Understanding these issues is an essential starting point to formulating strategies for management of older prisoners. One of the recommendations need to include ways to build a more supportive community and to address the specific needs of older individuals in prison and older prisoners living with addiction or mental illness, in order to achieve the most successful social reintegration into the social community.

There is a need to plan effectively for older prisoners' reintegration into the community through the development of appropriate policies and mechanisms. Plannings resetlements into a community begins in prison is crucial, providing an opportunity to enroll in health care, initiate social security benefits and identify available community resources.

An important component of the reentry experience is that of social integration into the roles and relationships of work, family and community. Broadly speaking, social integration can be understood as the extent to which an individual is enmeshed in, and feels a sense of belonging with, others in a social system (Hooyman, Kiyak, 2008). Such connectivity may be fostered by the assumption of key social roles, the receipt of essential social supports and resources, and/or the formation of social ties.

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