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Decarceration of older adults with mental illness in the USA – beyond the COVID-19 pandemic

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Abstract

Purpose ——Aging and mental illness both represent significant public health challenges for incarcerated people in the USA. The COVID-19 pandemic has further highlighted the vulnerabilities of incarcerated people because of the risks of infectious disease transmission in correctional facilities. Focusing on older adults with mental illness, this paper aims to examine efforts to decarcerate US correctional facilities during the COVID-19 pandemic and whether these approaches may lead to sustainable reforms beyond the pandemic.

Design/methodology/approach ——A narrative literature review was conducted using numerous online resources, including PubMed, Google Scholar and LexisNexis. Search terms used included “decarceration pandemic,” “COVID-19 decarceration,” “aging mental illness decarceration,” “jails prisons decarceration,” “early release COVID-19” and “correctional decarceration pandemic,” among others. Given the rapidly changing nature of the COVID-19

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pandemic, this narrative literature review included content from not only scholarly articles and federal and state government publications but also relevant media articles and policy-related reports. The authors reviewed these sources collaboratively to synthesize a review of existing evidence and opinions on these topics and generate conclusions and policy recommendations moving forward.

Findings ——To mitigate the risks of COVID-19, policymakers have pursued various decarceration strategies across the USA. Some efforts have focused on reducing inflow into correctional systems, including advising police to reduce numbers of arrests and limiting use of pretrial detention. Other policies have sought to increase outflow from correctional systems, such as facilitating early release of people convicted of nonviolent offenses or those nearing the end of their sentences. Given the well-known risks of COVID-19 among older individuals, age was commonly cited as a reason for diverting or expediting release of people from incarceration. In contrast, despite their vulnerability to complications from COVID-19, people with serious mental illness (SMI), particularly those with acute treatment needs, may have been less likely in some instances to be diverted or released early from incarceration.

Originality/value ——Although much has been written about decarceration during the COVID-19 pandemic, little attention has been paid to the relevance of these efforts for older adults with mental illness. This paper synthesizes existing proposals and evidence while drawing attention to the public health implications of aging and SMI in US correctional settings and explores opportunities for decarceration of older adults with SMI beyond the COVID-19 pandemic.

Keywords

Substance use disorder; Mental illness; Incarceration; Coronavirus; Geriatric; Decarceration

Introduction

Despite having just 5% of the world's population, the USA is home to over 20% of the world's incarcerated people (Wagner and Bertram, 2020). In 2019, there were more than two million people incarcerated in US correctional facilities at a given time (Kang-Brown *et al.*, 2021). The number of incarcerated older adults, often defined as over the age of 50, has grown considerably in recent decades (Morton, 1992); as of 2019, more than 21% of people incarcerated in US prisons were older than 50 years (Carson, 2018, 2020; Carson and Sabol, 2016). By 2030, people older than 55 years are expected to account for one-third of the US prison population (Chettiar *et al.*, 2012). Compared to the broader public, incarcerated people have disproportionately high burdens of chronic disease, such as diabetes, hypertension, asthma and arthritis (Fazel and Baillargeon, 2011). In addition, incarcerated older adults tend to experience earlier onset of aging-related health conditions compared with age-matched peers in the general population (Greene *et al.*, 2018). Paradoxically, incarcerated older adults may face barriers to accessing health care including stigma, correctional budget constraints, shortages of health professionals and lack of geriatric specialty services within correctional settings (Bedard and Pelleg, 2019). Although data is limited, some estimates suggest that incarcerating older adults may cost

between two to nine times as much as younger individuals (Ahalt *et al.*, 2013; Anno *et al.*, 2004).

Serious mental illness (SMI) is more common among incarcerated people relative to the general population (Fazel *et al.*, 2016; Prins, 2014). The National Institute of Mental Health defines SMI as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities," including conditions such as schizophrenia, bipolar disorder and depression. Research suggests that SMI is more prevalent among older incarcerated people compared to their nonincarcerated peers in community settings (Di Lorito *et al.*, 2018; Haesen *et al.*, 2019). The overlap between SMI and age is notable because, like older adults, people with SMI are more likely to carry chronic disease burden, including diabetes, cardiovascular disease and stroke (Mohamed *et al.*, 2019; Baughman *et al.*, 2016). Collectively, these findings suggest that a subset of the incarcerated population – older adults with SMI – is at unique risk for health complications.

While US court decisions have long indicated that incarcerated people have a constitutional right to adequate health care (Godwin, 1977; Estelle, 1976), researchers and criminal-legal stakeholders have continually raised concerns about the realities and adequacy of health care in US correctional facilities (KiDeuk *et al.*, 2015; Wilper *et al.*, 2009). Many correctional systems have shortages of health professionals willing to work in these environments (Chafin and Biddle, 2013; Morris and West, 2020). Additional barriers, such as overcrowding, drug formulary restrictions and budgetary limitations on public expenditures, may shape the degree to which incarcerated people can access necessary mental health care (Morris *et al.*, 2020). Some have noted the potential adverse effects of correctional environments on people with mental illness. For example, in a 1999 decision, a federal district judge summarized one US state's prison environment for individuals with mental illness as follows:

> It is deplorable and outrageous that this state's prisons appear to have become a repository for a great number of its mentally ill citizens. Persons who, with psychiatric care, could fit well into society, are instead locked away, to become wards of the state's penal system. Then, in a tragically ironic twist, they may be confined in conditions that nurture, rather than abate, their psychoses.
>
> Ruiz(1999)

The COVID-19 pandemic has highlighted unique health-care challenges for correctional facilities, as strategies to mitigate infectious disease transmission can be difficult to implement in these contexts (Hawks *et al.*, 2020). Just prior to the start of the COVID-19 pandemic, many states were routinely operating with prison populations beyond maximum estimated capacity (Carson, 2020). The overcrowding and inability to maintain physical distancing in correctional environments make a "perfect storm" for COVID-19 transmission. In a national US Department of Justice survey of data reported by jail facilities from March to June 2020, local jails tested roughly 9% of admissions for COVID-19; more than 11% tested positive (Minton *et al.*, 2021). Prisons across the country have reported COVID-19

outbreaks and, as of November 29, 2021, there were 439,620 COVID-19 cases and 2,661 related deaths among people incarcerated in US prisons (COVID Prison Project, 2021).

Older adults are at significant risk of morbidity and mortality from COVID-19 (CDC, 2020); as of November 24, 2021, people over the age of 50 constituted 722,388 (93%) of 773,812 US deaths related to COVID-19 (National Center for Health Statistics, 2021). Multiple factors, including decreased immune response and the prevalence of cooccurring medical conditions, contribute to the susceptibility of older adults to COVID-19 compared to younger population (Mueller *et al.*, 2020). In addition, because of psychiatric symptoms, cognitive impairment and psychotropic medication side effects, people with SMI may be disproportionately likely to experience complications from COVID-19 (Druss, 2020). In a cohort study of 7,348 adults diagnosed with COVID-19 in New York during 2020, a diagnosis of schizophrenia spectrum disorder was associated with nearly three times the odds of dying from COVID-19, ranking only behind age with regard to the strength of this association (Nemani *et al.*, 2021). To protect those particularly vulnerable to COVID-19, some facilities have expanded use of medical isolation, placing incarcerated people into solitary confinement to prevent disease transmission. However, the consequences of these measures, such as social isolation, limited exercise and limited outdoor activities, may have adverse effects, especially for incarcerated older adults with SMI (Cloud *et al.*, 2020). Other facilities have modified mental health services, for instance, by expanding use of telepsychiatry, to facilitate ongoing delivery of care (Burton *et al.*, 2021).

The COVID-19 pandemic has added new urgency to criminal-legal reform regarding incarcerated older adults with SMI. Given the health risks associated with incarceration during a pandemic, local, state and federal policymakers have pursued a variety of decarceration strategies to reduce incarcerated populations. The number of people in US correctional facilities fell 14% from 2.1 million to 1.8 million between 2019 and 2020 (Kang-Brown *et al.*, 2021). Although it is unknown whether these reductions reflected decarceration of older adults with SMI, the prevalence of older adults, as well as people with SMI, in US correctional facilities, suggests considerable numbers of older adults with SMI may have been diverted or released from incarceration since the start of the pandemic.

The COVID-19 pandemic offers opportunities to reconsider the ways in which older adults with SMI flow into and out of US correctional institutions. This article reviews a set of US decarceration responses to the COVID-19 pandemic with relevance for older adults with SMI, including the potential risks and benefits of these approaches. We also examine ways in which policymakers in the US and elsewhere might pursue sustainable approaches to decarceration of these populations beyond the COVID-19 pandemic.

Methods

A narrative literature review was conducted to identify decarceration strategies relevant to older adults with SMI during the COVID-19 pandemic. The authors used online resources including PubMed, Google Scholar and LexisNexis. Search terms used included, “decarceration pandemic,” “COVID-19 decarceration,” “aging mental illness decarceration,” “jails prisons decarceration,” “early release COVID-19” and “correctional decarceration

pandemic," among others. This review focused specifically on decarceration policies relevant to US jails and prisons. Given the rapidly changing nature of the COVID-19 pandemic, this review included content from not only scholarly articles and government publications but also relevant media articles and policy-related reports. These searches were conducted from approximately December 2020 to May 2021. The authors reviewed these sources collaboratively to synthesize a review of existing evidence and opinions on these topics and to generate conclusions and policy recommendations moving forward.

Approaches to decarceration: inflow and outflow

One way of understanding decarceration efforts during the COVID-19 pandemic is to conceptualize inflow to and outflow from US correctional facilities. Inflow refers to the number of people who become involved with criminal-legal systems and enter pathways leading to incarceration (e.g. arrest, detention and sentencing). Outflow refers to the number of people released from incarceration (e.g. bail, probation, parole, early release). Broadly, policies that reduce inflow and increase outflow tend to decrease the overall size of incarcerated populations (National Academies of Sciences, 2020). According to a nationwide analysis by the Vera Institute, the number of people incarcerated in US jails and prisons fell by approximately 14% between mid-year 2019 and mid-year 2020 (Kang-Brown *et al.*, 2021). During the pandemic, policymakers in the USA pursued various criminal-legal reforms shaping inflow and outflow of incarcerated individuals, often with particular relevance to older adults with SMI.

Inflow

Diverting people from jails via alternatives to incarceration became a necessity early in the COVID-19 pandemic. In April 2020, US Attorney General William Barr signed a memo directing US Attorneys and the Department of Justice to avoid unnecessary detention:

> For those defendants who have not committed serious crimes and who present little risk of flight (but no threat to the public) and who are clearly vulnerable to COVID-19 under CDC Guidelines.
>
> Office of the Attorney General(2020)

In addition to noting usual consideration of a defendant's "physical and mental condition" under the 1984 federal Bail Reform Act that outlines factors that judicial officers must consider regarding a defendant's release eligibility, the memo instructed consideration of the medical risks of a defendant being remanded into federal custody as a result of COVID-19 (Office of the Attorney General, 2020). Some older adults facing pretrial detention may have fit into this description because of the risks of COVID-19 complications and research suggesting justice-involved older adults may be less likely to pose a risk to public safety compared with younger individuals (National Academies of Sciences, 2020; Silber *et al.*, 2017; United States Sentencing Commission, 2017).

Beyond the federal system, police departments in cities across the country, including San Francisco, Philadelphia, Chicago, Fort Worth, Denver, Nashville, Santa Barbara and Washington D.C., announced policies to prioritize warnings, citations and education over

physical arrests (Brennan Center for Justice, 2021). “Cite-and-release” policies, wherein citations or warnings are issued for nonviolent low-level crimes instead of physical arrest and pretrial detention, reduce the number of entrants into correctional facilities (Stagoff-Belfort, 2020). Because people with SMI are often arrested and incarcerated for minor offenses, these strategies may have considerable effects on the rate of incarceration of people with SMI (Lamb and Weinberger, 1998). Older adults with SMI are also more likely to experience poverty; additional policies, such as emergency bail schedules (e.g. setting bail at $0) and releasing individuals on their own recognizance before trial, may have also facilitated diversion of older adults with SMI from jails during this time (City News Service, 2020; Kang-Brown *et al.*, 2021).

Outflow

The COVID-19 pandemic also prompted proposal of policies geared toward increasing outflow of older individuals and those with SMI from correctional facilities. Although it did not ultimately pass, the *COVID-19 Correctional Facility Emergency Response Act of 2020* was introduced in the US Congress in March 2020 proposing allocation of funds to state and local governments for the release, transition and reentry of individuals from prison above the age of 50 (United States Congress, 2020). Release mechanisms, such as limiting length of pretrial detention, increasing commutations and pardons, good time credits allowing for earlier release dates and judicial orders for administrative release, can increase population outflow from correctional systems (Prison Policy Initiative, 2021). These considerations may be particularly relevant for older adults with SMI, as lack of social supports or access to community psychiatric care can limit opportunities for safe transfer of these individuals from correctional contexts to community settings.

In addition to these types of federal recommendations, many states implemented expedited release programs to alleviate overcrowded correctional facilities and mitigate risk of infectious disease transmission (Brennan Center for Justice, 2020). Expedited release programs aim to reduce overcrowding in correctional facilities and focus on older adults in the prison population who have little time remaining in their sentences, multiple chronic health conditions or SMI, among other characteristics (Brennan Center for Justice, 2020; California Department of Corrections and Rehabilitation, 2021). For example, in April 2020, Virginia implemented an early release program for people convicted of nonviolent crimes that considered “access to proper health care for the treatment of an inmate’s medical and mental health needs” (Stewart, 2020). During November 2020, New Jersey granted early release to more than 2,200 individuals from its prisons on a single day (Wong, 2020). According to the US Department of Justice, from March to June 2020, approximately 208,500 incarcerated people received expedited release from local jails in response to COVID-19 (Minton *et al.*, 2021).

The associations between age and risks from COVID-19 were relatively well-known and publicized during the pandemic, which may have led to incorporation of age into these expedited release programs. By comparison, mental illness may have been used as a reason for maintaining incarceration. In March 2020, a US federal district court in Connecticut ordered a prison to expedite release of some individuals in prison into home confinement;

however, one of the criteria for eligibility was “Mental Health Care Level is less than IV,” making individuals requiring a high level of mental health care, regardless of age, ineligible (Martinez-Brooks v. Easter, 2020). From March to May 2020, the proportion of people who were receiving mental health treatment in New York jails grew from 44% to 51%; during that time period, just 851 (36%) of incarcerated people with mental health problems were released, compared with 1,580 (51%) of the general population (Gallear, 2020). A directive from the New York Governor’s Office for early release of people incarcerated for technical parole violations initially excluded persons with significant mental illness; this was later removed after protest from advocacy groups (A Challenge to Change, 2020; Hart, 2021). Furthermore, some defendants (e.g. those deemed incompetent to stand trial because of a mental disorder) faced prolonged detention during COVID-19 because of backlog or decreased admissions at state psychiatric facilities (The Marshall Project, 2020a, 2020b).

International context

Other countries have implemented decarceration policies relevant to older adults with SMI, though the details and impacts of these policies tend to vary. In April 2020, Dainius Pūras, the United Nations special rapporteur on the right to health, recommended that all countries consider the early release of, and provision of adequate health care to, incarcerated people with health vulnerabilities (Pūras, 2020). From January 1, 2020 to April 15, 2020, European countries released, on average, approximately 5.1% of their total correctional populations; however, Norway and Iceland each released approximately 14% and Turkey released as much as 35% of its total correctional population during this time period (Aebi and Tiago, 2020). Germany also implemented a policy of early release and nonexecution of short-term prison sentences, in conjunction with medical isolation of people infected in prisons, to mitigate disease risk for incarcerated populations (Dünkel, 2020). The COVID-19 pandemic has led to a global reckoning with the health risks of incarceration; one estimate suggested COVID-19-related decarceration policies had cumulatively reduced the global prison population by less than 6% (Harm Reduction International, 2020). Even Australia, with its relatively contained COVID-19 outbreak, has made efforts to decarcerate in the pandemic context (Hwang *et al.*, 2021).

Decarceration beyond the pandemic

As the policies of rapid decarceration spurred by the COVID-19 pandemic were instituted on an emergent basis, it remains to be seen how they will evolve beyond the pandemic. Evidence suggests some correctional populations have begun to increase again; from mid-year 2020 to late 2020, the number of people in US jails rebounded by 10% from approximately 575,500 to 633,000 (Kang-Brown *et al.*, 2021). Meanwhile, the sudden global spotlight on decarceration has provided the opportunity to reconsider the inflow and outflow of correctional populations, especially among older adults with SMI. Moving forward, additional research is necessary to better understand the effects, as well as the feasibility and sustainability, of decarceration policies relevant to older adults with SMI.

Diversion

Even before the COVID-19 pandemic, diversion programs related to mental health were developing across the US, which may help reduce inflow into correctional facilities. For example, definitions of mental health diversion may differ depending on the jurisdiction, but diversion programs are often designed to provide alternatives to incarceration that address underlying factors contributing to involvement. Prebooking diversion, such as crisis intervention teams or police-mental health co-responder models, seeks to divert people with mental health needs from incarceration to treatment. Research remains limited regarding the efficacy of these programs at reducing overall arrest rates among people with SMI but evidence suggests these models may improve linkages to mental health services (Dewa *et al.*, 2018).

For older adults with SMI who undergo arrest, postarrest diversion models, such as mental health courts and outpatient competency restoration (e.g. programs that offer community-based treatment and rehabilitation services in lieu of incarceration), may offer additional pathways away from incarceration. These programs have become more popular in recent years, with a national survey identifying as many as 392 adult mental health courts in the USA as of 2014, increased by 104 (36%) since 2009 (Marlowe *et al.*, 2016). Novel community-based competency restoration programs, such as those in the Los Angeles and Miami areas, have demonstrated early success in their efforts to safely manage individuals with SMI at the pretrial stage (Leifman and Coffey, 2020; Ochoa *et al.*, 2020). These programs are relevant for older defendants with SMI, given that those undergoing restoration are most often committed to jail-based or forensic inpatient programs and that odds of restoration decrease with older age (Morris and DeYoung, 2014). Studies indicate mental health courts and similar collaborative court models may be effective at reducing recidivism and increasing connection with treatment services (Marlowe *et al.*, 2016; Pinals and Callahan, 2020). Nonetheless, some argue these court models enable the criminal-legal system to serve as gatekeepers to mental health services and perpetuate the criminalization of mental illness (Seltzer, 2005).

The emergence of these diversion models, as well as the international attention on the health risks of incarceration during the COVID-19 pandemic, highlights the importance of considering age, mental health and other health-related factors relevant to incarceration in criminal legal policymaking moving forward. Amid the COVID-19 pandemic, some have suggested far more transformational reforms to support the well-being of people with mental illness. For example, a COVID-19 pandemic guidance document by the American Psychiatric Association suggested altogether eliminating incarceration for misdemeanor convictions (Committee on Psychiatric Dimensions of Disaster and COVID-19, 2020). The document noted that these suggestions, “while focused on the impact of COVID-19, may have more generalized application beyond the pandemic” (Committee on Psychiatric Dimensions of Disaster and COVID-19, 2020). Approximately one in four people held in US jails are incarcerated for misdemeanor offenses (Zeng and Minton, 2021), and these types of large-scale criminal-legal reforms, alongside strategies such as decriminalization of personal substance use and possession, may effectively increase decarceration of older adults with SMI (Kleinman and Morris, 2021). Given the bold scope of these proposals,

however, enacting these reforms may face more political and logistical barriers than less sweeping reforms (e.g. pilot programs), particularly in the absence of the urgency of a global pandemic.

Release and reentry

Even in the presence of robust diversion programs, some older adults with SMI may still face arrest and incarceration. Identifying and treating these individuals as early as possible during incarceration is key, not only for supporting their well-being but also for potentially reducing future risk of incarceration. One study of 79,211 incarcerated people in Texas from 2006 to 2007 found people with major psychiatric disorders were more likely to have experienced multiple incarcerations during the prior six years compared to people without these conditions (Baillargeon *et al.*, 2009). Although many undergo mental health screening upon entry into correctional facilities, a 2004 survey of over 18,000 incarcerated people in US correctional facilities found fewer than half of those taking psychotropic medications upon admission received these medications while incarcerated (Reingle Gonzalez and Connell, 2014). Older adults may also have age-related functional impairments, such as difficulty in walking long distances or climbing into bunk beds, that may escape detection on initial intake (Williams *et al.*, 2006). Improving the frequency and reliability of screening for mental illness and age-related impairments in correctional contexts, as well as linkage to treatment services, is vital for supporting older adults with these conditions.

Many decarceration strategies during the COVID-19 pandemic have focused on early release of older adults given heightened risks of morbidity and mortality from COVID-19. Prior to the pandemic, compassionate release, also known as medical or geriatric parole, had emerged as one strategy for granting early release for “prisoners facing imminent death, advancing age, or debilitating medical conditions” (Price, 2018). However, these policies are narrow in scope and restricted to limited circumstances, even during a global pandemic. According to data obtained by the Marshall Project, 10,940 people in federal prison applied for compassionate release from March to May 2020, with just 156 (1.4%) approved by wardens (Blakinger and Neff, 2020).

Decarceration efforts during the COVID-19 pandemic have also highlighted barriers to expedited release for individuals receiving high levels of medical or psychiatric care. If someone is experiencing acute symptoms of mental illness (e.g. psychotic symptoms requiring hospitalization) or profound cognitive impairment, releasing that person from incarceration may be challenging with regard to ensuring continuity of care and meeting treatment needs; all the while, keeping that individual incarcerated may not be therapeutic in the long-term either (Blakinger, 2020). Even if an individual receives adequate mental health screening and treatment during incarceration, these services alone may be insufficient for ensuring successful reentry into community settings and preventing return to incarceration. For example, in a study of 9,669 people released from the New Jersey Department of Corrections in 2013, provision of mental health services (e.g. prescription of antipsychotic medication) was not independently associated with any statistically significant differences recidivism rates after three years of follow-up (Zgoba *et al.*, 2020).

Preventing recidivism in older adults with SMI requires far more than a psychotropic prescription. When released from incarceration, older adults with SMI may have difficulty living independently in communities that might have changed significantly during their time away. During incarceration, social support systems, the strength of which can determine reentry success, often erodes (Mowen *et al.*, 2019). Formerly incarcerated older adults with SMI may struggle to navigate community resources and to satisfy basic needs, such as obtaining food, housing or health care (Serowik and Yanos, 2013). Further compounding these barriers, criminal records, lack of employment history and potential unfamiliarity with recent digital technologies may hinder the ability to obtain and maintain employment (Augustine, 2019; Pager, 2003). Although many people released from incarceration face similar challenges, the burdens of psychiatric illness, as well as age-related functional impairments, can exacerbate these barriers to successful reentry.

Reentry planning prior to release from incarceration can help support older adults with SMI during this transition (National Academies of Sciences, 2020). By partnering with community supervision programs (e.g. parole and probation offices) as well as community treatment and other supportive services, correctional systems can play a key role in ensuring “warm handoffs” for older adults with SMI upon release, thereby minimizing confusion and stress during reentry and linking them to necessary services as rapidly as possible. Unfortunately, some correctional facilities have shortages of qualified staff, such as social workers, who can identify necessary mental health and other supportive services for incarcerated people returning to the community (Families Against Mandatory Minimums, 2021). Moreover, because of interruptions in Medicaid enrollment that occur during incarceration, individuals with SMI may be released without insurance coverage, posing further challenges to continuity of mental health care and successful reentry (Lantsman and Osler, 2020). These insurance gaps may also prevent older adults with SMI from entering long-term care facilities in the community (Boucher *et al.*, 2021). Even when correctional systems can provide robust reentry planning, limited availability of community-based psychiatric treatment providers, housing options, employment opportunities and other resources may hinder the efficacy of these efforts. Additionally, some of these community-based resources, including mental health treatment options, may be unfamiliar with or poorly suited to meet the unique needs of formerly incarcerated individuals.

The COVID-19 pandemic has compounded the already-present challenges posed by the lack of facilities willing to accept older adults with complex mental and physical illness released from incarceration. For instance, shifts in employment opportunities, limited availability of treatment facility or shelter beds because of physical distancing efforts, viral testing requirements and restrictions on travel may further complicate these individuals’ return to their communities. In other ways, however, the pandemic may facilitate reentry planning; widespread use of telemedicine enables easier access to treatment services for people released to rural communities or areas with limited clinician availability. As older adults with SMI may not only have limited access to these technologies but also limited understanding of these devices after prolonged incarceration, additional training and support during and after incarceration may be necessary to capture these benefits.

Limitations

Given the continued evolution of incarceration-related policies in the context of the COVID-19 pandemic and the rapidly growing body of published work in this area, this narrative literature review does not cover all available publications on the topic. Although this review addresses numerous decarceration policies pursued in the USA and their relevance to older adults with SMI, concrete data regarding the effects of these policies, specifically on older adults with mental illness, remain limited. For example, in 2021, the Marshall Project filed a Freedom of Information Act request for data from several states revealing how many adults older than 55 years had been released because of the pandemic; despite this specific request, many states did not provide data broken down by age (Armstrong, 2021). This limited availability of data, despite the unique risks that incarceration and COVID-19 pose to older adults with SMI, reinforces the need for further data collection and research regarding the effects of decarceration policies on these populations.

Conclusion

Incarceration has long posed health risks to the people inside correctional facilities, and the COVID-19 pandemic has shined a global spotlight on these risks, including the ways in which incarceration can negatively impact the health of surrounding communities (Reinhart and Chen, 2020). Amid international efforts to reduce population sizes and overcrowding in correctional facilities, the COVID-19 pandemic has called for rethinking traditional approaches to arrest and incarceration, potentially inspiring renewed efforts toward decarceration moving forward. This article focuses on the unique and urgent health risks faced by older adults with SMI in US correctional facilities and highlights the need to study the effects and feasibility of decarceration policies relevant to these individuals. Although this article emphasizes the health-related effects of incarcerating these vulnerable populations, additional factors, such as considerations regarding public safety, retribution and deterrence, influence public discussions regarding criminal-legal reform. For now, the COVID-19 pandemic has shifted the balance between the criminal-legal system and public health across the USA and elsewhere. The extent to which aging, mental illness and other health-related needs will shape decarceration practices beyond the pandemic hangs in the balance.

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