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Article 97

Substance Use Disorder and the Older Offender

Keith Morgen, Tina Maschi, Deborah Viola, and Kristen Zgoba

Morgen, Keith, PhD, LPC, NCC, ACS, is an assistant professor of counseling and psychology at Centenary College where he publishes extensively on substance use disorder and mental health issues in treatment and prison settings. Dr. Morgen is the 2013-14 President of the International Association of Addictions and Offender Counselors (IAAOC), a division of the American Counseling Association.

Maschi, Tina, PhD, LCSW, ACSW, is an associate professor at the Fordham University Graduate School of Social Service. She has published extensively in the area of trauma, mental health, and aging in the criminal justice system and is the current President of the National Organization of Forensic Social Work.

Viola, Deborah, PhD, is an associate professor and associate director, Doctoral Program in Health Policy and Management, at New York Medical College, School of Health Sciences and Practice. Dr. Viola studies prisoner health and social justice.

Zgoba, Kristen, PhD, is a researcher at the New Jersey Department of Corrections Research and Evaluation Unit. She has conducted several federally funded studies on criminal justice issues that include the Sex Offender Registration and Notification Act (SORNA), trauma, coping, and aging in prison.

Abstract

Limited research covers substance use disorders (SUD) in the older offender (ages 55 years and older). This study (N=334) found limited cognitive coping resources, extensive trauma histories, and limited exposure to SUD/mental health care in-prison for older offenders with SUD in a state prison system.

The Center for Substance Abuse Treatment (CSAT, 2005) and The National Center on Addiction and Substance Abuse at Columbia University (CASA, 2010) both underscore that substance use disorder (SUD) is a pervasive problem within the American prison system. Recent estimates suggest that anywhere between one-half to two-thirds of incarcerated Americans meet the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000) criteria for substance abuse or dependence (CASA, 2010; Mumola & Karberg, 2006). The Substance Abuse and Mental Health Services Administration (SAMHSA) proclaimed the SUD epidemic in American prisons as an area in need of urgent and immediate attention (SAMHSA, 2011).

Despite the focus on SUD within the prison system, most of this work has focused on younger offenders with very little research (e.g., Arndt, Turvey & Flaum, 2002) addressing older offender SUD issues. The lack of information limits the development of treatment and support

services for the older offender in the prison system (Morgen, 2011). Consequently, this paper will examine demographic and psychosocial differences between the older offender in-prison with or without an SUD diagnosis.

Older Offender: Psychosocial and SUD Factors

Older offenders, defined as prisoners ages 50 and over (Stojkovic, 2007), are increasing in numbers both in America (Sabol & Couture, 2008) as well as other countries such as the United Kingdom, New Zealand, and Australia (Baidawi et al., 2011). Despite the crisis of the growing population of older offenders (Aday, 2003), limited research examines the psychosocial state of the older offender. However, recent work highlights the extensive mental health, medical, and trauma needs of the older offender (Haugebrook, Zgoba, Maschi, Morgen, & Brown, 2010; Maschi, Gibson, Zgoba, & Morgen, 2011; Maschi, Morgen, & Viola, in-press; Maschi, Morgen, Zgoba, Courtney, & Ristow, 2011; Maschi, Viola, Morgen, Koskinen, in-press).

Purpose of Paper

While the research slowly grows regarding the trauma, medical, and mental health needs of the older offender in prison, there is still a substantial lack of knowledge focused on SUD in the older offender population (Morgen, 2011). For instance, recent nationwide reviews of treatment facilities found that only between 7% and 17% of surveyed SUD treatment facilities offered SUD treatment programs designed for the older adult (Gunter & Arndt, 2004; SAMHSA, 2007). Knowledge on the older offender and SUD could inform in-prison treatment and support services as well as psychosocial services for the paroled offender. Consequently, this study will contribute to the limited older adult SUD literature by examining older offenders with and without an SUD diagnosis across several psychosocial variables critical to the SUD treatment and support process.

Method

Participants

The study (N = 334) consisted of male offenders in the New Jersey Department of Corrections (NJDOC) ages 55 years and older (M=60.81 years-old, SD = 5.36) in 14 state prisons supervised by the NJDOC as part of a study on trauma, mental health, and addiction in older offenders. Of these offenders, 43.4% (n=145) presented with a history of a substance use disorder diagnosis. The majority of the sample were Caucasian (n=142, 42.9%) and African-American (n=135, 40.8%).

Measures: Between-Groups

SUD diagnostic history. SUD diagnostic history was obtained via prisoner self-report.

Objective and subjective trauma. Objective and subjective trauma were measured using the 31-item Life Stressor Checklist-Revised (LSC-R) (McHugo et al., 2005). The LSC-R estimates the frequency of lifetime and current traumatic events (e.g., being a victim of and/or witness to violence), which is consistent with *DSM IV-TR* Criterion A for post-trauma stress symptoms (APA, 2000). It also accounts for stressful life events, such as losing a loved one, physical health problems, divorce, and financial problems. The LSC-R has good psychometric properties, including for use with diverse age groups and criminal justice populations. The LSC-

R enables the measurement of "objective" cumulative trauma and stressful life events, which is defined in this study as whether or not one or more traumatic or stressful life events have occurred, and "subjective" impressions of traumatic and stressful life events. For each of the individual traumatic and stressful life events experienced, participants were asked their current subjective impression of these events by rating each type of traumatic and stressful life events, on the degree to which it was bothersome within this past year. Each item was measured using a 5-point Likert scale from 1 = *not at all* to 5 = *extremely*. Researchers have reported that the LSC-R has demonstrated good criterion-related validity for detecting traumatic and stressful life events among prisoners (McHugo et al., 2005).

Healthy physical and mental health days. Healthy physical and mental health days were measured using the Health-Related Quality of Life Measure (Healthy Days Measure), a validated and extensively used brief survey of health-related quality of life (HRQOL; Centers for Disease Control and Prevention [CDC], 2000). The measure targets the number of unhealthy days (physical and mental) in the past month.

Perceived coping resources. Perceived coping resources were measured using the Coping Resources Inventory (CRI; Marting & Hammer, 2004). The CRI is a valid measure of self-reported coping resources to manage stressors and has been used in studies of older adults and criminal offenders (Marting & Hammer, 2004; Piquero & Sealock, 2000). The CRI is a 60-item scale with five subscales measuring cognitive, emotional, spiritual, physical, and social coping resources. Higher scores reflect enhanced coping resources. The CRI possesses strong internal consistency (alpha = .80) across the subscales and has good convergent and discriminant validity.

Prison stress. Prison stress was measured by a Likert-type scale on a 1 (never) to 5 (always) metric for self-reported stress.

Measures: Within-Group (SUD Diagnostic History)

In-prison services. In-prison services were measured via self-report (only of prisoners with a history of SUD diagnosis) of receiving any of the following services: psychologist, social worker, psychiatrist, health/medical services, alcoholics anonymous/narcotics anonymous (AA/NA) meeting, and SUD treatment. Furthermore, the health/medical, AA/NA, and SUD treatment services were dichotomously rated as helpful or not helpful.

Sampling Procedure

Data were collected through a self-administered survey given to inmates in 14 state prisons supervised by the New Jersey Department of Corrections (NJ DOC) as part of a study on trauma, mental health, and addiction in older offenders. Of approximately 25,436 prisoners housed in the NJDOC at the time of data collection, approximately 5% (n = 1,209) were aged 55 and above. A simple random sample from the administrative databases of the NJDOC produced a dataset of males ages 55 or older (N=334). Based on prior empirically supported theory (Maschi et al., 2011), the age of 55 or older was chosen for the sample.

Information to create the sampling frame included NJDOC administrative records data for State Bureau of Identification (SBI) numbers. The NJDOC Web site offender search option provides *publicly available* information on all adjudicated offenders in their system including name, State Bureau of Investigation (SBI) number, date of birth, gender, race/ethnicity, county of commitment, admittance date, and facility placement. Therefore, the contact information that the researchers accessed via the NJDOC is the same publicly available information available to the

general public. All prisoners identified by the NJDOC administrative database in the NJDOC at the time of sample selection were mailed an invitation, informed consent, and survey. Participants provided anonymous informed consent (e.g., checking a box – instead of signature – acknowledging voluntary participation in study) and those who gave consent completed an anonymous survey. Those surveys were mailed back to the researchers without any identifying information on the envelope. Thus, confidentiality of prisoner identity was maintained throughout the data collection process.

Results

Results are derived from between-group analyses (SUD diagnostic history yes/no) of multiple psychosocial variables as well as within-group frequencies for the SUD diagnostic history condition in regard to the history of in-prison services. Consistent with the recommendations of Perneger (1998), the Bonferroni Adjustment was not utilized for the multiple t-test between-group analyses (see Table 1).

Table 1

Between-groups analyses (N=334)

	SUD (n=145)		No SUD (n=189)		
Variable	M	SD	M	SD	t (df)
Objective Traumatic Events	11.96	5.30	9.39	5.57	-4.26(332)***
Subjective Reactions to Trauma	35.50	23.95	25.24	21.67	-4.07(327)***
Cognitive Coping Resources	39.11	8.12	41.41	8.34	2.34(286)*
Emotional Coping Resources	60.14	12.84	62.42	12.81	1.51(292)
Social Coping Resources	48.71	10.16	51.03	11.22	1.70(253)
Physical Coping Resources	35.91	9.01	36.63	9.10	0.58(212)
Spiritual Coping Resources	49.61	10.98	51.61	10.16	1.67(310)
Unhealthy Physical – Past Month	9.22	12.39	6.91	10.65	-1.77(310)
Unhealthy Mental – Past Month	6.55	10.45	4.26	8.12	-2.16(305)*
Prison Stress	2.63	1.15	2.39	1.14	-1.92(330)*

***p<.001; *p<.05

Between-Groups Analyses

Objective and subjective trauma. Prisoners with an SUD history reported significantly more lifetime traumatic events (M=11.96, SD=5.30), t (332) = -4.26, p<.001, as opposed to prisoners without an SUD history (M=9.39, SD=5.57). In addition, prisoners with an SUD history reported feeling significantly more impacted in a negative manner by these traumatic events (M=35.50, SD=23.95), t (327) = -4.07, p<.001, as opposed to prisoners without an SUD history (M=25.24, SD=21.67).

Unhealthy physical and mental health days. Though there was no significant difference between those prisoners with or without an SUD diagnosis on the number of unhealthy physical health days per past month, t(310) = -1.77, p = .08, prisoners with an SUD

disorder reported significantly more unhealthy mental health days (M=6.55, SD=10.45) than those without an SUD diagnosis (M=4.26, SD=8.12), t(305) = -2.16, p<.05.

Perceived coping resources. Prisoners with an SUD diagnosis reported significantly lower cognitive coping resources (M=39.11, SD=8.12) as opposed to those without an SUD diagnosis (M=41.41, SD=8.34), t(286)=2.34, p<.05. There were no significant differences for emotional, t(292)=1.51, p=.13, social, t(253)=1.70, p=.09, physical, t(212)=.58, p=.57, or spiritual coping, t(310)=1.67, p=.10.

Prison stress. Prisoners with an SUD diagnosis reported significantly more stress (M=2.63, SD=1.15) than those without an SUD diagnosis (M=2.39, SD=1.14), t(330)=-1.92, p<.05.

Within-Group Analyses: Participants with SUD Diagnosis (n=145)

Visits with a psychologist, social worker, or psychiatrist. Only between one-quarter and one-third of the older offenders with an SUD diagnostic history saw a psychologist (n=47, 32.4%), social worker (n=53, 36.6%), or psychiatrist (n=37, 25.5%) within the past 3 months in prison.

Health/medical services. A majority of older offenders with an SUD diagnosis received health/medical services in-prison within the past 3 months (n=124, 85.5%) with a majority of them (n=92, 74.2%) reporting satisfaction with the health/medical services.

SUD treatment and AA/NA. Only one-third of the older offenders with an SUD diagnosis received in-prison SUD treatment services within the past 3 months (n=46, 31.7%) with only a little more than half of those who received services (n=27, 58.7%) reporting the treatment as helpful. Furthermore, only one-third of the older offenders with an SUD diagnosis received in-prison AA/NA meetings (n=54, 37.2%) with the majority of those attending AA/NA in-prison (n=43, 79.6%) reporting the meetings as helpful.

Discussion

Considering the limited research on the older offender and SUD (Morgen, 2011), this paper addressed psychosocial variables relevant to the treatment process within older offenders with or without an SUD diagnosis. Findings highlight that the older offender with SUD (as compared to the older offender without an SUD) reported significantly more traumatic experiences, negative reactions to these traumas, heightened stress, and more mentally unhealthy days per past month coupled with significantly weaker cognitive coping resources to handle these psychological stressors. Despite the self-reported psychological distress, the majority of older offenders with SUD did not receive in-prison mental health or SUD treatment services. Only between one-quarter to one-third had a visit with a psychologist, social worker, or psychiatrist within the past 3 months. Furthermore, only one-third of older offenders with SUD received any form of in-prison SUD treatment or AA/NA meeting services within the past 3 months.

Of interest was the finding that the older offenders with or without an SUD did not significantly differ in self-reported social, spiritual, emotional, or physical coping whereas those with an SUD reported significantly lower cognitive coping. Cognitive coping is the ability to think through negative events and stresses and to effectively strategize a healthy and rational approach to handling difficult situations. For example, the stress-coping model of addiction outlines that individuals turn to substance use to buffer themselves from experiencing or thinking

about negative emotions and difficult life events (e.g., Aldridge & Roesch, 2008; Roth & Cohen, 1986). Similarly, enhanced self-efficacy, as opposed to avoidance coping, predicts better substance use outcomes (Litt, Kadden, Cooney, & Kabela, 2003; Miller & Longabaugh, 2003; Moos & Moos, 2005). Within this study sample, the older offenders with SUD reported weaker cognitive coping, thus reflecting a possibly limited degree of self-efficacy which may (in part) explain the SUD diagnosis while also highlighting an area in need of counseling services. Especially for those prisoners facing eventual parole/re-entry, assisting the older offender in constructing healthy cognitive coping resources may prevent recidivism to substance use and criminal behavior.

Understanding the impact of cognitive and behavioral approaches for in-prison substance abuse treatment is also important for younger offenders. As a result of stricter drug sentencing and *three strikes* legislation, younger offenders receive longer sentences and grow old in prison. Western (2007) noted that younger offenders have less opportunity to develop coping mechanisms, leading to increased reliance on substance use as a coping mechanism during and after incarceration. A reconsideration of who older prisoners are and who are more likely to age in prison is necessary for developing services and treatment programs to address this aging prison population *when they are incarcerated as younger adults*. Just as critical, traditional community partners may need to also reconsider support services typically offered to younger adults re-entering communities, like drug treatment, into long term and nursing home care offered for older, reentering, formerly incarcerated adults.

Our findings are somewhat more positive than a recent nationwide analysis of state prison facilities which found that 14.2% of state prisoners received SUD treatment services (CASA, 2010). Though the data from the older offenders in NJDOC facilities demonstrated a larger percentage (31.7%) of prisoners receiving SUD services, these numbers are still disturbingly low. Unfortunately, the SUD epidemic extends beyond the offender in-prison, as 36.6% of prisoners within the re-entry/parole process also report an SUD diagnosis (CASA, 2010), increasing their likelihood of relapse or recidivism.

Consequently, in-prison treatment is an important prevention strategy. Myriad reports highlight the financial cost-effectiveness of treatment. For example, the National Institute on Drug Abuse (2009) reported that for every one dollar spent on treatment, society saves 12 dollars in substance use, criminal justice, and healthcare costs. Yet, in-prison SUD services remain limited in scope and availability. The limited number of prisoners receiving in-prison SUD services is directly related to the financial, staffing, and other resources required for the provision of SUD services (Morgen, 2011).

Counseling Implications

These findings are quite relevant to the current state of counseling focused on older adults, substance use disorders, and incarcerated offenders. First, Briggs, Magnus, Lassiter, Patterson, and Smith (2011) presented an urgent and cogent call for professional counseling to catch up to the other helping professions (e.g., psychology, social work) in regard to the study of older adults and SUD, documenting only two articles focused on the subject across three counseling journals (*Journal of Counseling & Development, Journal of Mental Health Counseling,* and the *Journal of Addictions & Offender Counseling*) over a recent 10 year span (1999-2009). Second, the International Association of Addictions and Offender Counselors (IAAOC), a division of the American Counseling Association, recently announced a Presidential Initiative to encourage IAAOC members to emphasize offender-based research within

professional papers and presentations in an effort to build a stronger theoretical base to guide clinical practice (IAAOC, 2013). In addition, the goal of the initiative is to expand the awareness of SUD and offender research/theory (such as that focused on older adults) across all relevant areas of the American Counseling Association (e.g., Association for Adult Development and Aging, American Mental Health Counselors Association). Thus, this paper in VISTAS serves as one of the introductory efforts of that IAAOC initiative.

Specifically, these findings underscore the following two counseling implications. First, counseling and addictions counseling graduate programs should provide coursework and clinical practice with older offenders and SUDs. As emphasized by Briggs et al. (2011) and Morgen (2011), older adults with SUD are a counseling population in dire need of attention. For example, Stickle and Onedera (2006) provide guidance on numerous strategies to develop and implement curricula focused on older adults and counseling. Whether as a stand-alone course(s) or infused throughout the graduate counseling curriculum, professional counselors must be made aware of the unique needs of older adults receiving counseling services.

Second, prison/parole-based mental health and SUD counseling services must be tailored to the concerns and needs of the older adult. Consistent with the human growth and development competencies for counseling (Council for Accreditation of Counseling and Related Educational Programs, 2009), as well as the emphasis on conceptual foundation building in the creation of counseling competencies (Sperry, 2010), professional counselors (such as IAAOC members) should take the national lead in developing counseling competencies for the older adult in the prison/parole system. As a part of leading the initiative, professional counselors must collaborate with other disciplines to provide effective counseling services for older adults in prison. Consequently, counseling students need to learn how to work in an integrative manner with neuropsychologists, clinical/counseling psychologists, social workers, and physicians.

Limitations and Future Studies

The primary internal validity threat is the use of self-report data for sensitive issues such as SUD and trauma (Harrell, 1997; Harrison, 1997). The principal threat to external validity involves the generalizability of the NJDOC data to other state prison systems as well as the federal system. For instance, within the current economic conditions, some states are cutting funding to prisons. SUD and other psychosocial services cost money, thus these data may generalize only to other state prison systems with similar budgets and prison service allocations. These data should inform future research that examines the multivariate influences between variables and within groups. For example, studies of how coping resources predict subjective experiences of trauma and whether the history of an SUD would add to these basic findings and inform in-prison SUD treatment services for the older offender. Considering the limited research and theory specifically focused on the older offender and SUD, any new lines of inquiry would make an immediate contribution.

Conclusion

America's prison population is growing older with increased numbers of these older offenders reporting an SUD. Despite the seriousness of the issue, the older offender and SUD is typically under-reported or outright ignored in data reports and clinical best practices papers on working with SUD in-prison. Future studies must address the older offender in an effort to design and implement more elder-specific SUD services in the prison and parole systems.

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