

Miami-Dade County's Criminal Mental Health Project

Connecting Older Reentrants
to Health Coverage and
Public Benefits



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Connecting Older Reentrants to Coverage and Care


55+

aged adults

30%

by 2030

Adults aged 55 or older represent a growing share of the incarcerated population; by 2030, they are predicted to comprise 30% of the incarcerated population.¹ Older incarcerated adults exhibit physical and behavioral health conditions and disabilities at much higher rates than both their non-incarcerated peers and younger incarcerated individuals. For this reason, common reentry hurdles (such as finding housing and employment) are compounded by the health- and disability-related challenges many face upon return to their communities.²



The higher prevalence of infectious diseases, chronic medical conditions, disabilities, and cognitive impairments in this population means that older reentrants must find ways to meet their physical and behavioral health needs as part of the reentry process.³ This can involve securing health coverage, connecting with community-based medical

and behavioral health care, and attempting to ensure continuity for prescription drugs taken for chronic physical or mental health conditions. Those unable to work due to functional impairments (very common among incarcerated older adults; see “Health Needs of Older Reentrants” on p. 12) must also identify sources of subsistence income to remain stable.

Few prisoner reentry programs, court diversion programs, or health coverage enrollment initiatives are tailored to the needs of older reentrants, yet older adults are likely to comprise an increasing proportion of those seeking such forms of assistance. This brief examines how one such program, Miami-Dade County’s Criminal Mental Health Project, meets the needs of older adults returning from incarceration.

¹ Harrison, P. M., & Beck, A. J. (2005). *Prisoners in 2004*. Washington, DC: Bureau of Justice Statistics. Bulletin NCJ 210677; Aday, R. H. (2003). *Aging prisoners: Crisis in American corrections*. University Park, PA: Penn State University Press; Carson, E. A., & Anderson, E. (2016). *Prisoners in 2015*. Washington, DC: Bureau of Justice Statistics. Bulletin NCJ 250229; Austin, J., Hardyman, P. L., & Irwin, J. (2002). *Exploring the needs and risks of the returning prisoner population*. Washington, DC: Urban Institute.

² Williams, B. A., McGuire, J., Lindsay, R. G., Baillargeon, J., Cenzer, I. S., Lee, S. J., & Kushel, M. (2010). Coming home: Health status and homelessness risk of older pre-release prisoners. *Journal of General Internal Medicine*, 25(10), 1038–1044.

³ Feinberg, R., McKay, T., Green, J. O., & Bir, A. (2017). *Aging, reentry, and health coverage: Barriers to Medicare and Medicaid for older reentrants*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

The Criminal Mental Health Project: A Promising Approach

The Criminal Mental Health Project (CMHP) is a mental health diversion initiative within the Eleventh Judicial Circuit of Florida in Miami-Dade County. The CMHP was established in 2000 as a coordinated, comprehensive program to divert nonviolent misdemeanor defendants with serious mental illnesses (SMI) or co-occurring SMI and substance use disorders into community-based treatment and support services.

“As we help people to move toward community integration, we’re hoping people can live good lives in the least restrictive setting, live successfully in the community, make the community safer, and improve their own health.”

– CMHP staff member



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The CMHP is composed of both pre-booking and post-booking jail diversion programs, the latter of which includes case management, connection to community-based service providers, and individual assistance applying for federal benefits. Services are delivered through a closely coordinated, team-based approach, with collaboration among a project director, lawyers, case managers, peer specialists, and entitlement specialists.

Miami-Dade County presents a challenging context for the CMHP's work, as it has the highest percentage of residents with SMI among large U.S. communities, while Florida has one of the lowest national rankings for state funding for community mental health services.⁴ Traditionally, the CMHP had very limited resources to assist reentrants with connection to housing, treatment, and other medical services upon release from jail. As such, Supplemental Security Income and Social

Security Disability Insurance (SSI/SSDI) represented critical reentry resources for this population. These benefits continue to represent key pathways to Medicare and Medicaid for low-income individuals in Florida, as the state did not elect to expand Medicaid eligibility under the Patient Protection and Affordable Care Act. However, staff who attempted to assist their disabled clients in the SSI/SSDI process tended to experience a lengthy application process and very high rates of application denial.

⁴ Iglehart, J. K. (2016). Decriminalizing mental illness—the Miami model. *The New England Journal of Medicine*, 374(18), 1701–1703.

SOAR in Miami-Dade County

The SSI/SSDI Outreach, Access, and Recovery (SOAR) model took root within the CMHP in 2006, after the project director, Cindy Schwartz, was invited to attend an in-person training event held by the SOAR Technical Assistance Center (see “SOAR Program Overview” on p. 8). After training, she championed the SOAR approach in the CMHP.

“I came back totally engaged in this, and I told all my staff, ‘This is going to be the best thing that ever happened to us [to] help the people we serve become more self-sufficient, get housing, and it’ll help us maximize our limited resources so we can serve more people.’”

– CMHP Project Director



Despite the initial skepticism of other program staff and stakeholders, she began implementing the SOAR approach.

Now, the CMHP's entitlement specialists provide full-time support for SSI/SSDI applications through the SOAR model. Staff attribute some of the SOAR initiative's success in Miami-Dade to the decision to hire dedicated entitlement specialists for this task. Dedicated staffing

proved necessary when the case managers originally tasked with implementing SOAR struggled to prioritize labor-intensive SSI/SSDI applications against their clients' acute competing priorities in the post-release period.

“When people are coming out of jail, you have to first pay attention to their basic needs: where are they going to live, how are they going to get treatment, do they have medication.... Once we learned this [SOAR] technique, we taught it to our case managers and said to go do it, but it took a longer period of time because they were still addressing the basic needs. [SOAR is] a lot of work. There's no easy button here.”

– CMHP Project Director

SOAR Program Overview



Goal

The primary goal of the SOAR program is to increase access to SSI/SSDI benefits for qualified individuals who have mental illness and are at risk of homelessness, including those returning to their communities from jails and hospitals.



Core Program Elements

- ✔ Individualized assistance with application completion and submission by trained SOAR case managers.
- ✔ Accelerated, high-approval-rate process.
- ✔ Strategic planning with key community stakeholders, including SOAR team leads, the Social Security Administration and Disability Determination Services, housing and homeless service providers, and local hospital directors and medical records departments.
- ✔ Ongoing training and technical assistance (TA) provided by the SAMHSA SOAR Technical Assistance Center, including TA providers with expertise in implementing SOAR in criminal justice settings.



Training

- 1 Case managers receive SOAR training to learn how to assist qualified individuals by completing and submitting a complete SSI/SSDI application packet.
- 2 Training consists of seven online classes, estimated at 20 hours total.
- 3 The training includes a practice case component, which requires completion of a full sample application.



Dedicated entitlement specialists are a defining component of the Miami-Dade SOAR program, and a key factor to which staff attribute their high SSI/SSDI application acceptance rate.

Although the SOAR model is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and its TA provider (PRA, Inc.), no federal funding stream is attached to the program. Many states and localities fund SOAR through SAMHSA's Cooperative Agreements to Benefit Homeless Individuals (CABHI) and Projects for Assistance in Transition from Homelessness (PATH) funds, as well as state funds. In Miami-Dade County, SOAR implementation was supported by a Florida Reinvestment Grant, which funded three full-time entitlement specialists to assist jail diversion clients and other justice-involved individuals with SMI.

SOAR implementation also required partnership development with courts and corrections personnel, medical facilities, behavioral health inpatient programs, homeless and other community-based organizations, and local Social Security offices.

“Judge Steve Leifman and Cindy Schwartz developed a strong relationship with the local SSA [Social Security Administration] field office and Department of Disability Services... They were able to provide court staff, the public defender’s office, State Attorney’s office staff, family members of potential applicants, and all stakeholders who touch the lives of justice-involved people with information necessary to help them to understand how [SSI/SSDI] play a part in post-release success and recovery.”

– Staff from SAMHSA’s SOAR TA Center

Meeting the Needs of Older Reentrants

The CMHP program serves a diverse range of clients, including reentrants aged 50 years or older. Justice-involved individuals of this age are typically designated as “elderly” or “aging.” This age threshold is lower than typically used among the general population due to accelerated physiological aging that may result from factors such as substance abuse and inadequate access to health care before incarceration, and stress during incarceration.^{5,6}



Older reentrants are a uniquely high-needs population, with high prevalence of physical and behavioral health needs and comorbid health conditions. Linkage to health coverage is therefore a critical component of successful reentry following release from prison or jail and continued success beyond the reentry period.

Older reentrants are a heterogeneous population, and there are significant variations between those with and without serious mental illness, those with histories of felony versus misdemeanor convictions, and other distinctions.

⁵ Aday, R. H. (2003). *Aging prisoners: Crisis in American corrections*. University Park, PA: Penn State University Press.

⁶ Loeb, S. J., & Abudagga, A. (2006). Health-related research on older inmates: An integrative review. *Research in Nursing & Health, 29*(6), 556–565.

Health Needs of Older Reentrants



Older reentering individuals often have high physical and behavioral health needs, compared to both younger reentrants and older individuals with no justice system involvement.



Older persons in prisons and jails report higher rates of physical disabilities than their younger incarcerated counterparts. Compared to those ages 18 to 24, individuals 50 or older are 13 to 15 times more likely to report an ambulatory disability, 6 times more likely to report a hearing disability, and 4 to 5 times more likely to report a vision disability.⁷

50+
aged adults

15x
ambulatory
disability

6x
hearing
disability

5x
vision
disability

71%
substance
abuse

A study of incarcerated persons aged 55 or older found that 71% reported a substance abuse problem. They had also been using their primary substance longer (a median of 43 years) compared to younger individuals.⁸

40%
cognitive
impairments

A separate study of incarcerated persons aged 55 or older found that 40% had cognitive impairments, higher than the rate among older non-incarcerated individuals.⁹

40%
state prisoners

52%
jail inmates

Self-reported rates of mental health issues among older incarcerated persons are lower than those among younger state and federal prisoners, but they are nevertheless substantial, at 40% of state prisoners aged 55 or older and 52% of jail inmates aged 55 or older.¹⁰




⁷ Bronson, J., Maruschak, L. M., & Berzofsky, M. (2015). *Disabilities among prison and jail inmates, 2011–12*. Washington, DC: Bureau of Justice Statistics.

⁸ Arndt, S., Turvey, C. L., & Flaum, M. (2002). Older offenders, substance abuse, and treatment. *The American Journal of Geriatric Psychiatry*, 10(6), 733–739.

⁹ Williams, B. A., Ahalt, C., & Greifinger, R. (2014). The older prisoner and complex chronic medical care. In S. Enggist, L. Møller, G. Galea, & C. Udesen (Eds.), *Prisons and health* (pp. 165–170). Copenhagen, Denmark: World Health Organization Regional Office for Europe.

¹⁰ Glaze, L. E., & James, D. J. (2006). *Mental health problems of prison and jail inmates*. Washington, DC: Bureau of Justice Statistics. Special Report NCJ 213600.



Staff at the CMHP and the SOAR Technical Assistance Center identified several common challenges of older reentering individuals that can also affect SSI/SSDI applications.

Many older reentrants have longer histories of cumulative trauma and greater distrust of government systems and persons in authority positions.

As a result, they may be hesitant, unwilling, or unable to share personal information with entitlement specialists. Older reentrants sometimes struggle to communicate openly with staff members who are significantly younger than they are. Due to greater life experience, older reentrants may also be better able to “present well,” projecting a facade that obscures their true impairments.

Older adults often have a history of cycling in and out of the criminal justice system, leading to fragmented and unconsolidated medical records.

Because medical records provide the foundation for the SSI/SSDI application, a lack of comprehensive records can result in insufficient documentation of disability and delays in application submission.

“A lot of people at age 60 are not just going to open up and say, ‘My psychotic symptoms get in the way of being able to concentrate.’ You have to build up the rapport... There’s that mentality of ‘I’ve been through life,’ and they’re not willing to admit the situation they’re in right now.”

– *Entitlement Specialist*



Older reentrants often have less family and social support than their younger counterparts.

Family members can provide entitlement specialists with a more complete picture of a client's daily activities and functional activity level. Without family, entitlement specialists often lack that information. Family members can also serve as representative payees for clients' social security payments, if SSA determines that the beneficiary is unable to adequately manage their own payments (often due to cognitive impairment, disability, or substance abuse). If a beneficiary requires a payee but has no willing individuals, SSA can designate an organization as the payee; however, this presents an additional hurdle to receipt of benefits.

Older reentrants face very limited housing options. SSI payments may not fully cover rent, particularly in areas with a higher cost of living.

Some older reentrants require care in a nursing home, but Medicare provides nursing coverage only in very specific circumstances (up to 200 days total in a skilled nursing facility), and many nursing homes choose not to accept Medicaid. Staff also noted a lack of appropriate, affordable independent living placements for low-income older adults.

Compared to younger SSI/SSDI applicants, older applicants have had more years in which they could work.

Being older can present a "catch-22" regarding SSI/SSDI work history requirements. It means that applicants must demonstrate more quarters of paid work than younger applicants, which can be a problem for those who spent many of their hypothetical "working years" incarcerated. Yet those who have, indeed, spent many years employed face an additional challenge in demonstrating that a more recent impairment prevents them from working.

"They will be held to the standard of, 'You did this work for 30 years, why can't you do it now?'"

– Entitlement Specialist

Promising CMHP Strategies for Serving Older Reentering Individuals

Despite the challenges inherent in working with older reentrants, staff at the CMHP identified several promising strategies for serving this population.

“She was all professional. They communicate and keep it simple, and I appreciate that. They talk to you; you’re human.”

– Older Client



Integrating the SOAR program into a larger CMHP has allowed the Miami-Dade team to collaboratively serve a broad range of clients. In particular, staff highlight the use of dedicated entitlement specialists (staff members whose primary job function is to assist clients with SOAR applications) as critical to the program's success. Ms. Schwartz emphasizes that after hiring a full-time entitlement specialist, and shifting this responsibility away from multi-function case managers, the program saw significant increases in application approval rates and decreases in approval time.

Peer specialists with personal experience in the criminal justice system played a crucial role in building trust and rapport with older reentrants.

The CMHP's peer specialists engage older reentrants by spending time with them in casual settings, such as parks or inexpensive restaurants. These individuals draw on their own life experiences to understand the needs of reentering individuals and to relate to them using language and conversation topics that build authentic connection and trust.

"It does help, but it has to be the right place... They're also going through so much, they have to be in a place where they can hear that."

– Peer Specialist



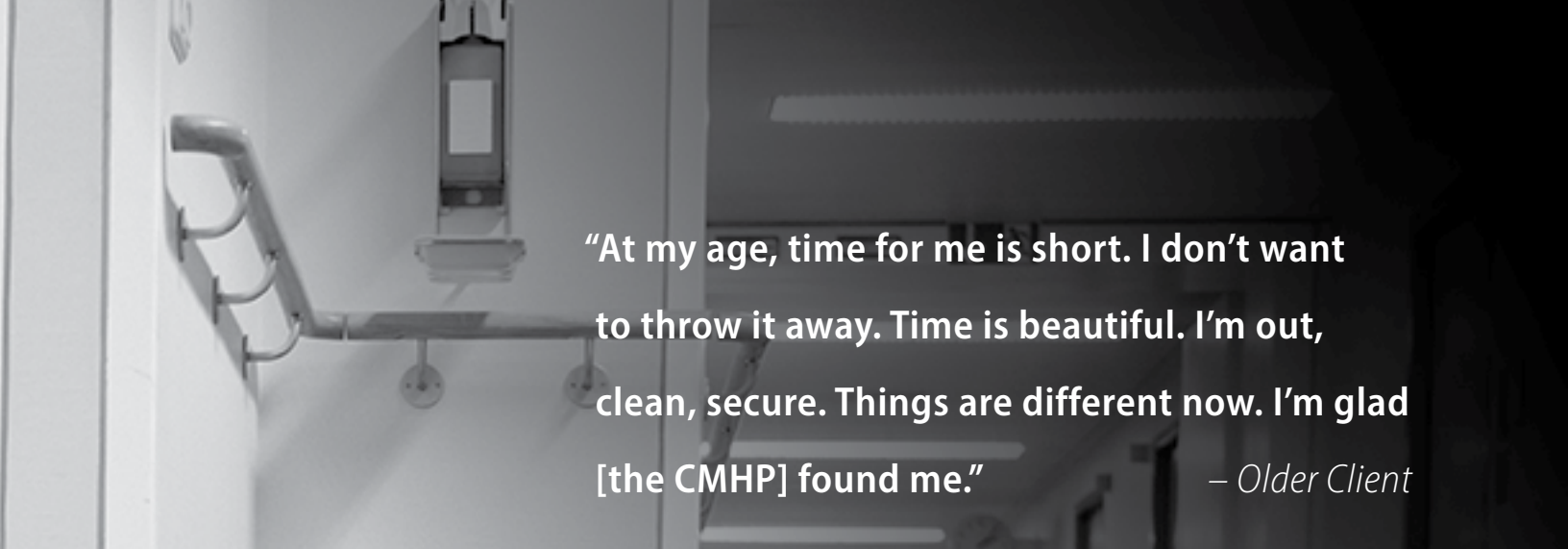
Clear and respectful communication can be especially important when working with older reentrants.

Staff noted that respect helps to build trust and rapport when staff members are younger than their clients. Simplicity, clarity, expectations management, and frequent status updates were seen as key by staff and their older clients alike. Staff noted that communication must also be tailored to individual clients' illnesses, preferences, and needs. For example, many older reentrants would find direct instructions overly blunt and rude, whereas those with schizophrenia may need simple directives.

Strong writing skills are critical for assisting older reentrants with the SSI/SSDI application process.

Given the precise and detailed requirements of SSI/SSDI and the limited time allocated to SSA application processing staff, applications must strike a balance between being concise and informative. Staff at the CMHP highlighted the importance of strong writing that focuses on the client's symptoms and functional

impairments, and connects these impairments to their work capabilities. For clients receiving current treatment for their physical and behavioral health conditions, entitlement specialists often worked closely with their medical providers to obtain documentation of a client's expected level of functioning and capability to work if medical treatments were discontinued.



“At my age, time for me is short. I don’t want to throw it away. Time is beautiful. I’m out, clean, secure. Things are different now. I’m glad [the CMHP] found me.”

– Older Client

Connecting older adults with benefits requires strong partnerships with corrections staff, judges, medical and behavioral health facilities, homeless and other community-based organizations, and local Social Security offices. These relationships facilitate appropriate referrals to the SOAR program and an expedited application process for clients. Strong relationships with providers accelerate delivery of medical records to entitlement specialists and increase providers’ willingness to accept SOAR clients as patients.

When these strategies are in place, and the challenges of serving older individuals can be addressed, staff noted that older adults may actually demonstrate greater follow-through and more reliable program engagement than their younger counterparts. With greater life experience, and a longer time cycling through the criminal justice system, many appear ready for a change by the time they start working with CMHP staff.

“The initial relationships helped us to grow more relationships, and we’d actively leverage them to build new ones. We would ask, ‘Here’s what we did with this provider, would that work for you?’” Staff also noted that coordination within the local Medicaid behavioral health managing entity helped to motivate and facilitate these connections.

– Specialist

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