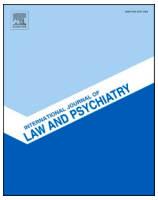
International Journal of Law and Psychiatry 89 (2023) 101905

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

journal homepage: www.elsevier.com/locate/ijlawpsy



Stigma management during reintegration of older incarcerated adults with mental health issues: A qualitative analysis

Helene Seaward [a,*], Sophie Dieffenbacher [b], Jens Gaab [c], Marc Graf [d], Bernice Elger [a,e], Tenzin Wangmo [a]

[a] University of Basel, Institute for Biomedical Ethics (IBMB), Bernoullistrasse 28, 4056 Basel, Switzerland
[b] Psychiatric Hospital of the University of Basel, Division for Psychosomatics and Psychotherapy, Wilhelm Klein-Strasse 27, 4002 Basel, Switzerland
[c] University of Basel, Division of Clinical Psychology and Psychotherapy, Faculty of Psychology, Missionsstrasse 62, 4055 Basel, Switzerland
[d] Psychiatric Hospital of the University of Basel, Forensic Psychiatric Hospital, Wilhelm Klein-Strasse 27, 4002 Basel, Switzerland
[e] University of Geneva, Center for legal medicine (CURML), Medical faculty, Rue Michel-Servet 1, 1211 Genève, Switzerland

ARTICLE INFO

Keywords:
Stigma
Double stigma
Old
Prison
Forensic
Reintegration
Resettlement

ABSTRACT

Introduction: The number of older prisoners with mental health issues released from prisons and forensic psychiatric institutions is rising. Their successful integration is important due to its implications for the public's safety and the individual's health and well-being. However, reintegration efforts are hampered due to the double stigma attached to 'mental illness' and 'incarceration history'. To alleviate the burden of such stigma, affected persons and their social networks employ stigma management strategies. This study sought to investigate the stigma management strategies of mental health professionals supporting older incarcerated adults with mental health issues in their reintegration process.

Methods: Semi-structured interviews with 63 mental health professionals from Canada and Switzerland were carried out as part of the overall project. To address the reintegration topic, data from 18 interviews were used. Data analysis followed the thematic analysis approach.

Results: Mental health professionals emphasized the double stigmatization of their patients which impaired their quest for housing. Lengthy searches for placement frequently resulted in patients' unnecessary long stays in forensic programs. Nevertheless, participants outlined that they were at times successful in finding appropriate housing for their patients due to the use of certain stigma management strategies. They stated that they, first, established initial contacts with outside institutions, second, educated them about stigmatizing labels and, third, provided ongoing collaboration with public institutions.

Discussion: Incarcerated persons with mental health issues face double stigmatization that affects their reentry process. Our findings are interesting as they illustrate ways in which stigma can be reduced, and how the reentry process can be streamlined. Future research should include the perspectives of incarcerated adults with mental health issues to shed more light on the various options that they seek for successful reintegration after imprisonment.

1. Introduction

In Europe, 111 incarcerated persons per 100.000 inhabitants were released in 2017 (Aebi & Tiago, 2019). Successful reintegration of these individuals is important as they tend to have high recidivism rates with 2-year reconviction rates ranging from 26 to 60% (Yukhnenko, Sridhar, & Fazel, 2019). Successful reintegration also results in better health and well-being of the formerly incarcerated person (Semenza & Link, 2019). Central issues upon release are finding a place to live, securing employment, and (re-) establishing social networks (Cantora, 2015; Cherney & Fitzgerald, 2016; Wyse, 2018). The stigma attached to imprisonment is one critical factor challenging all dimensions of the reentry process into society (Harding, 2003; Moran, 2012).Individuals are stigmatized due to possessing a trait or characteristic that conveys a devalued social identity in a particular social context (LeBel, 2008). Goffman (1963) described it as '*an attribute that is deeply discrediting*

* Corresponding author.
E-mail addresses: helene.seaward@unibas.ch (H. Seaward), sophie.dieffenbacher@upk.ch (S. Dieffenbacher), jens.gaab@unibas.ch (J. Gaab), marc.graf@upk.ch (M. Graf), b.elger@unibas.ch (B. Elger), tenzin.wangmo@unibas.ch (T. Wangmo).

https://doi.org/10.1016/j.ijlp.2023.101905
Received 3 April 2023; Received in revised form 30 May 2023; Accepted 31 May 2023
Available online 15 June 2023
0160-2527/© 2023 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY license (http://creativecommons.org/licenses/by/4.0/).

within a particular social interaction' (p.3). He created a framework for the concept of 'stigma', embedding the process of stigmatization in social interactions, not within the stigmatized individual. This stigmatization process occurs when people identify certain characteristics of others that are believed to violate a social norm. A criminal conviction represents one such marker that carries a stigma (LeBel, 2012). It characterizes a person as dangerous, dishonest, unreliable, aggressive, unpredictable, disreputable, and untrustworthy (Anazodo, Ricciardelli, & Chan, 2019; Hirschfield & Piquero, 2010; LeBel, 2012; Moran, 2012). Being stigmatized as a formerly incarcerated person negatively affects successful reentry into society through reduced access to housing, employment, or educational opportunities (Keene, Smoyer, & Blankenship, 2018; Link & Phelan, 2001). It consequently interferes with their reintegration prospects after release (Moran, 2012).

Moreover, formerly incarcerated persons are often affected by multiple burdens of stigma due to race/ethnicity, economic circumstances (disadvantaged backgrounds, low financial resources), mental health or substance use issues (Anazodo et al., 2019; Gausel & Thørrisen, 2014; LeBel, 2008; van Olphen, Eliason, Freudenberg, & Barnes, 2009). The combination of different stigmatizing categories within one individual is thought to increase the stigmatization experience manifold. For instance, incarcerated adults with mental health issues combine the labels 'mentally ill' and 'incarceration history'. When considering the 'mentally ill' label separately, persons are often labeled as dangerous (unpredictable and violent), weak, strange, disruptive, incompetent, and blameworthy (Ran et al., 2021; Tyerman, Patovirta, & Celestini, 2021). For the 'incarceration' label, perceived dangerousness is the strongest predictor of stigmatization and social distancing (Hirschfield & Piquero, 2010). Further, the combination of both labels disproportionally strongly affects the reentry process of such formerly incarcerated persons with mental illness (Livingston, Rossiter, & Verdun-Jones, 2011; West, Vayshenker, Rotter, & Yanos, 2015).

Some stigmatizing characteristics are visible, while others can be hidden, at least to some extent (Gausel & Thørrisen, 2014). Both, a criminal conviction as well as mental health issues are markers that can be concealed (LeBel, 2008). The person carrying that stigmatized label can therefore choose the conditions of disclosure, with some exceptions such as jobs where employers ask routinely for a copy of the criminal record before establishing a work contract. In most other situations, the individual can decide when, how, where, and to whom potentially stigma-inducing information will be disclosed (Camacho, Reinka, & Quinn, 2020; Cherney & Fitzgerald, 2016). Each strategy will have consequences on the experience of social exclusion or prejudice from others as well as feelings of belonging (Camacho et al., 2020; Newheiser & Barreto, 2014). These strategies are not only applied by stigmatized persons but also by their social networks and caregivers (Cherney & Fitzgerald, 2016). Given the importance of stigma during the reintegration process, it is central to skillfully handle the disclosure of stigmatizing information.

Within the last two decades, the number of older incarcerated adults has risen (Baidawi & Trotter, 2016; Di Lorito, Völlm, & Dening, 2018). Alongside this development, the number of older adults reentering society has also grown (Wyse, 2018). For instance, in Switzerland, the percentage of older adults reentering society after incarceration has grown from 7% in 1998 to 15% in 2021 (Bundesamt für Statistik, 2022). In Canada, The number of older supervised persons released to the community in Canada has risen from 2.310 in 2009 to 3.486 in 2018 (Correctional Services Canada, 2019). With these growing numbers, more weight is given to the subject matter.

Further, current literature on the reentry process of former prisoners is based on the 'average' incarcerated adult (Wyse, 2018), who are predominantly young adults. However, the needs of older adults in the reentry process differ substantially. For instance, while most incarcerated younger adults return to self-reliant housing, older adults will often seek placement in nursing homes or other forms of assisted housing (Aday & Krabill, 2012). They are more likely to show effects of institutionalization such as dependence on institutional structures and contingencies as well as social alienation and withdrawal (Correctional Services Canada, 2019; Shantz & Frigon, 2009). Their reentry needs are complicated due to increased mental and somatic health needs (Maschi, Morrisey, & Leigey, 2013) including multiple chronic health conditions and end-of-life issues (Higgins & Severson, 2009). They often lack family support and have a small social network (Kamigaki & Yokotani, 2014; Williams & Abraldes, 2007; Wyse, 2018). Additionally, they commonly have few financial resources and low prospects to return to the labor market (Williams & Abraldes, 2007; Wyse, 2018).

There is little research on what the reentry process entails for formerly incarcerated older adults with mental health issues and how stigma affects their search for housing during reintegration. At the same time, the reentry process is central in avoiding criminal and clinical recidivism and scholars emphasized the need for special programs and support options for older incarcerated adults returning to the community (Shantz & Frigon, 2009; Wahidin & Powell, 2001). This study focuses on the experiences of mental health professionals on reentry planning, specifically finding appropriate housing for older incarcerated adults with mental health issues and their stigma management strategies. This research, therefore, fills an important gap, as it sheds light on the reintegration process of an under-researched population.

2. Methods

This article follows the "Journal article reporting guidelines" for qualitative research by (Levitt et al., 2018). Moreover, to describe the population of interest, we refer to 'older adults with mental health issues' to follow recommendations on the use of respectful language suggested by Tran et al. (2018). Incarcerated persons with mental health issues are housed either in forensic psychiatric institutions or in prisons, depending on the respective state's referral system. A great proportion of research focuses on forensic patients exclusively. Our study targeted both parts of this population (in prisons and forensic institutions), which is additional reason why we used the general description 'older adults with mental health issues' instead of solely referring to 'forensic patients'. However, some mental health professionals interviewed in this study used the term 'forensic' patients when talking about older incarcerated adults with mental health issues. We transcribed the interviews verbatim and therefore did not change this wording.

2.1. Study design

This qualitative study is part of a larger research project on the mental health of older persons in detention (*Agequake in Prisons –second part: Mental health care and forensic evaluation of aging prisoners and persons serving security measures in Switzerland; SNSF grant number 166043)*. The overall goal of the project was to provide insight into aging in prison, experiences with prison mental health care, and living with mental disorders in the prison context. The project used a mixed-methods approach, collecting qualitative and quantitative data. The quantitative data collection aimed at estimating prevalence rates of mental disorders amongst incarcerated older adults as well as depicting the mental health care provided. The qualitative data collection applied an explorative approach to examine complex social phenomena around aging and mental health in prison.

The analyses provided in this article are based on one section of the data gathered from the qualitative interviews. This article focuses exclusively on health care providers' knowledge of stigmatization during the reentry process of older incarcerated adults. Other topics have been analyzed and presented elsewhere (see for example Haesen, Merkt, Elger, & Wangmo, 2021; Merkt et al., 2021; Merkt et al., 2021; Mussie, Pageau, Merkt, Wangmo, & Elger, 2021; Pageau et al., 2021; Pageau, Seaward, Habermeyer, Elger, & Wangmo, 2022; Seaward et al., 2021; Seaward et al., 2021; Shaw, Seaward, Pageau, Wangmo, & Elger, 2022; Wangmo, Seaward, Pageau, Hiersemenzel, & Elger, 2021).

We obtained ethics approval from the lead regional ethics committee (Ethikkommission Nordwest- und Zentralschweiz, EKNZ) and from the local ethics committees (Bern, Vaud, Zürich) in May 2017. Further, BE and TW designed the research project. Both have many years of research experience on the topic of older incarcerated adults and in the application of qualitative methodology. (Elger, Handtke, & Wangmo, 2015a, 2015b; Wangmo et al., 2015; Wangmo et al., 2016; Wangmo, Hauri, Meyer, & Elger, 2016). Two research assistants who completed their doctoral education as part of this project conducted the interviews. Both were trained in qualitative data collection and received supervision by TW and BE throughout the data collection and analyses processes.

The rationale for including participants from the two countries, Switzerland and Canada, as part of our project was due to their similar developments in regards to aging of their prison populations, as outlined in the introduction. Certain key characteristics of this older prison population are comparable, such as high disease burden, high utilisation of prison health services, as well as increased support need for care during and after incarceration. Interviewing experts from both countries is valuable because the data may reveal similar views about the challenges, but also present different opinions about strategies to address them.

2.2. Data collection

We conducted semi-structured interviews with mental health professionals working with incarcerated persons. The face-to-face interviews were held between April 2017 and January 2018. We applied convenience and purposive sampling to select mental health professionals MHPs. Included participants were those with a background in psychiatry, psychology, psychiatric nursing, and social work. They were required to have a minimum of 10 years of overall work experience and some practice in working with older incarcerated adults. We included mental health professionals working at psychiatric clinics that house forensic units and forensic psychiatric services that provide mental health care to correctional institutions. All Swiss and Canadian participants working in forensic institutions were recruited directly by one of the authors (HS). Participants working in institutions run by Correctional Services Canada were directly recruited by this federal government agency.

Potential participants were first contacted via email or phone. We then provided study information and informed consent documents to all participants via email. We clarified questions regarding study participation and the purpose of the research project before we scheduled an interview. We obtained written informed consent before the start of the interview, either via email or in person. At the scheduled time and place of the face-to-face interview, the researchers again explained the purpose of the study, pointed out that all data would be treated confidentially, and reminded the respondents that they could refuse to participate at any time. We interviewed participants in person or via telephone. We did not provide compensation for participation.

The semi-structured interview followed a topic guide specifically developed for the purpose of this study. The open-ended questions covered topics on specificities of mental health care provided for older adults, particular needs of older incarcerated adults, access to mental health care, role conflicts, and risk assessments of older incarcerated adults. The topic of stigmatization during reentry emerged spontaneously in the conversation with various participants, without being specifically asked as part of the topic guide.

Interviewer and participant met for the first time on the day of the interview, thus, there was no relationship prior to data collection. Only one interview meeting took place with each participant and no repeat interview was done. Interviews were held in the language spoken by the participant, either English, French, German or Swiss German. Thereafter the interviews were transcribed verbatim in the language of the interview, except for Swiss German interviews, which were transcribed in Standard German. Swiss German is a spoken dialect and it is common practice to use Standard German in writing. All interviews were audio-recorded upon the consent of the participant and transcribed verbatim, paying particular attention to the anonymization of the information collected.

Moreover, to describe the population of interest we refer to 'older adults with mental health issues' to follow recommendations on the use of respectful language suggested by Tran et al. (2018). Incarcerated persons with mental health issues are housed either in forensic psychiatric institutions or in prisons, depending on the respective state's referral system. Our study focused on both parts of this population, which is additional reason why we used the general terminology 'older adults with mental health issues' instead of solely referring to 'forensic patients'. However, some mental health professionals interviewed in this study used the term 'forensic' patients when talking about older incarcerated adults with mental health issues. We transcribed the interviews verbatim and therefore did not change this wording.

We completed 63 interviews with mental health professionals in Canada and Switzerland. Please see Table 1 for details on the participant characteristics. We performed data analysis along with ongoing data collection. In so doing, we were able to identify when data saturation was reached and were able to include more participants if needed. We identified data saturation by applying the principles presented by (Fusch & Ness, 2015); the ability to obtain additional new information has been attained, further coding is no longer feasible, and there is enough information to replicate the study.

2.3. Data analysis

We processed and organized the qualitative data using the software program MAXQDA. We conducted the analysis using the thematic analysis approach by Braun and Clarke (2006). As a first step, five of our project members read and coded collaboratively eight interviews. This in order to create a consistent basic coding tree. During this process, the study team discussed various nuances that became apparent in the data and reached consensus on the dimensions identified by each code, its name, and its definition. In a next step, three members of the study team (two of whom were HS and TW) coded all remaining transcripts individually and met to discuss the new codes, resolve disagreements, and sort the final coding tree. The interviews were analyzed in their original language for the entire data analysis process, as all study team members were proficient in the languages included. Only the final quotes used in this article were translated into English, the translations were checked by an English native speaker.

Given the wealth of information collected and the broader scope of the interviews, exclusively the coded data on reentry and stigma perceptions and management were extracted and examined in this paper. It is important to note that this topic was not specifically addressed in our interview guide but emerged spontaneously during our conversations

Table 1
Participant characteristics.

		Switzerland	Canada	Total
Number of participants		29	34	63
Participants' gender	*Female*	8	22	30
	Male	21	12	33
Interview length (in minutes)	*Range*	48–90	28–92	28–92
	Mean	71	60	41.18
	Standard Deviation	14.16	11.49	17.36
Language regions	*German-speaking*	16	–	16
	French-speaking	13	5	18
	English-speaking	–	29	29
Number of Participants per type of institution	*Penal institutions*	23	21	44
	Forensic-Psychiatric Institutions	6	13	19

with the interviewees. For this reason, not all 63 participants discussed the topic but was brought up by a large proportion of participants from both countries. Namely, 18 participants raised the issue of which 14 were from Canada and 4 from Switzerland. The two main authors SD and HS carefully read this data segment in its entirety and reanalyzed it in light of the purpose of this study. This in-depth examination of a theme was also conducted using thematic analysis. The results were discussed with all co-authors and are presented below in the form of two major themes depicting first the experiences with stigmatization during the reentry process and second the stigma management strategies applied to alleviate the impact of the 'forensic label' to find community placement. Both themes are divided into subthemes, please see Fig. 1 for an overview. Further, the participants from Canada and Switzerland are presented jointly as no considerable differences were found. Nevertheless, for reasons of transparency and traceability Canadian interviewees are presented as CXXX and participants from Switzerland as SXXX.

3. Results

3.1. Mental health professionals' experiences of stigma during the reentry process of older incarcerated persons

3.1.1. Double stigmatization

Many respondents emphasized that forensic patients carried the burden of two stigmatizing labels: First, being a person with a history of incarceration, and second, having a severe mental illness. *"We have mental health stigma and of course then this offender stigma as well." (C647/C648)*. They stated that stigma associated with these two labels have hampered their efforts to find placement in public institutions for their older patients:

"And really, they are, they are difficult to market. When you can take a, you know, a little granny that lives in the community and is quiet versus you saying 'hey will you take somebody from the pen?' They get to choose (laughing)." (C660).

A few respondents challenged the stigmatizing attitudes of society. They stated that as part of recovery, a person who finishes his/her sentence should be considered a full member of society again. They should not have to carry the burden of their past, as they served their sentence and are released. The public should not judge these persons any longer based on their offence for which they have already served their time: *"When someone is released from the measure [court-mandated treatment], then it is something else, he has the right to be looked at as a blank sheet." (S863)*. Similarly, another participant emphasized how society should not exclusively judge forensic patients by the stigmatizing part of their identity, but see them as a whole person who has committed a crime, has an illness and has served the time for the crime plus received the treatment: *"But recovery is kind of, you know, how we also look at the clients as a whole, beyond just their status as an offender." (C652)*.

Participants claimed that the mental health issues that their patients experienced were particularly rare. This is because their patients frequently suffered from severe forms of mental disorders such as treatment-resistive schizophrenia. These severe courses of psychiatric diseases are uncommon even for mental health specialists in the community who usually treat milder cases. Thus, the forensic label was particularly tied to the severity of patients' disorders possibly exacerbating stigma experienced by the older forensic patient.

"So, our community-based agencies are not really used to dealing with people who are/ who have active psychosis, who have treatment-resistive symptoms. (…) there is still a lot of stigma". (C646).

In a similar fashion, respondent C663 expressed his/her rejection experiences with the incarceration label: *"So why are you not taking him? 'He's an offender'. That's the only response I get back, nobody wants offenders."*. Some participants explained that the incarceration history influences people to maintain social distance partly due to anxiety, as illustrated by *(S975) "I think that is an obstacle, where many people are afraid of contact when something like that raised, that someone has a criminal background."* Moreover, a few participants emphasized that the degree of stigmatizing experiences was much greater when both labels were combined:

"I think people aren't given uh fair opportunities once they have that label (…) it's more exponential than rather just double the stigma. (…) if you put them together um you know it's just that much more difficult." (C654).

In addition, a few participants explained that age did not play a role as a stigmatized label, once they carried the forensic identity: *"But the,*

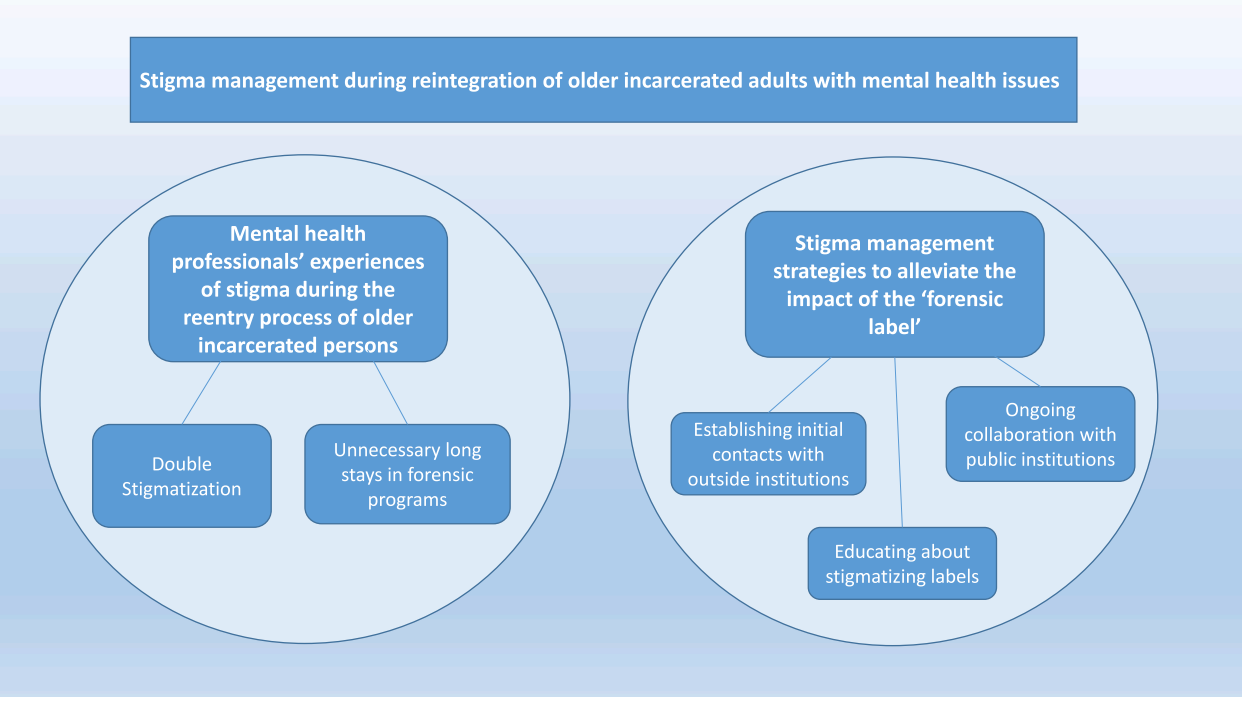


Fig. 1. Main topics on participants' experiences with double stigma and their stigma management strategies.

the inhibition is often very high for public institutions, to take on forensic patients, virtually no matter how old." (S968). Several respondents stated that when they are looking for housing to place their older incarcerated patients, the label 'forensic' elicits fear in members of the general. Thus, because of the incarceration piece of their patients' stigmatized identity, their request for their older patient's placement being rejected by public institutions. One reason for this anxiety was claimed to be a person's fear of something that is completely unknown to them, that they have never come in contact with, as explained by participant *C643:*

"Especially once they/ unfortunately once they have that forensic label so to say. It um/ there is that fear of the unknown with the general you know, public and it can create some difficulties."

Further, the incarceration history highlights the fact that the person was imprisoned for a crime committed, thus symbolizing that the person is aggressive and a risk to society. A few respondents highlighted that this 'incarceration' label takes the spotlight and consequently triggers fear, as illustrated by S968: *"So, if you committed a crime, then you are like, then you're perceived uh, often you're reduced to the delict and of course that triggers anxiety."*.

"Um most people are touched by mental illness in some way or form. Um it's more so the forensic piece (P1: Yeah, I agree) I find that is the biggest (…) people are worried about the forensic title." (C647/C648).

In the particular case of older forensic patients, public nursing homes were concerned about formerly incarcerated persons being a risk to their other patients. This fear resulted in the rejection of forensic patients from the nursing home before a first encounter could have happened: "*Our elderly patients that we would refer to a long-term care nursing home would be denied immediately because of the fact that they're forensic and that's scary." (C647/C648)*. Several participants explained that they tried to vouch for their older patients to enable initial contact with future landlords and nursing home administrators. However, they were frequently not seen as reliable sources as they were working in the interest of their patients.

"Because they do not/ we find that we are not a trust/ they don't see us as a trustworthy source. They see us as someone that is trying to get them into the community, and they are seeing forensic elderly populations as high risk to the other clients that are living there. Even if we say they are stable." (C643).

3.1.2. Unnecessary long stays in forensic programs

Several Canadian respondents explained that they struggled to find placement for their older patients in public institutions due to social rejection and exclusion that was linked to the stigma attached to the combined label of 'mentally ill' and 'incarceration history'. Their inability to find housing for their patients led to patients remaining in forensic programs longer than necessary. Participants further stressed that once patients are ready for release, they naturally do not require the highly specialized resources that are offered in forensic services, which are consequently wasted due to prolonged stays, as summarized by respondent C643:

"But we were able to make fairly good progress um in you know, drawing attention to the fact that they are improperly housed within the forensic program. They, they do not require the services of forensic mental health band and it is a/ really a waste of resources and dollars to have someone who could be fully supported in the community and then in a different area provided the funding was available. You know, as opposed to um to being stuck in a forensic program."

One respondent claimed that not only resources were wasted but also the older patients could be better cared for in public institutions, where they are specialized for geriatric care: "*And because the forensic geriatric doesn't necessarily get placed in the community where they would probably strive a lot better in terms of the environment, hum and resources." (C651)*. Along the same lines, a few participants emphasized once forensic patients got older, their needs changed. Cognitive issues and the need for care became more dominant while risk needs became less relevant in their daily care:

"They might look very much like an Alzheimer's patient or a dementia patient from the community and have the same day-to-day concerns and behavioral problems and symptoms, but the 'offender' label is certainly a barrier to get/ an additional barrier to get into any of these community care facilities." (C673).

The same respondent explained that these higher levels of care reduced the older patients' housing opportunities. Older incarcerated adults can frequently not return into self-reliant housing but need to be placed in institutions that are able to provide a high level of care such as nursing homes:

"It is particularly difficult because in in terms of release prospects, they seem to have fewer release prospects just because of the level of care they need now." (C673)

Additionally, some participants highlighted that once older patients no longer posed a risk to society, they should be eligible for public geriatric services. They also emphasized how they were unrightfully kept within the prison system due to a lack of appropriate housing and held back from advancing their lives past imprisonment.

"As soon as they are not a risk anymore then they should not be in this system. They should be just um able to access you know general geriatric services if they need that for health issues. Or to go live their lives, you know without the constraints of our system." (C646).

3.2. Stigma management strategies to alleviate the impact of the 'forensic label'

3.2.1. Establishing initial contacts with outside institutions

Several participants stated that the key concern in finding placement for their patients was to establish initial contact with public institutions so that these patients are placed in the community. Due to the forensic label, they frequently experienced social rejection that prevented a first encounter with public institutions. To avoid such rejection, professionals would hide their affiliation with the prison system. For instance, a few respondents explained that when they emailed landlords or long-term care homes, they would erase their email signature, as illustrated by C647/C648:

So any time we show up with a client to view an apartment. 'Well, who are you?' and 'what do you do' and the questions start. Or if I were to email a landlord, I always erase my email signature so that people don't see [name of institution 1] 'mental health and the law program' you know, because then that's like… (…) people are worried about the forensic title.".

Others emphasized that this first getting to know each other was the key to succeeding in their goal of placing their older patients in an appropriate community housing. One respondent made this contact happen by *"asking if we can get in the door for a tour." (C646)*. By using different tricks and techniques, the same respondent stated that *"Because of the forensic label um it has been very difficult to establish partnerships with the long-term care facilities here. Um but we/ we are getting better at it." (C646)*.

In a next step, after establishing initial contact between the public institution and representatives of the prison system, contact needed to be made between the older patient and the nursing home or landlord so that the latter sees the patient like any other older person. For instance, some respondents explained that they enrolled one of their patients in a nursing home's day program in order for the staff and other individuals at those institutions to address their own implicit biases:

"*We will get them going in the day program and then get them accepted into the day program and then look at placement. Once they are accepted into a day program normally that relationship is built enough that we can place them in other nursing homes because they sa/ we can say 'well they go independently to the day program there and they are fine. And you can ask their staff'" (C646)*.

Another respondent further elaborated how the older patients' involvement in the nursing home program *"helps to bring down the stigma of the 'forensic' label when we have them partake in community stuff." (C644)*. In addition, a patient's attendance at public programs served as a sort of reference that the older person moved beyond the criminal

career and that this person was stable, as illustrated by respondents (C647/C648):

"When the administrator would call the CCAC [Community Care Access Center] person and say, 'what's this?' and 'what's forensic?' and she would say 'well he was accepted to [name of institution 2] and they know him, and he attends um he attends programs there and he's very well liked and like that part of his life is over. He's stable, there's no difference'."

3.2.2. Educating about stigmatizing labels

Once an initial relationship between public institutions and nursing homes was built, respondents emphasized a shift towards educating their partners in public institutions. Several respondents claimed that both the mental health issues and incarceration labels carried a stigma that needed to be challenged by educating the general public. For instance, the participant (C651) stated that *"And there again, getting society to learn more about it rather than the sort of dramatized visions that you see in the media or the movies, that stigmatizes mental health."*. This need for more information on mental health issues was not limited to the general public, even *"staff need to have a better understanding of mental health. There is a lot of stigma." (C667)*.

In addition to education on mental health, information about the peculiarities of 'forensic programs' are needed. Respondents explained that typical questions revolved around the content and purpose of the program as well as the implications for the older person's dangerousness, as summarized by respondents C647/C648:

"So, the nursing home still needed a lot of education on forensics (…) yeah that even within our mental health agencies they'll s/ yeah, they'll say, 'well what is that?' and 'what do you mean, a disposition?' and, and you know 'well is this person dangerous?' that's/ I mean that/ I've had a couple community mental health frontline workers ask me that about my clients. So, you have to do education on that as well." (C647/C648).

Several respondents described providing education as creating an atmosphere that invites their partners from public institutions to ask unresolved questions and to discuss reasons and objectives of the cooperation. Amongst others, it was key to delve into conversations about issues such as how the forensic program was structured and how recovery was pictured by the representatives of forensic programs. For instance, participant C645 explained that they needed to clarify "*how we might approach situations, how we care for people who are elderly and have mental health [issues]and I think that that is really where the focus needs to be*". These interactions were described as essential in creating a mutual understanding of how to support the patient, as outlined by the following participants:

"Just try to do our best to, to decrease the stigma where it does exist (…) answering questions like if people have questions inviting them to ask so that we can help develop an understanding and hopefully if we develop a mutual understanding and they understand that there's all these supports wrapped around this person then they're deserve/ you know (…) Continue in education in the nursing homes and with CCAC as well um with staff and just you know giving education/ uh providing education about what the program is, how we see peoples' recovery, how this is a rehabilitation program um that sort of thing too." (C647/C648).

3.2.3. Ongoing collaboration with public institutions

Several participants explained that next to education about the particularities of forensic patients, it was central to provide long-term support for partner institutions. Once the older patient was placed in a day program or similar, the focus shifted towards "*developing a relationship with them" (C646)*. Most participants emphasized that solid collaborations were built by regular meetings, ongoing dialogue, and prompt support. Several respondents highlighted that the support from forensic programs needed to entail clear allocations of roles and approachable contact persons. Some respondents explained designating one person or one department, here called *"liaison case manager"*, responsible to organize support and to offer information, as illustrated by the respondent *(S696):*

"We have developed a program in our department called the 'liaison case manager', (…) to facilitate the connection with the institution that will receive them afterward. Those will do connecting work between the prison and the institution and will maintain continuity in the relationship between patient and prison."

Other interviewees explained that they developed a 'role clarification sheet' to delineate roles and responsibilities to provide low-threshold access to support and information:

"It's role clarification sheets. So, it's um a/ just a document that kind of outlines who to call, when um if someone is requesting something. It's kind of like a guide that's meant to be helpful to/ it can be helpful to family, patient and the placement, the people working there, um about what to do when and how to better understand and also inviting them to call forensic outreach services if they have questions and not be afraid to do that." (C647/C648).

These easy and fast communication channels to obtain assistance with (former) forensic patients were central in providing the feeling that *"there is another support that is going to help them monitor, you know, issues or whatnot." (C646)*. This guaranteed integration into an assistive network increased the public institution's willingness to accept older forensic patients, as summarized by the interviewee *(S696):*

"And, um, we realized that it, it makes it easier, it makes institutions say: Ah well… if there is a c/ the case manager who is also there to help us to… to take care of these people, and who can reassure us, and well, we agree to take him."

Most participants described the nature of their support as being only an arm's reach away to clarify any questions on the phone but also to be on site regularly to meet patients and staff personally. Most importantly, interviewees explained that "*We have to talk to them." (C643)*. It was considered vital to engage in an ongoing dialogue that allows identifying challenges and potential areas where help was needed. For instance, one respondent explained that s/he "*would say 'how might we help? What can we supply you with?' and mobilize those resources out." (C645)*. Another respondent described how they provided face-to-face contact by visiting one institution on a biweekly rhythm:

"I believe like building those relationships with um/ like we have two workers going there - he is a couple hours away - they go there um/ between the two of them they are up there at least once every two weeks visiting the patient (I: Ok) and speaking to the staff, you know and building that relationship and that support. So that helps." (C644).

This ongoing support and collaboration that the forensic liaison team provides was described as resembling the support replacing what close family members would usually do for their close ones. Namely, discuss the problem and needs of their older family member, look for support options in the community, and to keep in touch to assure needs are still met. This was summarized by interviewee C664:

"If grandpa is not doing well in the community the family does not get together and throw him in a prison, right? They get together and come up with a plan for grandpa. And so they call the local health authority, they engage with a case manager, they look at supportive housing. And that is the same response we need for our offenders who are on conditional release. So we are still theoretically supervising them but they are community members. But I think what we are missing here is that sort of advocacy and that family support."

4. Discussion

To our knowledge, this is the first study to investigate the combined stigma of older persons suffering from mental health issues with a history of incarceration and its influences on finding housing during their reentry. Using a qualitative interview methodology, we assessed mental health professionals' experiences with stigma and reintegration management. This research focuses on older adults, who are a particularly under-researched population within prison studies, while at the same time possessing different reintegration needs in comparison to their younger counterparts. Additionally, it sheds light on the perspective of mental health professionals, who play a critical role in facilitating the

successful reintegration of formerly incarcerated adults.

Our research highlights that older incarcerated adults who have mental health issues are particularly limited in their housing options after their release from prison due to their double stigma. The most dominant consequences of stigma mentioned by the study participants were social rejection by members of the general public that resulted in restrictions in housing opportunities after incarceration and prolonged stays in forensic programs. One reason for the reported public's rejection of 'forensic' patients was their unfamiliarity with this specific group of people. As a result, the stigma management strategies applied by the mental health professionals targeted at increasing knowledge, familiarity, and personal contact with this population.

Even though the European Prison Rules state that *"all prisoners shall have the benefit of arrangements designed to assist them in returning to free society after release"* (33.3.) (Council of Europe: Committee of Ministers, 2006), incarcerated persons reentering society are often left alone (Weber, 2018). Our sample of healthcare providers, who assisted their patients in the reintegration process, might be an exception to the norm. These results are consequently likely to not represent the full reality of reintegration processes but provide important implications to facilitate persons' successful return to society. While most health care professionals are working on re-integration processes during incarceration, they are often underfinanced and struggle to provide equivalent health care during incarceration (Bretschneider & Elger, 2014; Elger, 2008). This might limit the time available for preparing release from prison, especially for older incarcerated persons where it is particularly difficult to find housing options.

Above all, it is noteworthy that our participants confirm previous findings that the combination of multiple stigmas weighs particularly heavily. This interaction of several stigmatizing identities cannot be equated with a simple addition of factors but represents rather an additive effect, creating highly discriminating situations (Hirschfield & Piquero, 2010; LeBel, 2012; West, Mulay, DeLuca, O'Donovan, & Yanos, 2018). One explanation for this effect might be due to an intensification on three levels: Both labels, 'mentally ill' and 'incarceration history', independently contribute to perceptions of rarity/unfamiliarity (Feldman & Crandall, 2007; Hirschfield & Piquero, 2010), perceived dangerousness (Corrigan & Kleinlein, 2005; Feldman & Crandall, 2007; LeBel, 2012), and perceived responsibility for their stigmatized identity (Corrigan & Kleinlein, 2005; Gausel & Thørrisen, 2014; Schnittker, 2014). The combination of both stigmatized identities might amplify the perceptions of the general public on these dimensions, leading to higher levels of stigmatization from others. Similarly, our findings indicated that the unfamiliarity with this population, the perceived dangerousness due to the crime committed, and the severity of mental illnesses (e.g. treatment-resistive symptoms) contributed to fear and anxiety from the general public that resulted in the occurrence of stigma. These are important findings as the bulk of previous research focused on the effects of one stigma only (Gausel & Thørrisen, 2014; LeBel, 2008) while the 'forensic' combination is notably under-researched (Hirschfield & Piquero, 2010; LeBel, 2012; West et al., 2018).

Further, our participants underlined that it was a difficult endeavor to find placement for their older patients in public institutions. Stigma was considered one important aspect that contributed to the difficulties in finding housing for older (formerly) incarcerated adults, as also highlighted by other authors (Chiricos, Barrick, Bales, & Bontrager, 2007; Hirschfield & Piquero, 2010; LeBel, 2012; Pogorzelski, Wolff, Pan, & Blitz, 2005; Skipworth & Humberstone, 2002). Their lengthy search for housing led to prolonged stays of their older patients in forensic programs that they were already residing in. This resulted in inadequate placing of their patients as they did not require the intensive care provision and the security level of the forensic program. In fact, it is estimated that one to two-thirds of all forensic psychiatric patients are inappropriately placed with respect to their level of risk, at most commonly higher security levels than needed (Hare Duke, Furtado, Guo, & Völlm, 2018). This misplacement was explained to be the consequence of a lack of low and medium-security long-term care units, which required patients to remain in high-security facilities longer than needed (Harty et al., 2004; Pierzchniak et al., 1999; Reed, 1997). This raises ethical and financial concerns as secure services come with severe restrictions, which are not proportional for these older patients who have served their time and the additional particularly costly continued care that must be provided.

Particularly in regards to older incarcerated adults, numerous authors have already pointed out this problem of inadequate housing and lack of special programming within correctional institutions and in the community (Aday & Krabill, 2012; Kamigaki & Yokotani, 2014; Shantz & Frigon, 2009; Walker, Griffiths, Yates, & Völlm, 2021; Williams, Stern, Mellow, Safer, & Greifinger, 2012). To ensure the smooth reentry of older formerly incarcerated adults, transitional programs need to be developed to increase the chances for successful reintegration (Williams et al., 2012). Particularly in light of the effects of stable housing on reduced recidivism and well-being (Keene et al., 2018; Wong, Bouchard, Gushue, & Lee, 2019). Nevertheless, our findings illustrate that care providers were able, at times, to secure placement for their older patients in public institutions, that were not specialized for forensic patients but for older adults needing intensive care. The key here seemed to be, to provide expert knowledge on forensic populations to the nursing home staff. Thus, the lack of specialized units for older (formerly) incarcerated adults could be compensated by providing well-managed support teams. One important aspect of this form of support was clear allocations of roles and responsibilities with approachable contact persons from the prison system, who offered information and organized additional support where needed.

Further, our findings showed that certain strategies were successful in placing older forensic patients in public nursing homes: participants tended first to conceal their patients' stigmatized identity to facilitate an encounter between the program's representatives and the patient. In the next stage, the stigmatizing 'forensic' label would no longer be concealed but explained to increase knowledge and awareness of this population. Thus, after overcoming initial resistance and reluctance by using concealment strategies, participants shifted towards full disclosure strategies. In other words, participants emphasized that after getting the foot in the door, all efforts were aimed at debunking the stigma by providing education about this population, enabling personal contact, and providing support in responding to their specific needs.

These stigma management strategies have previously been linked with differing risks and consequences (Cherney & Fitzgerald, 2016). For instance, concealing one's stigmatized identity prevents instances of prejudice and discrimination (Camacho et al., 2020). At the same time, concealment can negatively affect the well-being of stigmatized persons through thought suppression, hypervigilance to stigma-related cues, and the anticipation of discrimination (Camacho et al., 2020) and is linked to adverse health outcomes (Quinn, 2017). Interestingly, our participants have not illustrated experiencing any negative consequences from concealing or disclosing their patients stigmatized identity. This could suggest that those in charge of health care and release planning are able to shield their patients from these undesirable side effects and buffer initial stigmatizing experiences such as social rejection (Livingston et al., 2011). At the same time, they might withhold situations from their patients during which they could learn to manage stigmatizing experiences and grow from them. Future research needs to assess patients' perceptions of risk and consequences of surrogates' support during reentry.

Contact and education-based interventions are common and effective methods in reducing stigma (Livingston, Milne, Fang, & Amari, 2012; Rao et al., 2019). Particularly face-to-face contact that allows direct interaction with members of the stigmatized groups have been shown to be effective in changing attitude, knowledge, and behavior in members of the general public (Corrigan & Rao, 2012; Dalky, 2012; LeBel, 2008). Our participants stated that regular contact decreased perceived dangerousness and reduced anxiety towards forensic patients.

Older patients' regular contact with public institutions happened through their participation in nursing home's day programs. This contributed not only to less stigma but also served as a reference for their stability and integrity. This is particularly important as previous authors have emphasized the need for formerly incarcerated persons to have members of the general public vouching for them, to increase chances to obtain employment or housing (Anazodo et al., 2019).

Further, it is worth emphasizing that interviewees exclusively discussed nursing homes as housing options for older adults leaving correctional or forensic institutions. Literature discussing 'average' adults leaving prison highlight the importance of finding housing similarly but discusses the difficulties of returning to self-sustained housing (Keene et al., 2018; Schartmueller, 2020). Older incarcerated adults' health status is worse in comparison to their younger counterparts as well as when contrasted to same-aged adults living in the community (Fazel, Hope, O'Donnell, Piper, & Jacoby, 2001; Wangmo et al., 2015). Their high needs profiles might be a reason why a big proportion of older adults reentering the community return to care homes instead of independent living options. Nevertheless, not every older person will require the intensive care of a nursing home when returning to society. Future studies examining the perspectives of incarcerated adults could shed more light on the various options that older adults seek after imprisonment.

4.1. Limitations and future research

Our findings are limited to the perspective of mental health professionals who may have supported (formerly) older incarcerated adults in finding housing. However, to assess the reentry process to a wider extent, the views of the population at stake and their close social networks should also be examined. This is particularly important in light of the relationship between public stigma and self-stigma. Self-stigma is the internalization of public stigma, which refers to the stigmatizing perceptions that the public holds about a certain group. Self-stigma is linked to aspects such as self-esteem, depressive symptoms, and perceived community adjustment (Moore, Stuewig, & Tangney, 2016). By shielding formerly incarcerated persons from stigmatizing experiences, patients' self-stigma could potentially be reduced, leading to improved functioning of older formerly incarcerated adults after their release. Future research should assess this relationship, taking in the user perspective to evaluate the usefulness of health professionals' support during their reentry process in regard to levels of self-stigma. Nevertheless, our research provides important insights into surrogates' experiences of the reentry process and stigma perceptions, which are particularly under-researched.

Moreover, the interview-guide that we used to structure the interviews did not target reintegration and stigmatization of older incarcerated adults specifically. This subject emerged spontaneously during the conversations with our interviewees. For this reason, only a smaller part of our sample discussed this issue and it is possible that we did not cover all facets of it. As for instance, our results were limited to the impact of stigma on housing. Other aspects such as reconnection with social networks, securing financial resources, care of chronic health conditions, and employment issues were not discussed. Thus, more research is needed in identifying the many aspects that affect successful reintegration of older (formerly) incarcerated adults with mental health issues.

Additionally, our research followed a qualitative study design with limitations inherent to this methodology. First, we applied a purposive sampling methodology, which aims at including a small number of respondents that are most likely to provide the relevant information (Campbell et al., 2020). Due to this sampling methodology, we might have attracted participants with a certain set of opinions that influenced our findings. Those who agreed to be interviewed might over-represent particularly motivated health care personnel who put more efforts in organizing re-integration than the average mental health professional, or who held positions providing enough time to do it. Thus it is particularly relevant, that even these mental health professionals encountered significant difficulties to plan reintegration due to multiple stigma. Second, social desirability might have affected the opinions expressed during the interviews. However, we emphasized anonymity and confidentiality to attenuate the effect of social desirability. Third, our results are not generalizable to all contexts but provide some transferability to other forensic settings. Last, it is interesting that the gender distribution amongst participants was contrastive in the two countries with more female participants being amongst the Canadian participants and vice versa for Switzerland. However, we have not seen any striking differences in the opinions raised between genders.

5. Conclusions

Incarcerated persons with mental health issues face double stigmatization that affects their reentry process. Social rejection resulting from this stigma interferes with the efforts of the personnel planning release from prison to public housing. Due to the strong impact of stigma, mental health professionals adopt strategies that facilitate their search for their older patients' placement. After first concealing their patients' stigmatized identity to get a foot in the door, they will shift towards disclosing the stigmatized label with contact and education-based strategies. Additionally, the lengthy searches for placement and lack of specialized placement options at release often resulted in prolonged stays in forensic programs, calling for greater focus on low security and halfway houses. Our findings are interesting as they, on the one hand, illustrate ways in which stigma can be reduced but on the other hand how the reentry process can be streamlined.

Declaration of Competing Interest

None.

References

Aday, R. H., & Krabill, J. J. (2012). Older and geriatric offenders: Critical issues for the 21st century. In L. Gideon (Ed.), *Special needs offenders in correctional institutions*. SAGE Publications Inc.

Aebi, M. F., & Tiago, M. M. (2019). *Prisons and prisoners in Europe 2018: Key findings of the SPACE I report*.

Anazodo, K. S., Ricciardelli, R., & Chan, C. (2019). Employment after incarceration: Managing a socially stigmatized identity. *Equality, Diversity and Inclusion: An International Journal, 38*(5), 564–582. https://doi.org/10.1108/EDI-09-2018-0175

Baidawi, S., & Trotter, C. (2016). Psychological distress among older prisoners: Associations with health, health care utilization, and the prison environment. *Journal of Correctional Health Care, 22*(4), 354–366.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Bretschneider, W., & Elger, B. S. (2014). Expert perspectives on Western European prison health services: Do ageing prisoners receive equivalent care? *Journal of Bioethical Inquiry, 11*(3), 319–332. https://doi.org/10.1007/s11673-014-9547-y

Bundesamt für Statistik. (2022). *Straf- und Massnahmenvollzug: Entlassungen nach Geschlecht*. Nationalität und Alter. https://www.bfs.admin.ch/asset/de/je-d-19.04.02.53.

Camacho, G., Reinka, M. A., & Quinn, D. M. (2020). Disclosure and concealment of stigmatized identities. *Current Opinion in Psychology, 31*, 28–32. https://doi.org/10.1016/j.copsyc.2019.07.031

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., … Walker, K. (2020). Purposive sampling: Complex or simple? Research case examples. *Journal of Research in Nursing, 25*(8), 652–661. https://doi.org/10.1177/1744987120927206

Cantora, A. (2015). Navigating the job search after incarceration: The experiences of work-release participants. *Criminal Justice Studies, 28*(2), 141–160. https://doi.org/10.1080/1478601X.2014.947032

Cherney, A., & Fitzgerald, R. (2016). Efforts by offenders to manage and overcome stigma: The case of employment. *Current Issues in Criminal Justice, 28*(1), 17–31. https://doi.org/10.1080/10345329.2016.12036054

Chiricos, T., Barrick, K., Bales, W., & Bontrager, S. (2007). The labeling of convicted felons and its consequences for recidivism*. *Criminology, 45*(3), 547–581. https://doi.org/10.1111/j.1745-9125.2007.00089.x

Correctional Services Canada. (2019). Aging and dying in prison: An investigation into the experiences of older individuals in federal custody. Retrieved from https://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20190228-eng.aspx#_Toc536691340.

Corrigan, P. W., & Kleinlein, P. (2005). The impact of mental illness stigma. In *On the stigma of mental illness: Practical strategies for research and social change* (pp. 11–44). American Psychological Association. https://doi.org/10.1037/10887-001.
Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *The Canadian Journal of Psychiatry, 57*(8), 464–469. https://doi.org/10.1177/070674371205700804
Dalky, H. F. (2012). Mental illness stigma reduction interventions: Review of intervention trials. *Western Journal of Nursing Research, 34*(4), 520–547.
Di Lorito, C., Völlm, B., & Dening, T. (2018). Psychiatric disorders among older prisoners: A systematic review and comparison study against older people in the community. *Aging & Mental Health, 22*(1), 1–10. https://doi.org/10.1080/13607863.2017.1286453
Elger, B. S. (2008). Towards equivalent health Care of Prisoners: European soft law and public health policy in Geneva. *Journal of Public Health Policy, 29*(2), 192–206. https://doi.org/10.1057/jphp.2008.6
Elger, Handtke, & Wangmo. (2015a). Informing patients about limits to confidentiality: A qualitative study in prisons. *International Journal of Law and Psychiatry, 41*, 50–57. https://doi.org/10.1016/j.ijlp.2015.03.007
Elger, Handtke, & Wangmo. (2015b). Paternalistic breaches of confidentiality in prison: Mental health professionals' attitudes and justifications. *Journal of Medical Ethics, 41*(6), 496–500. https://doi.org/10.1136/medethics-2013-101981
Fazel, S., Hope, T., O'Donnell, I., Piper, M., & Jacoby, R. (2001). Health of elderly male prisoners: Worse than the general population, worse than younger prisoners. *Age and Ageing, 30*(5), 403–407. https://doi.org/10.1093/ageing/30.5.403
Feldman, D. B., & Crandall, C. S. (2007). Dimensions of mental illness stigma: What about mental illness causes social rejection? *Journal of Social and Clinical Psychology, 26*, 137–154. https://doi.org/10.1521/jscp.2007.26.2.137
Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *Qualitative Report, 20*(9), 1408–1416. ://WOS:000367440900003.
Gausel, N., & Thørrisen, M. M. (2014). A theoretical model of multiple stigma: Ostracized for being an inmate with intellectual disabilities. *Journal of Scandinavian Studies in Criminology and Crime Prevention, 15*(1), 89–95. https://doi.org/10.1080/14043858.2013.864841
Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Prentice-Hall.
Haesen, S., Merkt, H., Elger, B., & Wangmo, T. (2021). Chains, trains and automobiles: Medical transport for prisoners in Switzerland. *European Journal of Criminology, 0*(0). https://doi.org/10.1177/1477370820988837, 1477370820988837.
Harding, D. J. (2003). Jean Valjean's dilemma: The management of ex-convict identity in the search for employment. *Deviant Behavior, 24*, 571–595. https://doi.org/10.1080/713840275
Hare Duke, L., Furtado, V., Guo, B., & Völlm, B. A. (2018). Long-stay in forensic-psychiatric care in the UK. *Social Psychiatry and Psychiatric Epidemiology, 53*(3), 313–321. https://doi.org/10.1007/s00127-017-1473-y
Harty, M.-A., Shaw, J., Thomas, S., Dolan, M., Davies, L., Thornicroft, G., Carlisle, J., Moreno, M., Leese, M., Appleby, L., & Jones, P. (2004). The security, clinical and social needs of patients in high security psychiatric hospitals in England. *The Journal of Forensic Psychiatry & Psychology, 15*(2), 208–221. https://doi.org/10.1080/14789940410001703967
Higgins, D., & Severson, M. E. (2009). Community reentry and older adult offenders: Redefining social work roles. *Journal of Gerontological Social Work, 52*(8), 784–802. https://doi.org/10.1080/01634370902888618
Hirschfield, P. J., & Piquero, A. R. (2010). Normalization and legitimation: Modeling stigmatizing attitudes toward ex-offenders. *Criminology: An Interdisciplinary Journal, 48*, 27–55. https://doi.org/10.1111/j.1745-9125.2010.00179.x
Kamigaki, K., & Yokotani, K. (2014). A reintegration program for elderly prisoners reduces reoffending. *Journal of Forensic Science & Criminology, 2*(4), 401.
Keene, D. E., Smoyer, A. B., & Blankenship, K. M. (2018). Stigma, housing and identity after prison. *The Sociological Review, 66*(4), 799–815. https://doi.org/10.1177/0038026118777447
LeBel, T. P. (2008). Perceptions of and responses to stigma. *Sociology Compass, 2*(2), 409–432. https://doi.org/10.1111/j.1751-9020.2007.00081.x
LeBel, T. P. (2012). Invisible stripes? Formerly incarcerated Persons' perceptions of stigma. *Deviant Behavior, 33*(2), 89–107. https://doi.org/10.1080/01639625.2010.538365
Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suarez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA publications and communications board task force report. *American Psychologist, 73*(1), 26–46. https://doi.org/10.1037/amp0000151
Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology, 27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363
Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. *Addiction, 107*(1), 39–50. https://doi.org/10.1111/j.1360-0443.2011.03601.x
Livingston, J. D., Rossiter, K. R., & Verdun-Jones, S. N. (2011). 'Forensic' labelling: An empirical assessment of its effects on self-stigma for people with severe mental illness. *Psychiatry Research, 188*(1), 115–122. https://doi.org/10.1016/j.psychres.2011.01.018
Maschi, T., Morrisey, M. B., & Leigey, M. (2013). The case for human agency, well-being, and community reintegration for people aging in prison: A statewide case analysis. *Journal of Correctional Health Care, 19*(3), 194–210.
Merkt, H., Haesen, S., Eytan, A., Habermeyer, E., Aebi, M. F., Elger, B., & Wangmo, T. (2021). Forensic mental health professionals' perceptions of their dual loyalty conflict: Findings from a qualitative study. *BMC Medical Ethics, 22*(1), 123. https://doi.org/10.1186/s12910-021-00688-2
Merkt, H., Wangmo, T., Pageau, F., Liebrenz, M., Devaud Cornaz, C., & Elger, B. (2021). Court-mandated patients' perspectives on the psychotherapist's dual loyalty conflict – Between ally and enemy [original research]. *Frontiers in Psychology, 11*(3713). https://doi.org/10.3389/fpsyg.2020.592638
Moore, K. E., Stuewig, J. B., & Tangney, J. P. (2016). The effect of stigma on criminal Offenders' functioning: A longitudinal mediational model. *Deviant Behavior, 37*(2), 196–218. https://doi.org/10.1080/01639625.2014.1004035
Moran, D. (2012). Prisoner reintegration and the stigma of prison time inscribed on the body. *Punishment & Society, 14*(5), 564–583. https://doi.org/10.1177/1462474512464008
Mussie, K. M., Pageau, F., Merkt, H., Wangmo, T., & Elger, B. S. (2021). Challenges in providing ethically competent health care to incarcerated older adults with mental illness: A qualitative study exploring mental health professionals' perspectives in Canada. *BMC Geriatrics, 21*(1), 718. https://doi.org/10.1186/s12877-021-02687-9
Newheiser, A.-K., & Barreto, M. (2014). Hidden costs of hiding stigma: Ironic interpersonal consequences of concealing a stigmatized identity in social interactions. *Journal of Experimental Social Psychology, 52*, 58–70. https://doi.org/10.1016/j.jesp.2014.01.002
van Olphen, J., Eliason, M. J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment, Prevention, and Policy, 4*(1), 10. https://doi.org/10.1186/1747-597X-4-10
Pageau, F., Cornaz, C. D., Gothuey, I., Seaward, H., Wangmo, T., & Elger, B. S. (2021). Prison unhealthy lifestyle and poor mental health of older persons—A qualitative study [original research]. *Frontiers in Psychiatry, 12*. https://doi.org/10.3389/fpsyt.2021.690291
Pageau, F., Seaward, H., Habermeyer, E., Elger, B., & Wangmo, T. (2022). Loneliness and social isolation among the older person in a Swiss secure institution: A qualitative study. *BMC Geriatrics, 22*(1), 90. https://doi.org/10.1186/s12877-022-02764-7
Pierzchniak, P., Farnham, F., Taranto, N. d., Bull, D., Gill, H., Bester, P., McCallum, A., & Kennedy, H. (1999). Assessing the needs of patients in secure settings: A multi-disciplinary approach. The Journal of Forensic Psychiatry, 10(2), 343–354. doi: https://doi.org/10.1080/09585189908403688.
Pogorzelski, W., Wolff, N., Pan, K. Y., & Blitz, C. L. (2005). Behavioral health problems, ex-offender reentry policies, and the "second chance act". *American Journal of Public Health, 95*(10), 1718–1724. https://doi.org/10.2105/ajph.2005.065805
Quinn, D. M. (2017). When stigma is concealable: The costs and benefits for health. In *The Oxford handbook of stigma, discrimination, and health* (pp. 287–299). https://doi.org/10.1093/oxfordhb/9780190243470.001.0001
Ran, M.-S., Hall, B. J., Su, T. T., Prawira, B., Breth-Petersen, M., Li, X.-H., & Zhang, T.-M. (2021). Stigma of mental illness and cultural factors in Pacific rim region: A systematic review. *BMC Psychiatry, 21*(1), 8. https://doi.org/10.1186/s12888-020-02991-5
Rao, D., Elshafei, A., Nguyen, M., Hatzenbuehler, M. L., Frey, S., & Go, V. F. (2019). A systematic review of multi-level stigma interventions: State of the science and future directions. *BMC Medicine, 17*(1), 41. https://doi.org/10.1186/s12916-018-1244-y
Recommendation Rec(2006)2 of the Committee of Ministers to Member States on the European Prison Rules. (2006). https://rm.coe.int/european-prison-rules-978-92-871-5982-3/16806ab9ae.
Reed, J. (1997). The need for longer term psychiatric care in medium or low security. *Criminal Behaviour and Mental Health, 7*(3), 201–212. https://doi.org/10.1002/cbm.173
Schartmueller, D. (2020). A home is more than a roof over your head: Post-prison reintegration challenges in Austria. *European Journal of Probation, 12*(1), 17–33. https://doi.org/10.1177/2066220320908252
Schnittker, J. (2014). The psychological dimensions and the social consequences of incarceration. *The Annals of the American Academy of Political and Social Science, 651*(1), 122–138. https://doi.org/10.1177/0002716213502922
Seaward, H., Wangmo, T., Egli-Alge, M., Hiersemenzel, L.-P., Graf, M., Elger, B. S., & Habermeyer, E. (2021). Incarcerated older persons' motivation to engage in criminal court-mandated treatment: Findings from a qualitative study. *Forensic Science International: Mind and Law, 2*, Article 100057. https://doi.org/10.1016/j.fsiml.2021.100057
Seaward, H., Wangmo, T., Vogel, T., Graf, M., Egli-Alge, M., Liebrenz, M., & Elger, B. S. (2021). What characterizes a good mental health professional in court-mandated treatment settings?: Findings from a qualitative study with older patients and mental health care professionals. *BMC Psychology, 9*(1), 121. https://doi.org/10.1186/s40359-021-00624-4
Semenza, D. C., & Link, N. W. (2019). How does reentry get under the skin? Cumulative reintegration barriers and health in a sample of recently incarcerated men. *Social Science & Medicine, 243*, Article 112618. https://doi.org/10.1016/j.socscimed.2019.112618
Shantz, L. R., & Frigon, S. (2009). Aging, women and health: From the pains of imprisonment to the pains of reintegration. *International Journal of Prisoner Health, 5*(1), 3–15.
Shaw, D., Seaward, H., Pageau, F., Wangmo, T., & Elger, B. S. (2022). Perceptions of collective and other unjust punishment in Swiss prisons: A qualitative exploration. *International Journal of Prisoner Health, 19*(2), 241–250. https://doi.org/10.1108/IJPH-06-2021-0059
Skipworth, J., & Humberstone, V. (2002). Community forensic psychiatry: Restoring some sanity to forensic psychiatric rehabilitation. *Acta Psychiatrica Scandinavica, 106*(s412), 47–53. https://doi.org/10.1034/j.1600-0447.106.s412.11.x
Tran, N. T., Baggio, S., Dawson, A., O'Moore, E., Williams, B., Bedell, P., … Wolff, H. (2018). Words matter: A call for humanizing and respectful language to describe

people who experience incarceration. *BMC International Health and Human Rights, 18*. https://doi.org/10.1186/s12914-018-0180-4

Tyerman, J., Patovirta, A.-L., & Celestini, A. (2021). How stigma and discrimination influences nursing care of persons diagnosed with mental illness: A systematic review. *Issues in Mental Health Nursing, 42*(2), 153–163. https://doi.org/10.1080/01612840.2020.1789788

Wahidin, A., & Powell, J. L. (2001). The loss of aging identity: Social theory, old age, and the power of special hospitals. *Journal of Aging and Identity, 6*(1), 31–48.

Walker, K., Griffiths, C., Yates, J., & Völlm, B. (2021). Service provision for older forensic mental health patients: A scoping review of the literature. *The Journal of Forensic Psychiatry & Psychology, 32*(1), 29–50. https://doi.org/10.1080/14789949.2020.1817525

Wangmo, T., Hauri, S., Meyer, A. H., & Elger, B. S. (2016). Patterns of older and younger prisoners' primary healthcare utilization in Switzerland. *International Journal of Prisoner Health, 12*(3), 173–184. https://doi.org/10.1108/IJPH-03-2016-0006

Wangmo, T., Meyer, A. H., Bretschneider, W., Handtke, V., Kressig, R. W., Gravier, B., … Elger, B. S. (2015). Ageing prisoners' disease burden: Is being old a better predictor than time served in prison? *Gerontology, 61*(2), 116–123. https://doi.org/10.1159/000363766

Wangmo, T., Meyer, A. H., Handtke, V., Bretschneider, W., Page, J., Sommer, J., … Elger, B. S. (2016). Aging prisoners in Switzerland: An analysis of their health care utilization. *Journal of Aging and Health, 28*(3), 481–502. https://doi.org/10.1177/0898264315594137

Wangmo, T., Seaward, H., Pageau, F., Hiersemenzel, L.-P., & Elger, B. S. (2021). Forensic-psychiatric risk evaluations: Perspectives of forensic psychiatric experts and older incarcerated persons from Switzerland [original research]. *Frontiers in Psychiatry, 12*(933). https://doi.org/10.3389/fpsyt.2021.643096

Weber, J. (2018). Prisoner resettlement in Switzerland: Diverse approaches of a common aim. In *Prisoner resettlement in Europe* (pp. 343–361). Routledge.

West, M. L., Mulay, A. L., DeLuca, J. S., O'Donovan, K., & Yanos, P. T. (2018). Forensic psychiatric experiences, stigma, and self-concept: A mixed-methods study. *The Journal of Forensic Psychiatry & Psychology, 29*(4), 574–596. https://doi.org/10.1080/14789949.2018.1425473

West, M. L., Vayshenker, B., Rotter, M., & Yanos, P. T. (2015). The influence of mental illness and criminality self-stigmas and racial self-concept on outcomes in a forensic psychiatric sample. *Psychiatric Rehabilitation Journal, 38*(2), 150–157. https://doi.org/10.1037/prj0000133

Williams, B., & Abraldes, R. (2007). Growing older: Challenges of prison and reentry for the aging population. In R. B. Greifinger (Ed.), *Public health behind bars*. Springer.

Williams, B. A., Stern, M. F., Mellow, J., Safer, M., & Greifinger, R. B. (2012). Aging in correctional custody: Setting a policy agenda for older prisoner health care [article]. *American Journal of Public Health, 102*(8), 1475–1481. https://doi.org/10.2105/AJPH.2012.300704

Wong, J. S., Bouchard, J., Gushue, K., & Lee, C. (2019). Halfway out: An examination of the effects of halfway houses on criminal recidivism. *International Journal of Offender Therapy and Comparative Criminology, 63*(7), 1018–1037.

Wyse, J. (2018). Older men's social integration after prison. *International Journal of Offender Therapy and Comparative Criminology, 62*(8), 2153–2173. https://doi.org/10.1177/0306624x16683210

Yukhnenko, D., Sridhar, S., & Fazel, S. (2019). A systematic review of criminal recidivism rates worldwide: 3-year update. *Wellcome Open Research, 4*, 28. https://doi.org/10.12688/wellcomeopenres.14970.3