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Psychosocial and Re-Incarceration Risks Among Older Adults in Mental Health Courts

Abstract

Objective

Older adults are increasingly involved in the criminal justice system, yet there is limited research regarding their needs and experiences. This study examined differences in psychosocial experiences and reincarceration between older and younger adults with psychiatric disorders involved in the criminal justice system.

Methods

Participants (N = 80) were recruited from two mental health courts in the midwestern United States. Bivariate analyses examined age-related differences in psychosocial experiences and reincarceration between younger and older participants.

Results

Older adults, on average, experienced more [treatment adherence](#) and fewer probation violations than younger adults during the 6-month follow-up; however, they experienced comparable risk for reincarceration. Older adults' substance use, service use, housing instability, and program retention were similar to their younger counterparts.

Conclusion

Despite older mental health court participants' treatment adherence and reduced probation violations, they are at risk for incarceration, substance use, and housing instability.

Disciplines

Social and Behavioral Sciences



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Psychosocial and Re-Incarceration Risks among Older Adults in Mental Health Courts

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Abstract

Objectives—Older adults are increasingly involved in the criminal justice system, yet there is limited research regarding their needs and experiences. This study examined differences in psychosocial experiences and re-incarceration between older and younger adults with psychiatric disorders involved in the criminal justice system.

Methods—Participants (N=80) were recruited from two mental health courts (MHC) in the Midwestern United States. Bivariate analyses examined age-related differences in psychosocial experiences and re-incarceration between younger and older participants.

Results—Older adults, on average, experienced more treatment adherence and fewer probation violations than younger adults during the six-month follow-up; however, they experienced comparable risk for re-incarceration. Older adults' substance use, service use, housing instability, and program retention were similar to their younger counterparts.

Conclusions—Despite older MHC participants' treatment adherence and reduced probation violations, they are at risk for incarceration, substance use and housing instability.

Keywords

psychosocial and recidivism risk; psychiatric disorders; older age

Over the past decade, the population of older adults in the criminal justice system has quickly grown and is becoming a population of great concern for correction officials, stakeholders, and advocates (1). Between 1995 and 2010, people in custody age 55 and older

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quadrupled due to longer sentences, increased life sentences, limitations in early release authority, and increased illegal activity among older adults (2). An estimated 9% of people currently in state and federal prisons or local jails are over age 50. There are few estimates of how many older adults involved in corrections have psychiatric disorders. One study found 14% of people over age 50 in a Utah prison reported having a psychiatric disorder (3), while 23% of 180 older adults entering the Iowa prison system experienced psychiatric problems and 71% reported substance abuse problems (4). Another report indicated more than half of men over age 59 in prison in England and Wales met diagnostic criteria for a clinical and/or personality disorder (5). More recent research finds that people over age 55 in prison often have extensive histories of trauma, substance use, and mental health concerns (6).

Once in the criminal justice system, older adults are at risk of victimization and are vulnerable due to physical, psychiatric, and/or cognitive impairment and lack of proper medical care for complex, co-occurring conditions (2). Staff often misunderstand psychiatric disorders and changing mental states among older prisoners, which can elicit unnecessary disciplinary responses from prison officials. In order to address older adults' complex needs and to promote their safety within the justice system, stakeholders advocate for alternatives to prison for older adults with and without histories of illegal activity (2). Diversion programs and alternative courts, in particular, are recommended for this population (7).

Mental health courts (MHCs) are one of many programs intended to divert people with psychiatric disorders from prison. Once in a MHC, participants receive intensive, supervised mental health and substance use treatment. While prior research indicates that older adults are more likely to be diverted to programs like MHC (8), and that older adults are at lower risk of re-incarceration even when controlling for criminal record (9), our in-depth review of the literature found an absence of research focused on older adults in MHCs. The main objective of this analysis is to gain greater understanding of the challenges experienced by older adults with mental health problems who are involved in MHCs and to compare their psychosocial experiences and re-incarceration risk with younger MHC participants in order to guide developmentally-informed interventions.

Methods

Participants from two Midwestern MHCs were recruited for the study between September 2010 and October 2011. Both MHCs in this study serve participants with DSM-IV mental disorders who often have had extensive prior involvement in the justice system. One court accepts people with felony charges only; the other accepts people with both felony and misdemeanor charges. Through flyers and MHC staff referral, adults who were not in custody and were enrolled in the MHC for between two and eighteen months were recruited for this study. Ninety-one participants met eligibility criteria; eighty participants (88%) consented to study participation (40 from each court). The 11 eligible participants who were not enrolled did not participate because they did not return the researcher's phone call, did not have a working number, or displayed paranoid delusions that interfered with the consent process.

PROCEDURES

All participants completed in-person interviews at locations convenient to them. The interview included a standardized measure of symptom severity and self-reported questions regarding demographics, psychiatric history, including all diagnoses, and legal history. Participants provided additional consent for the collection of administrative data regarding MHC program retention, days spent in jail, probation violations, treatment and social service use, treatment adherence, substance use, and housing stability for each of the six months following their interview. An Institutional Review Board at the University of Chicago reviewed and approved the study.

MEASUREMENT

The *Anchored Brief Psychiatric Rating Scale* (BPRS; 10), an 18-item measure with symptom severity reported on a 7-point scale from 1 (*not reported*) to 7 (*very severe*), was used to estimate psychiatric symptoms in the seven days prior to participant interviews. We collected staff-reported administrative data for each of the six months following participants' interviews. Administrative data included: (1) days in jail (dichotomized at the end of the follow-up: 0 = none, 1 = any days in jail); (2) probation violations (six-months summed); (3) substance use (six months of urine analyses summed); (4) program retention (dichotomized after follow-up: 0 = terminated from program or missing 4+ months during the follow-up; 1 = still enrolled or graduated); (5) treatment and/or social service use, including individual/group therapy, non-clinical groups (e.g., skill building, GED preparation, 12-step, and vocational training), psychiatric visits, and substance use treatment (six-months summed); (6) housing moves (six-months summed); and (7) treatment adherence, assessed each month by caseworkers using a four point scale (1=never; 4=always/almost always follows treatment; six months of scores summed).

ANALYSIS

We divided the sample based on age in order to examine differential risks among older and younger MHC participants. Although there is variability in how researchers define older adults in studies involving people in the justice system who have psychiatric disorders, older adults are commonly defined in corrections as people 50 years and older (11). We followed this convention. Of the sample of 80 participants, 33 were 50 years and older; 47 were 49 years and younger. We conducted one-way ANOVAs, Welch's two-tailed t-tests, Fisher's exact tests and chi-square analyses in order to estimate group differences. Direct communication with staff minimized missing administrative data; however, in cases where missing data were unavoidable, we either omitted the case or averaged the scores. Specifically, if data on substance use ($n = 7$) and housing instability ($n = 9$) were missing, the cases were omitted from analysis. Missing data regarding service use ($n = 2$) and treatment adherence ($n = 8$) were managed by averaging the missing month for cases missing one or two months; cases missing three or more months of data were omitted ($n = 9$ for service use; $n = 4$ for treatment adherence). No data were missing for program retention.

Results

Over half of participants were male (55%) and African-American (56%). Participants' mean age was 39.6 years old ($SD = 12.1$, range 19–65). On average, participants completed 11.3 years of education ($SD = 2.5$). Most participants were unemployed (95%) and over half received disability insurance. The average annual income among participants was \$5,369 ($SD = 5,302$); the majority of participants were living below the federal poverty line (89%). Most participants' self-reported primary diagnosis was bipolar disorder (59%) or schizophrenia/schizoaffective disorder (29%). Most also reported a co-occurring substance use disorder (84%). On average, participants were not experiencing severe psychiatric symptoms during the week prior to the research interview ($M = 34.2$, $SD = 10.4$). Most participants reported the charge leading to MHC involvement was either theft/burglary (44%) or drug-related (21%), and most were felony charges (86%). Other than higher incomes among older adults, there were no statistically-significant differences in these characteristics between older and younger participants. Descriptive statistics by subsample are displayed in Table 1.

In the six months following the interviews, older adults, on average, adhered to treatment more frequently and violated probation at a lower rate than younger participants; however, the difference in their rates of serving time in jail was not statistically significant. Older and younger participants experienced comparable levels of treatment and social service use, program retention, substance use, and housing moves (see Table 1).

Conclusions

This study provides novel examination of psychosocial and re-incarceration risks among older adults in MHCs. Despite older adults' higher incomes, greater treatment adherence, lower rate of probation violations, and comparable level of treatment and social service use in the six-month follow-up period, they reported similar experiences with substance use, incarceration, and housing instability during this timeframe. While prior research indicates that older adults are at lower risk of re-incarceration (9), this study found no statistically-significant difference in the re-incarceration risks of older and younger MHC participants with comparable histories of justice system involvement. This finding challenges existing literature and provides the backdrop for future work that can examine differential predictors of risk based on age. Given the multiple vulnerabilities and challenges that older adults experience in custody (2), it is important to note that one in five older adults in this study was incarcerated during the six-month follow-up period. These findings, along with recent research that suggests an upward trend in first-time substance abuse treatment among older adults and greater representation of cocaine, heroin, marijuana and methamphetamine use in these admissions (12), highlight ongoing risks experienced by older adults that should be considered in clinical and social service provision.

There are several limitations to this study. Because of the small sample size and limited statistical power, the current data cannot be used to discern differential predictors of re-incarceration or other risks between older and younger adults in corrections. Future research and interventions would benefit from examination of psychiatric, social, legal, and other

contextual factors associated with substance use, housing instability and incarceration among older adults in MHCs. Further, in order to address the study's limitations related to generalizability and a relatively short follow-up period, future research would benefit from extended follow-up with cohorts of MHC participants from multiple sites, including follow-up with participants who do not complete the program.

Acknowledgments

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Table 1

Comparisons between older and younger mental health court (MHC) participants

	Younger Adults (n=47) %(n) or \bar{M} (SD)	Older Adults (n=33) %(n) or \bar{M} (SD)	Statistic (df)	p value	Effect size
Sociodemographic Characteristics					
Age	31.57 (SD=8.31)	51.12 (SD=5.49)			
Sex					
Male	55.3% (26)	54.5% (18)	$\chi^2 (1) = 0.01$	0.56	
Female	44.7% (21)	45.5% (15)			
Race					
African American, Latino, Native American, or Biracial	63.8% (30)	69.7% (23)	$\chi^2 (1) = 0.30$	0.38	
White	36.2% (17)	30.3% (10)			
Income (range: \$0–22,080)	4,210 (SD=4,940)	6,984 (SD=5,439)	$F (1, 77) = 5.57$	0.02*	$Eta^2 = 0.07$
Education (range: 3–16 years)	11.26 (SD=1.98)	11.52 (SD=3.05)	<i>Welch's t</i> (51) = 0.18	0.67	
Living arrangements					
Institution ¹	34.0% (13)	18.2% (15)	$\chi^2 (1) = 2.70$	0.15	
Community ²	25.5% (34)	33.3% (18)			
Months in MHC (range: 2–18 months)	7.11 (SD=4.93)	8.24 (SD=5.56)	$F (1, 78) = 0.93$	0.34	
Psychiatric Diagnosis and Symptoms					
Primary psychiatric disorder					
Schizophrenia/schizoaffective disorder	34.0% (16)	33.3% (11)	<i>Fisher's</i> (3) = 0.78	0.94	
Bipolar disorder	53.2% (25)	54.5% (18)			
Major depression	2.1% (1)	3.0% (1)			
Other ³	10.6% (5)	6.1% (2)			
Psychiatric hospitalizations 2 yrs. prior to MHC (range: 0–15)	1.55 (SD=2.66)	1.45 (SD=1.92)	$F (1, 78) = 0.03$	0.86	
Brief Psychiatric Rating Scale (range: 18–61)	35.96 (SD=10.88)	31.61 (SD=9.23)	$F (1, 78) = 3.50$	0.07	
Legal History					
Primary charge leading to MHC involvement					

	Younger Adults (n=47) %(n) or \bar{M} (SD)	Older Adults (n=33) %(n) or \bar{M} (SD)	Statistic (df)	p value	Effect size
Theft/burglary	34.0% (16)	57.6% (19)	<i>Fisher's</i> (3) = 6.36	0.09	
Drug-related	21.3% (10)	21.2% (7)			
Battery/assault	21.3% (10)	15.2% (5)			
Other ⁴	23.4% (11)	6.1% (2)			
Charge Type					
Misdemeanor	14.9% (7)	12.1% (4)	<i>Fisher's</i> (1) ⁵	1.00	
Felony	85.1% (40)	87.9% (29)			
Arrests in 2 yrs. prior to MHC (range: 1–13)	2.87 (SD=2.17)	3.00 (SD=2.76)	<i>F</i> (1, 78) = 0.05	0.82	
Psychosocial Experiences—6 Months Post-Interview					
Treatment adherence (range: 6–24) ⁶	20.33 (SD=4.21)	22.07 (SD=3.41)	<i>Welch's t</i> (73) = 3.97	0.05*	<i>Cohen's d</i> = 0.45
Treatment and service use (range: 4–36)	18.78 (SD=5.30)	17.39 (SD=6.61)	<i>F</i> (1, 69) = 0.98	0.33	
Program retention					
Yes	87.2% (41)	93.9% (31)	<i>Fisher's</i> (1)	0.46	
No	12.8% (6)	6.1% (2)			
Substance use (range: 0–7)	0.86 (SD=1.52)	0.63 (SD=0.94)	<i>F</i> (1, 73) = 0.60	0.44	
Housing moves (range: 0–9)	1.83 (SD=1.82)	1.23 (SD=1.87)	<i>F</i> (1, 69) = 1.84	0.18	
Criminal Justice System Experiences—6 Months Post-Interview					
Probation violations (range: 0–7) ⁷	1.09 (SD=1.52)	0.48 (SD=0.97)	<i>Welch's t</i> (75) = 4.56	0.04*	<i>Cohen's d</i> = 0.47
Any days in jail ⁷					
Yes	40.0% (18)	21.2% (7)	χ^2 (1) = 3.09	0.09	
No	60.0% (27)	78.8% (26)			

¹ Includes inpatient treatment facility, psychiatric hospital, or nursing facility.

² Includes living with family or roommates, alone, in recovery home, or homeless.

³ Category includes depression not otherwise specified by participant, generalized anxiety disorder, agoraphobia, and attention deficit disorder.

⁴ Category includes solicitation, criminal trespassing, forgery, probation violation, resisting arrest, and driving with a revoked license.

⁵ A test statistic for the Fisher's exact test is not reported because a test statistic for 2x2 contingency tables is not produced using Fisher's method, only the p-value.

⁶ Monthly adherence scores were summed after the six-month follow-up period; for participants who were terminated from the program, missing, or graduated before the end of the follow-up period, monthly adherence was considered missing. See text for information on missing data management.

⁷ n = 45 for younger participants; two people were excluded from the analysis because they were terminated from the program in the first month of follow-up.