Letters to the Editor

Mental Health, Substance Use, and Socioeconomic Needs of Older Persons Paroled or Placed on Probation

TO THE EDITOR: Older adults are the fastest growing age demographic behind bars, and they face elevated risks of mental health problems, substance misuse, and poor social reintegration after release from incarceration (1,2). Meeting the psychosocial needs of this burgeoning population is a serious concern. Research is needed to inform how parole and probation programs can coordinate services to mitigate adverse health and criminal justice outcomes.

To characterize this group, we analyzed data from older U.S. adults (age ≥50) who completed the annual National Survey for Drug Use and Health within the 2005–2014 period. We used chi-square tests to compare socioeconomic, mental health, and substance use characteristics for those who reported being on parole, probation, or both over the past year (N=499) and those who reported being on neither (N=60,561). The prevalence values and comparisons were adjusted for sampling design. Individuals residing in institutions (including nursing homes, hospitals, prisons, and jails) or experiencing homelessness outside of shelters were excluded from our analysis. Therefore, survey respondents were likely the most socially engaged and healthiest subset of justice-involved individuals. [An online supplement provides tabulated statistics.]

Older adults with recent correctional supervision were more likely than the comparison group to have not graduated from high school (29%, N=146, versus 16%, N=9,944), report income below the federal poverty level (26%, N=146, versus 8%, N=5,870), have no health insurance (22%, N=99, versus 7%, N=4,282), and report poor or fair health (35%, N=185, versus 20%, N=12,535). They were also more likely to receive government assistance (35%, N=200, versus 14%, N=9,582).

Past-year major depression and serious psychological distress were more common for older adults with recent correctional supervision (depression, 16%, N=69, versus 5%, N=3,255; distress, 23%, N=117, versus 6%, N=4,101). This group was more likely than those without correctional supervision to utilize outpatient and prescription mental health services (outpatient, 20%, N=96, versus 6%, N=3,697; prescription, 28%, N=145, versus 12%, N=7,639). Alcohol and drug use disorders were more prevalent (alcohol use, 21%, N=110, versus 3%, N=2,035; drug use, 7%, N=37, versus .6%, N=292), as was specialized substance use treatment (14%, N=77, versus .4%, N=297).

We found high socioeconomic, mental health, and substance use needs among older adults with recent correctional supervision but also high services utilization across all three areas. These findings suggest that multiple needs are common among these individuals and that barriers to services access are not insurmountable in parole and probation settings. This seems to be consistent with recent perspectives arguing that correctional supervision programs must address complex psychosocial needs to reduce risk of criminal recidivism (3,4). Existing programs, however, tend to overemphasize services within one particular domain of need (4,5).

Our findings support the rationale for developing multidisciplinary and case management–based parole and probation programs to help identify, prioritize, and address various needs. Multidisciplinary parole and probation services could include collaborations with community organizations that work with older justice-involved individuals. Policy makers might consider strategies to encourage such collaborations and develop systems for secure and convenient information and resource exchange. Community health care practitioners will encounter older adults with correctional involvement and must be aware that they are likely to have complex psychosocial needs. Finally, additional research is needed to understand the specific needs and service utilization patterns of this often overlooked population.

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Public Psychiatry's Accomplishments: Bound for Nowhere?

TO THE EDITOR: In a letter to the editor of *Psychiatric Services* (1), some members of the senior Yale Psychiatry faculty viewed the analyses I offer in "Perhaps I Touched the Minaret, or How Patient-Centered Care Remains a Dream" (2) as driven by "defeat," "despair," "discouragement," and "disillusionment" (1). Their only reference to the analyses was the "unfortunate" citing of 1960s programs as "evidence that public psychiatry has declined." I still take my later failures to replicate this 1960s collaboration with the Texas Department of Rehabilitation as such evidence (3). The state-sponsored training resulted in full-time, continuous competitive employment of multiple chronically hospitalized patients. In contrast, a recent benchmark for employment success was 41% working at least one day within a three-month period. I leave it to readers to decide whether competitive employment opportunities for people with severe mental illness have declined.

The Yale critics go on to cite "tremendous progress . . . in recent years" (1). One example they provide is "jail diversion" at Yale (1). In the years up to 1997, when I retired from academia, I worked in no community or department where we allowed people with a mental illness to be sent to jails. For example, the Springfield, Illinois, police routinely called our 24-hour on-call case manager or Community Support Network office. A typical request was, "We have someone who we think is your client, and if she isn't, she should be. Will you come?" We went to the site and took responsibility if the person was our client or mentally ill (4).

The Yale critics reported participation in the Connecticut jail diversion program. Has diversion met the needs of New Haven's citizens who have psychiatric illness? In 2015, Supervisory Assistant Public Defender Bevin Salmon, who works at the New Haven Superior Court, said "I've been doing this for about 13 years, and . . . to see [my] mentally ill clients incarcerated because there aren't enough treatment spots for them . . . has been a constant problem" (5).

The state of social and community psychiatry truly disappoints me (2), and reports from academia provide no reassurances. Contrary to the Yale critics' speculations, as I said in my Personal Accounts column (2), I remain gratified by my work and by the patients I have helped and who have taught me medicine. I have learned from them that we cannot depend on all patients' coming to our offices. Psychiatrists have pioneered prevention programs to identify vulnerable people with severe mental illness who are living in community settings and to provide active care over time to improve their well-being. Programmatic prevention can be used to reduce police encounters and the need for diversion. Two elements are important in this effort. First, interventions in the community can address functional impairments and disabilities of people with severe mental illness: homelessness, unemployment, substance abuse, encounters with police, and so forth. Second, collaborative arrangements can provide on-site mental health workers to intervene when police are concerned about a client or nonclient with mental illness.

By understanding our patients, we become experts in the tailoring of medicine and environments to protect and restore health to individuals. By having all medical students and psychiatric residents master the skills of preventive interventions, home visits, agency collaborations that concern a patient, and on-site home or work supervision to ensure that patients take their prescribed medications, we take an important step toward overcoming today's adversities.

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Relationship Between Supervisor Factors and Therapist Knowledge, Attitudes, and Use of EBP in a Large Public Behavioral Health System

TO THE EDITOR: Research has identified the importance of supervisors in implementation processes, given their ongoing support of therapists' skill development and competence in evidence-based practice (EBP) (1,2). It is therefore crucial to understand the specific supervisor characteristics that facilitate or hinder implementation of EBP. Findings from the organizational and management fields suggest that supervisor understanding of and commitment to innovation may affect staff knowledge of and attitudes toward EBP (3). Two supervisor characteristics that may reflect supervisor understanding of and commitment to innovation include supervisor knowledge of and attitudes toward EBP. Given the limited research in this area, we examined whether supervisor knowledge of and attitudes toward EBP are related to therapist implementation factors (knowledge of and attitudes toward EBP) and implementation outcomes (the self-reported use of EBP).