Forensic Issues in the Elderly

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What Does the Forensic Population Include?

- NGRI - Not Guilty by Reason of Insanity
- GBMI - Guilty but Mentally Ill
- Competent to Stand Trial
- Pre-Trial
- Civilly committed Sex Offenders (depending on state/jurisdiction)
- State and federal prisoners
- Jail inmates
- Probationers and parolees

Mental Health Statistics

- By 2030, age of 65 and older will reach 72.1 million (overall population)
- Surpassing the 42.3 million in 2010
- Estimated that 20% of people age 55 experience some type of mental health issues (i.e. anxiety, severe cognitive impairment, depression or bipolar disorder.
- 2 million of the 34 million Americans aged 65 or older suffer from some sort of depression, which can co-occur with Alzheimer's disease, Parkinson's disease, heart disease, cancer or arthritis.
- 14-20% (1 in 5) has a mental health or substance use disorder
- Older men have the highest rate of suicide compared to any other age group
- Men aged 85 years or older have a suicide rate of 45.23 per 100,000 compared to 11.01 per 100,000 of all ages

What does that mean in an inpatient psychiatric setting

Legal Status

- Involuntary Emergency Admission-petition to court (IEAs account for 90% of NHH admissions)
- Involuntary Admission (non-emergency)-petition to court
- Revocation of Conditional Discharge-administrative action
- Voluntary-need medical director approval
- Voluntary by guardian-need medical director approval

INVOLUNTARY EMERGENCY ADMISSION PETITION

What is an IEA Petition? A 7-page document that contains:

- Information about how to file the petition (page 1);
- Signed statements from the petitioner alleging how the person engaged in dangerous behaviors (pages 2-3);
- (Optional) signed statements of a witness alleging how the person engaged in dangerous behaviors (page 4);
- A current medical exam (page 5);
- A current mental status exam (page 6); and
- Certification from a MD or APRN from the mental health center confirming that the patient meets criteria and the document is complete and accurate (page 7).

How does the person get to the local emergency room for an involuntary emergency admission (IEA)?

- Voluntarily and/or with family, treatment providers, or friends;
- By police transport if the police have placed the person in protective custody due to the person's behaviors in the community; or
- After the filing of a Complaint and Prayer-
  The petitioner and a Justice of Peace must sign a document alleging the person's dangerous behaviors and give it to law enforcement. Law enforcement shall then be authorized to locate the person and transport him/her to a local emergency room.

How do you prove a person is dangerous because of mental illness?

See In the Matter of B.T. 153 N.H. 255 (2006).

Symptoms of agitation, delusion, disorganized thinking, and paranoia are ***insufficient*** to prove by clear and convincing evidence that B.T. poses a potentially serious likelihood of danger to herself or to others.

How is "danger" to self established for an IEA petition?

Within 40 days person: Inflicted serious bodily injury on self; or	**Within 40 days person**: Threatened to inflict serious bodily injury on self; and	**Person lacks capacity:** The person's behavior demonstrates that s/he so lacks the capacity to care for his/her own welfare; and
Attempted suicide; and	There is a likelihood that an act or attempt of serious self-injury will occur if admission is not ordered.	There is a likelihood of death, serious bodily injury, or serious debilitation will occur to the person if admission is not ordered.
There is a likelihood the act or attempted act will recur if admission is not ordered.		(see RSA 135-C:27)

What can the court decide?

- The court can dismiss the petition.
- The court can find that there is "clear and convincing" evidence that the person is a danger to self or others as a result of mental illness and needs treatment/admission to NHH.
- The court can decide how long the person should be involuntarily admitted.
- The court can order a person involuntarily admitted for no more than 5 years.

What is a "conditional discharge?"

A "conditional discharge" is an agreement between the patient, mental health center, and NHH allowing the patient to return home on the **condition** that:

- Patient- will comply with medications and treatment;
- Mental Health Center-will monitor the patients compliance with treatment and return the patient to NHH if the patient fails to take medications, attend treatment appointments, or becomes dangerous; and
- NHH-will re-admit the patient for treatment upon a completed request to return the patient by the mental health center.

How does the patient get returned to NHH if s/he fails to take her medications or engage in treatment while on a conditional discharge?

- Mental Health Center staff return a patient to NHH by "revoking" the patient's conditional discharge.
- "Revoking" a conditional discharge requires the mental health center staff to provide written and verbal notice to the patient of the plan to return her/him to NHH.

What happens to a patient when his/her conditional discharge is temporarily revoked?

- S/he is taken by law enforcement to NHH for admission.
- NHH doctor/APRN assesses the patient's mental health status.
- NHH treatment team members speak with the patient, mental health staff, and family members to confirm the reasons his/her conditional discharge was revoked.
- NHH doctor/APRN decides to "absolutely" revoke the patient's conditional discharge or to discharge the patient home.

What if a patient has outstanding criminal charges?

The treatment team must be aware of a patient's outstanding criminal charges/orders to address privileging and discharge planning. Typically, the orders are:

-Outstanding bail orders
-Mental Health Court orders
-Domestic Violence Orders
-Not Competent to Stand Trial (restorable?)
-Not Guilty by Reason of Insanity decisions

Elderly forensic population

- Health of a 50-year old prisoner compares to that of a 65-year old living in the community-accelerated aging
- Prison population grew by 42% between 1995-2010
- 55 and older prison population grew at 282%, 6 times the overall rate
- Rate of incarceration of elder person exceeds the incarceration rate of all persons in most countries.
- Pew Research Center and the American Civil Liberties Union found that older inmates accounted for more than 16% of the prison population (246,600)
- It's projected that by 2030, older prisoners will account for one-third of all incarcerated persons.

Elder forensic population causes for incarceration

- 65% serving for non-violent offenses (fraud, larceny, burglary, breaking and entering, and traffic and public order violations) and drug charges, most of which occurred earlier in their lives.
- Older individuals are committing more crimes and being arrested with an increased frequency
- The number of violent crimes are increasing, such as murder, aggravated assault and sex crimes

Economics of incarceration

- Older prisoners are the most expensive, costing 2 to 5 times more, mean of $68, 270 per individual vs younger inmates mean of $34,135 annually.
- U.S. spends $16 billion annually on an incarcerated older person
- State correctional budgets have increased 674% in the past 25 years.f

Health Effects of aging in prison

- Accelerated aging exacerbates medical and psychiatric conditions
- Stressful conditions of prison confinement-overcrowding, social deprivation and violence
- High prevalence rate of communicable and chronic diseases-hepatitis, HIV, TB, arthritis, hypertension, gastric ulcer, prostate disease, pulmonary disease, cardiovascular disease, cerebrovascular accidents, Alzheimer's, dementia, chronic pain and cancer.
- High rates of depression, anxiety, trauma history, stress and cognitive impairment
- Cognitive impairment rates of 40-60%
- Elderly sex offenders have a higher rate of dementia

Crimes of the elderly- 1930 research Perspective

First-time offenders:
- Drunkenness
- Sex offenses
- Embezzlement
- Fraud

5 year Study out of Eloise Hospital in Michigan:
January 1935-1940, 60% of offenses were committed by "Seniles" and dementia responsible for exhibitionism and pedophilia

Study in Allegheny County, Pennsylvania:
5% of the male sex offenders were charged with "bastardy and fornication" were senile men and 12% were accused of sex crimes against children.

1930 Reasons

- Possible organic
- Dementia and other pathological conditions
- Elimination of certain inhibitions which lead to primitive behaviors
- Continuation of "normal" sex drives but with weakened moral inhibitions
- Revival of the sex life
- "Instinctive" desires, such as the subconscious hope of leaving descendants

- *Suicide has a higher rate with elderly men*

Geriatric forensic evaluees

- Elderly individuals are less likely to be arrested
- However, the number of elderly being arrested and incarcerated in jails and prisons has increased the last 20 years
- Due to increase in elderly population
- Aging for those who are already incarcerated

- Ex. Florida tripled its population of inmates older than 55 from 1991 to 2001

Geriatric forensic evaluees

- Have more physical health problems (i.e. hypertension and cardiac disease)
- More likely to be arrested for alcohol-related crime
- At least half have a diagnosable psychiatric disorder
- Abuse or be dependent on alcohol (67.7%)
- Dementia (44.4%)
- Antisocial Personality Disorder (32.3%)
- 80% have had a psychiatric hospitalization
- 60.6% were facing violent charges
- 80.8% were recidivists

Risk factors for violence in the elderly forensic population

- Males
- Minority
- Low socioeconomic status
- Past history of violent offenses
- Alcohol abuse and dependence and alcohol use at the time of the offense
- Psychotic symptoms, especially paranoia, when there is a delusional belief about the victim and the accessibility of the victim
- Access to weapons
- Accessibility to the victim (violent acts in their own homes against family member (spouse)).

South Carolina Study 1991- 1998 aged 60 and older

- 60.6% were arrested for a violent crime
- 39.4% were arrested for a non-violent crime
- 87.9% were male
- Two-thirds of the sample was Caucasians, one-third was African American
- African Americans were more likely than Caucasians to be arrested for a violent offense
- Lower educational levels were more likely to be arrested for violent offenses
- 6.1% was employed, 49.5% unemployed, 43.4% was retired
- 45.5% were divorced or separated at time of offense

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- 25.3% reported past head injury with loss of consciousness
- 12.1% had seizures
- 13.1% had history of cerebrovascular accident

- 80% had been convicted of at least one prior offense
- Ones with prior offenses, 43.8% had been violent
- 9% had been convicted of homicide, 37.4% previous charge was related to substances

Psychiatric History of sample

- 68.7% had more than one psychiatric disorder
- 67.7% had alcohol dependence
- 44.4% antisocial personality disorder
- 25.2% psychotic disorder [schizophrenia 14.1%, Affective Disorders 11.1%, Delusional disorder 6.1%, Major Depression 6.1%
- 47.5% prior psychiatric hospitalizations
- 45.5% had been on psychiatric medications
- 49.5% had a family history of mental illness
- 19% had a history of at least one suicide attempt

Symptoms at time of alleged offense

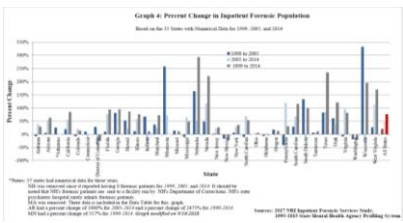
- 28.3% were using alcohol
- 31.3% paranoia was present and was strongly associated with violent charges

Incompetent to stand trial

- 32.2% were found incompetent to stand trial
- Had a strong association with a diagnosis of dementia
- Dementia is not easily treatable or reversible, making non-restorability higher
- Poses placement problems
- Nursing homes may refuse to admit do to being accused or convicted of felonies
- Forensic hospitals may not have treatment units geared towards their needs
- Communities may be reluctant to accept them into group home settings

Forensic Study by National Association of State Mental Health Program Directors (NASMHPD) on from 1999-2016

- The purpose was to investigate the forensic trends and their prevalence nationwide, and to explore the factors driving the trends on forensic patients in State psychiatric hospitals.
- 37 states were a part of the study as they responded to the survey
  - NH was removed since it reported having 0 forensic patients for *1999, 2005*, and *2014* and it noted that NH's forensic patients are sent to a facility run by NH's Department of Corrections. NH's state psychiatric hospital rarely admits forensic patients.
- National trend lines show a **76 percent increase** in the number of forensic patients in state hospitals from 1999 to 2014, the trend is **not** consistent across all states.



Forensic Study-Reason for Increase Length of Stay

- Defendants requiring that competency evaluations
- Competency training and restoration services
- NGRI patients remain at state psychiatric hospitals for long periods of time
- The beds occupied by NGRI patients, lower the state hospital's turnover rate, which means that there are fewer opportunities for the state hospital to admit new patients

Forensic Study-Waitlists

- Waitlists hinder the state's ability to admit both civil and forensic patients to their state psychiatric hospitals in a timely manner.
- These waitlists can also lead to states being held in contempt, or threatened with contempt, by courts ordering timely admission for forensic patients requiring inpatient services.

New Hampshire Hospital Admissions

- NHH does not have an "emergency room" capable of admitting patients from the street.
- People are admitted with assistance from other hospital clinicians, mental health providers, and/or guardians, usually after the patient has been assessed in a local hospital emergency room.
- Each patient must have a "legal status" for admission.
- Each patient must have "medical clearance" for admission.

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