The physical and mental health of older offenders

Marlo Gal[1]
Mountain Institution, Correctional Service of Canada

Recent reports[2] *indicate that the average age of offenders incarcerated by the Correctional Service of Canada (CSC) has been increasing and that offenders over the age of 50 are the fastest growing subgroup. Currently older offenders account for 13% of the offender population. The two most predominant issues for this population are physical and mental health. This article reviews these issues in the older offender population and the implications they have on the institutions.*

Physical health

Knowledge about older offenders' physical health is important for identifying the institutional needs of older offenders (e.g., the palliative care program) and to develop solutions to effectively manage them. DeLuca[3] pointed out that increasing age is associated with a deterioration of health and an increased need for medical services. In addition to the normal aging process, many offenders prematurely deteriorate as a result of substance abuse and poor dental hygiene. DeLuca suggested that the increasing demand for medical services to meet the needs of the aging offender population will exert pressure on already limited resources. For example, it was reported that the annual cost of incarceration is $23,000 U.S. per offender while the annual cost of incarcerating an elderly inmate is $69,000 U.S.

Physical health concerns of older offenders

A number of studies[4] have shown that older offenders have multiple health problems. The most common ailments among this population are cardiovascular disease, diabetes, arthritis, hypertension and cancer.

Using information from the Offender Intake Assessment (OIA), which provides a global indicator of health problems, dietary problems and dental problems, Gal[5] compared older and younger offenders' health needs, (see Table 1). Of the older offenders, 54% had identified physical health as a problem at the time of admission compared to less than one quarter of the younger offenders. Poor diet was also more likely to be identified as a problem for older offenders. Interestingly, there was no difference in reported dental problems between older and younger offenders.

Table 1

Percentage of older and younger offenders with physical health issues identified by OIA

	Younger offenders	Older offenders	χ^2
Poor Physical Health	23.7	53.6	327.3***
Poor Diet	7.2	14.3	47.9***
Poor Dental	15.5	15.6	0

*** $p < .001$

A similar pattern emerged with groups of older offenders as seen in Table 2. Among the 50 to 54 year old age group, 46% reported health problems at the time of admission and the rate increased to 79% for offenders over the age of 65. The rate of dietary problems ranged from 11% to 14% for offenders 50 to 64, and increased to 22% for offenders over 65. Consistent with US studies, these results suggest that older offenders will require a great deal of attention in addressing their health problems.

Table 2

Percentage of offenders with physical health issues in OIA by age categories

	Younger	50-54	55-59	60-64	65+	χ^2
Poor Physical Health	23.7	45.7	50.7	61.5	79.1	373.8***
Poor Diet	7.2	14.5	10.9	14.0	22.4	59.1***
Poor Dental	15.5	18.7	12.3	15.0	12.8	4.8

***$p < .001$

Prevalence of mental health problems among older offenders

Studies that have examined the prevalence rates of mental health problems among older offenders are mixed. Some studies[6] have shown that older offenders have greater social, psychological and physical health needs than younger offenders, while other researchers[7] indicate that older offenders have fewer mental health concerns.

McCreary and Mensh[8] compared the Minnosota Multiphasic Personality Inventory (MMPI) profiles of older and younger offenders and found that older offenders were more neurotic, less psychotic and exhibited less anti-social symptomatology than younger offenders. However, older offenders were more hypochondrial, depressed and repressed than younger offenders were. They concluded that the pattern of psychopathology among offenders over the age of sixty is more reflective of psychological malfunctioning than sociopathic malfunctioning.

Motiuk and Porporino[9] assessed the prevalence, nature and severity of mental health problems among the male offender population using the *Diagnostic Interview Schedule*. Comparisons across age groups indicated that dementia was the only mental health problem for which older offenders had higher rates. However, it was noted that the prevalence rates of disorders such as alcohol abuse (58%), anxiety (45%) and depression (32%) were relatively high for this population and should be of some concern.

A number of factors have been shown to be related to or augment existing mental health problems. These include stress, depression and suicide risk factors.

Stress

The difficulty that an older offender may encounter in an attempt to cope with the stress of imprisonment can impact on the development of physiological and/or psychological problems.[10] Bergman and Amir[11] found that the strain of incarceration produces an accelerated deterioration in both the physical and mental health status of the elderly. In addition, the older offender may have also experienced other major life changes such as the loss of loved ones and friends. The lack of a supportive social network can also adversely affect the older offender because social support from significant others is one of the key factors that can serve to buffer the effects of continuous stress.[12]

With respect to sources of stress, Vega and Silverman[13] reported that the two most disturbing events that older offenders identified were being locked up and abrasive interactions with other inmates. Most (92%) of the older offenders indicated that they had few, if any, interpersonal problems with staff. However, the majority (78%) indicated that they had problems with other offenders.

More recently, Gal[14] examined the psychosocial stressors that offenders are experiencing in an effort to identify those situations that are unique or more likely to be problematic for older offenders. A stress scale from the 1995 Inmate Survey was used. The scale was factor analyzed and three factors emerged, offence and sentence issues, personal stressors and institutional stressors. The offence and sentence factor contains items such as sentence length and getting parole. The personal stressors factor contains items such as family, health and relationships. The institutional stressors factor contains items such as substance abuse problems and school/work problems. Results from the survey are presented in Table 3.

Overall, older offenders were less likely to be stressed than younger offenders were. However, it was noted that older and younger offenders did differ in terms of the items identified as being stressful.

With respect to sentence issues, younger offenders were somewhat more concerned about being transferred to another institution than older offenders, while older offenders were

Table 3

A comparison of older and younger offenders' perceived stressors

Stress Type	Younger offenders (%)	Older offenders (%)	χ^2
Offence & sentence issues			
Getting parole	56.8	56.7	.5
Getting transferred	39.4	34.8	6.3*
My offence	46.7	53.9	6.1*
Length of my sentence	58.6	63.6	4.7
How soon I will be released	62.9	64.0	.3
Personal stressors			
Family Issues	63.8	67.8	6.4*
Physical Health	47.0	54.1	10.7**
Mental Health	38.7	30.8	17.2***
Relationships with Inmates	39.9	35.0	5.7*
Relationships with Staff	40.0	32.5	12.0**
Physical safety	32.6	32.8	4.1
Institutional stressors			
A drug/alcohol problem	20.0	6.9	41.3***
Financial problems	31.6	21.1	51.0***
School or work	28.7	18.2	32.1***
Double bunking	59.3	54.8	8.9***
Getting enough tobacco	37.4	24.1	34.6***
Percentage who scored above 4 (considered stressed)	37.1	29.5	8.3**

** p < .05; ** p < .01; *** p <.001*

more stressed about their offence. This is probably reflective of the fact that many of the older offenders were convicted of a sexual offence involving a child, and the prison subculture of non-acceptance of such offenders.

In terms of personal stressors, older offenders were somewhat more stressed about family issues and their physical health than younger offenders. Somewhat surprisingly, older offenders were less stressed about mental health issues than younger offenders. Older offenders were significantly less stressed about all of the institutional stressors than younger offenders. In particular they were less stressed about a drug and/or alcohol problem, school/work issues and financial problems. This is probably reflective of the fact older offenders are somewhat more stable than younger offenders are.

Depression

Depression is quite common among older non-incarcerated adults[15] and older offenders.[16] Flynn reported that depression is the most frequently reported mental health problem among older offenders.[17] She suggested that incarceration accentuates an offender's sense of loss. In addition, some offenders may also be suffering from withdrawal (e.g., alcohol or drugs), either at the time of admission or during the incarceration period, which, in combination with depression may result in increased risk for suicide.

To investigate feelings of depression among the older offender population, the 1995 Inmate Survey was used. As seen in Table 4, the overall level of depression as measured by the Inmate Survey was somewhat higher for the younger offenders with 25% meeting the cut-off compared to only 19% of the older offenders. It appears that older offenders displayed fewer symptoms of depression and reported greater life satisfaction than younger offenders.

Table 4

A comparison of older and younger offenders on depression

	Younger offenders	Older offenders	χ^2
Felt hopeless about the future	35.8	32.7	1.2
Felt content	44.8	53.5	10.1**
Felt lonely	65.9	61.5	5.3
Felt optimistic	55.1	62.1	8.0*
Felt depressed	49.8	42.9	9.8**
Felt bored or had little interest in things	59.6	47.8	25.5*
Felt happy	51.1	55.5	6.0*
Had thoughts about possibly ending my life	13.0	11.6	4.7
Felt fear about my personal safety	19.6	18.7	1.4
Depression Score	25.3	19.5	

* $p < .05$ ** $p < .01$

Suicide

Statistics gathered by the World Health Organization (WHO) have repeatedly illustrated that the elderly succeed at suicide at a rate that far exceeds any other age group for both North America and most western countries. Offenders have also been identified as a high-risk group to commit suicide. Therefore, one would expect a strong relationship between age and suicide among older offenders. However, the research on the relationship between age and suicide among offenders is mixed. Some researchers suggest that older offenders are not at greater risk to commit suicide[18] while others found a higher incidence of suicide among older offenders.[19]

In Canada, between fiscal year 1991-1992 and fiscal year 1996-1997, offenders aged 50 and over who had committed suicide constituted 10% of population. Given that older offenders only accounted for 8.5% of the population, these results suggest that older offenders committed suicide at a slightly higher rate than would be expected. Therefore, it may be useful to identify those factors associated with suicidal behaviour that may be unique to the older offender.

The OIA has nine suicide indicators that are used to identify offenders who may be at risk for suicide at the time of admission. As seen in Table 5, there were only 3 statistically significant differences between older and younger offenders. Younger offenders were more likely to have had a previous suicide attempt and were also more likely to have been under the influence of alcohol/drugs than older offenders. Older offenders were more likely to have lost a spouse/relative (10% vs 6%) than younger offenders were. It was expected that older offenders would be more likely to lose a spouse and/or family member because of their age.

Table 6 presents the OIA suicide indicators across the age categories. The same three indicators were significant. However, the differences were more accentuated across the expanded age categories.

Table 5

OIA suicide by older and younger offenders

	Younger offenders	Older offenders	χ^2
Inmate may be suicidal	5.9	4.9	1.3
Inmate has previous suicide attempt	21.5	15.0	18.5***
Inmate has recent psychological/ psychiatric intervention	16.5	17.4	.5
Loss of relative/spouse	6.7	10.1	10.2***
Major problems	7.9	7.2	.5
Influence of alcohol/drugs	4.9	1.9	14.8***
Signs of depression	9.8	10.8	.9
Expressed suicide attempt	4.2	3.6	.4
Has suicide plan	1.1	1.0	0

****p <.001*

Table 6

OIA suicide risk indicators by age categories

	Younger	50-54	55-59	60-64	65+	χ^2
Inmate may be suicidal	5.9	5.0	5.0	6.3	2.3	2.9
Inmate has previous suicide attempt	21.5	16.0	17.0	13.2	8.8	21.6***
Inmate has recent psychological/ psychiatric intervention	16.5	15.7	23.6	16.8	9.9	11.1*
Loss of relative/spouse	7.0	8.1	15.0	9.9	5.5	23.4***
Major problems	7.9	7.5	7.6	8.5	3.3	2.7
Influence of alcohol/drugs	4.9	2.6	1.8	0	2.2	16.3***
Signs of depression	9.8	10.4	13.3	9.9	7.8	3.6
Expressed suicide attempt	4.2	2.6	4.5	5.4	2.2	3.4
Has suicide plan	1.1	.6	.5	3.1	1.1	6.5

**p <.05 ***p <.001*

Among the older offender age groupings, some interesting trends emerged. For example, the rate of recent psychological intervention was highest among offenders aged 55 to 59 and lowest among those 65 and over. Offenders aged 55 to 59 also had the highest rate of previous suicide attempts (17%). Wichman, Serin and Motiuk[20] identified four predictors of suicide among offenders, inmate may be suicidal, inmate has a previous suicide attempt, inmate has received psychological/psychiatric intervention and signs of depression. The results presented indicate that offenders aged 55 to 59 were more likely to have three of those indicators (no difference for inmate who may be suicidal). Therefore, offenders in the 55 to 59 age groups may be at higher risk for committing suicide than other older offenders. However, overall there is not sufficient data to suggest that older offenders are at higher risk for suicide.

Implications of physical and mental health needs

From a financial perspective the combination of the physical health problems and the type of health care available at the prison often requires that the older offender be transferred to community medical facilities. This is an expensive undertaking because the offender requires constant supervision by two on-site correctional officers.

From a treatment perspective, particularly for correctional psychologists, it is important to have knowledge about the types of health problems that older offenders have. It has been suggested that this type of knowledge can be valuable in assisting the psychologist to discuss the illness and related issues with the offender, as well as to communicate these problems and concerns with other health care professionals. It has been shown that correctional psychologists can assist the correctional health care system through involvement in interventions such as the palliative care program, in the Pacific region.[21]

From a responsivity perspective, some treatment programs may need to be modified for the older offender to participate. Most correctional programs are two to three hours in duration per day for a period of three months and this may be too long for an older offender to sit and give their full attention too. Programs may have to be delivered for a shorter duration and over a longer period of time so that the older offender can participate without being in discomfort.

It may also be beneficial to incorporate wellness programs that promote physical well being. Aday and Rosefield[22] suggested that programs such as walking, gardening, woodworking, ceramics, low impact exercises, prison support groups and other more passive recreational activities can prove successful among older offenders. Programs such as those listed above could prevent serious physical health problems (e.g. cardiac arrest) or help in the rehabilitation from serious health conditions. Rubenstein[23] noted that when programs have been offered specifically for the older offender, it resulted in increases in self-respect, a reduction in feelings of loneliness and depression, an increased desire for social interaction, and a renewed intellectual interest. ■

[1] 4732 Cemetery Road, P.O. Box 1500, Agassiz, British Columbia, V0M 1A0.

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