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Objectives

1. Identify associated influences of health impairment among male prison inmates aging in Oklahoma state correctional facilities.
2. Discuss best practices in addressing the healthcare needs of older male prisoners.

Why Male Prison Inmates?

(Pew, 2008; 2009)

- The facts are clear:
  - The United States incarcerates more people than any other country in the world
  - **1 in 100** adults is behind bars
    - 1 in 9 are African-American males , ages 20-34
    - Men 10 times more likely to be held in jail or prison than women
  - **1 in every 31** adults is under some form of correctional control
    - Spending levels have outpaced education and Medicaid
    - Increased exposure to communicable diseases
    - Risky lifestyle behaviors (e.g., tattooing and piercing, unprotected sex, fighting, intravenous drug use, smoking)

Prison Policy and Population Control

(Ditton & Wilson, 1999)

- State prison population growth linked to increasing time served
- Sentencing Reform (1970's-1990's)
  - *Indeterminate* – parole board authority to release
  - *Determinate* – fixed prison terms with good-time credits
  - *Mandatory* – specified time
  - *Sentencing guidelines* – Range of time based on given offense and offender characteristics
  - *Truth-in-sentencing policies* – Mandatory serving of substantial portion of sentence with parole and good-time credits restricted or eliminated
- **RESULT**: An increasing number of male offenders are expected to: 1.) Serve longer sentences and; 2.) remain prison over a longer period of time.
  - Currently, male inmates who have committed violent crimes serve 85% of their sentence

Eligibility for Early Release
(VERA, 2010)

- Most states permit parole/release of older prisoners at age 60-65
  - *Most require the prisoner have certain physical conditions including chronic illness or age-associated disease that requires long-term care and/or has left the inmate physically incapacitated beyond correctional system resources*
- Louisiana
  - Has lowest age of eligibility for parole/release at 45 years
- Oklahoma
  - Eligibility/parole permitted for those who **(1)** committed crime before 7/1/1998; **(2)** must be 60 years of age; **(3)** have served at least 50% of a sentence imposed under truth-in-sentencing guidelines (VERA Institute of Justice, 2010)

Current Trend: Prisoners enter or reenter prison as young or middle aged adults but exit as older adults

Impact of Policy Reform on Aging

- 1992-2001: Number of state and federal inmates aged 50 and older rose 173% from 41,586 to 113, 358 (NIC, 2004)
- In Oklahoma:
  - Number of newly admitted prison inmates over age 45 has more than doubled since 1990 (Pew, 2008)
  - Inmates 50 and older represent the fastest growing age demographic in the OK DOC system and grew from 879 to 3,627 in 2008 (6.4% to 14.3%, Connelly, 2008; VERA, 2010)
  - Ave. age of inmates has steadily increased and is currently 37.4 years (OKDOC, 2010)

Defining "who" is **OLD** in Prison
(Aday, 2003)

- **<u>Assumption:</u>** Prison inmates are 10-15 years older than non-incarcerated peers (Aday, 2003)
  - Male prison inmates have an average of 3 co-occurring health conditions during imprisonment
- Approximately 27 states have adopted a chronological definition of "older prisoner"
  - 15 states use "50"
  - 5 state use "55"
  - 4 states use "60"
  - 2 states use "65"
  - 1 state uses "70"

Care of Prisoners

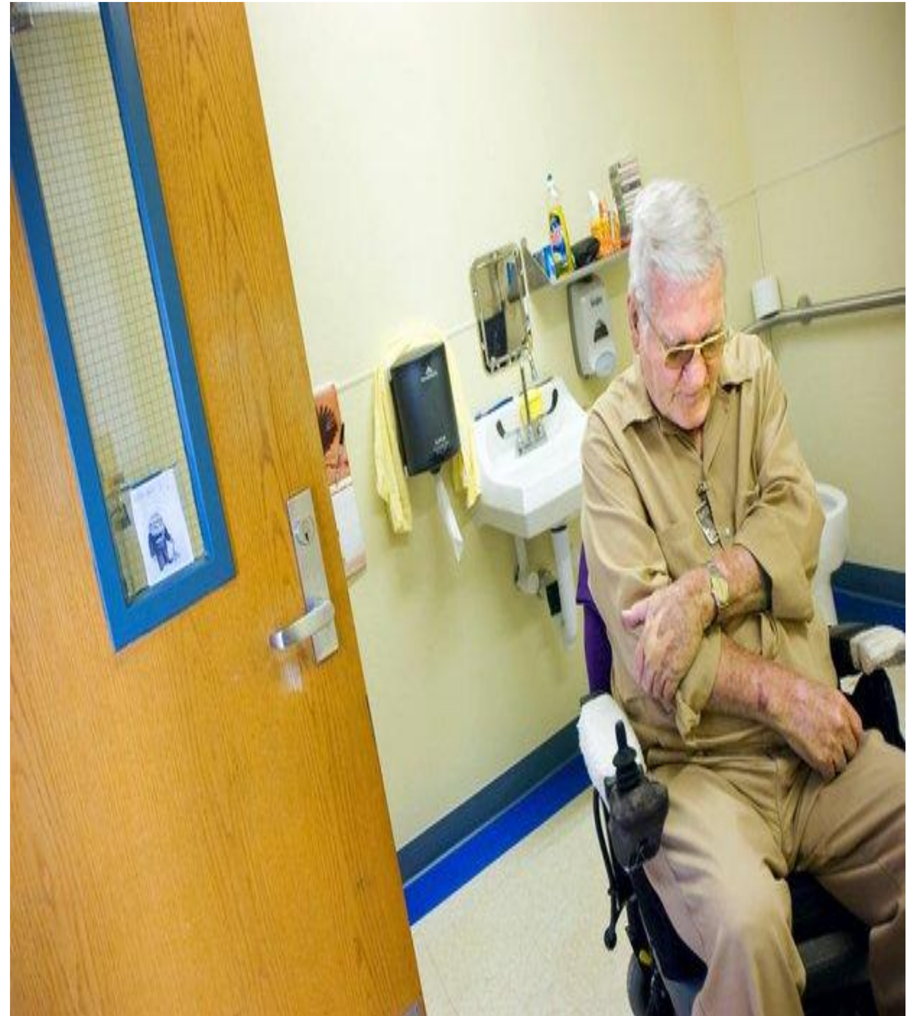
- 1976 Supreme Court ruling Estelle v. Gamble
  - Inmates have constitutional right to "access to care for serious medical needs unimpeded by prison officials."
  - Entitled to **(1.)** medically ordered care; **(2.)** autonomous medical judgment according to professional standards

Ethical Dilemmas in the Care Prison Inmates

1. Physician-Patient relationship
   - Mutual respect, trust, patient comfort and autonomy not easily achieved
2. Informed Choice
   - Understanding health information underscored by poor literacy and contextual barriers of surveillance and coercion
3. Confidentiality/Privacy
   - Confidentiality rules of prison often interfere with access to care
4. Moralism
   - Societal belief that inmates do not deserve compassion or "considerate care"
   - Age, illness, and suffering are means to fulfilling justice (
5. Health Literacy
   - Inmates tend to engage in self-care practices against medical advice/consultation without adequate knowledge or educational opportunities (Loeb & Steffensmeier, 2006; 2010)
6. Dying and Death
   - Incarcerated populations have a greater risk of dying which often demands some form of hospice care or release from prison (Binswanger et al., 2007)

Care Options for Prison Inmates

- Entry/Reception
- Annual Physicals
- Sick Call
- Infirmaries
- Hospital Visitation(s)



Aging and Health in Prison

- Incarceration Effect
  - What contributes to health disparity?
    - Prisoners tend to have better longevity non-incarcerated populations (Mumola, 2007)
    - Members of ethnic minority groups (i.e., African-Americans, Hispanic-Americans) in prison tend to experience better health and longevity than White-Caucasian (Mumola, 2007)
    - Inmates aging in prison develop increased risk of ADL impairments which translate into long-term care health needs (Williams et al., 2006; Williams et al., 2009)
    - Health of prisoners associated with life course history including life event stressors, race/ethnic experiences, lifetime prevalence of criminal behavior, etc. (London & Myers, 2006)
    - Incarceration results in cumulative disadvantage across the life course, including health outcomes (London & Myers, 2006)

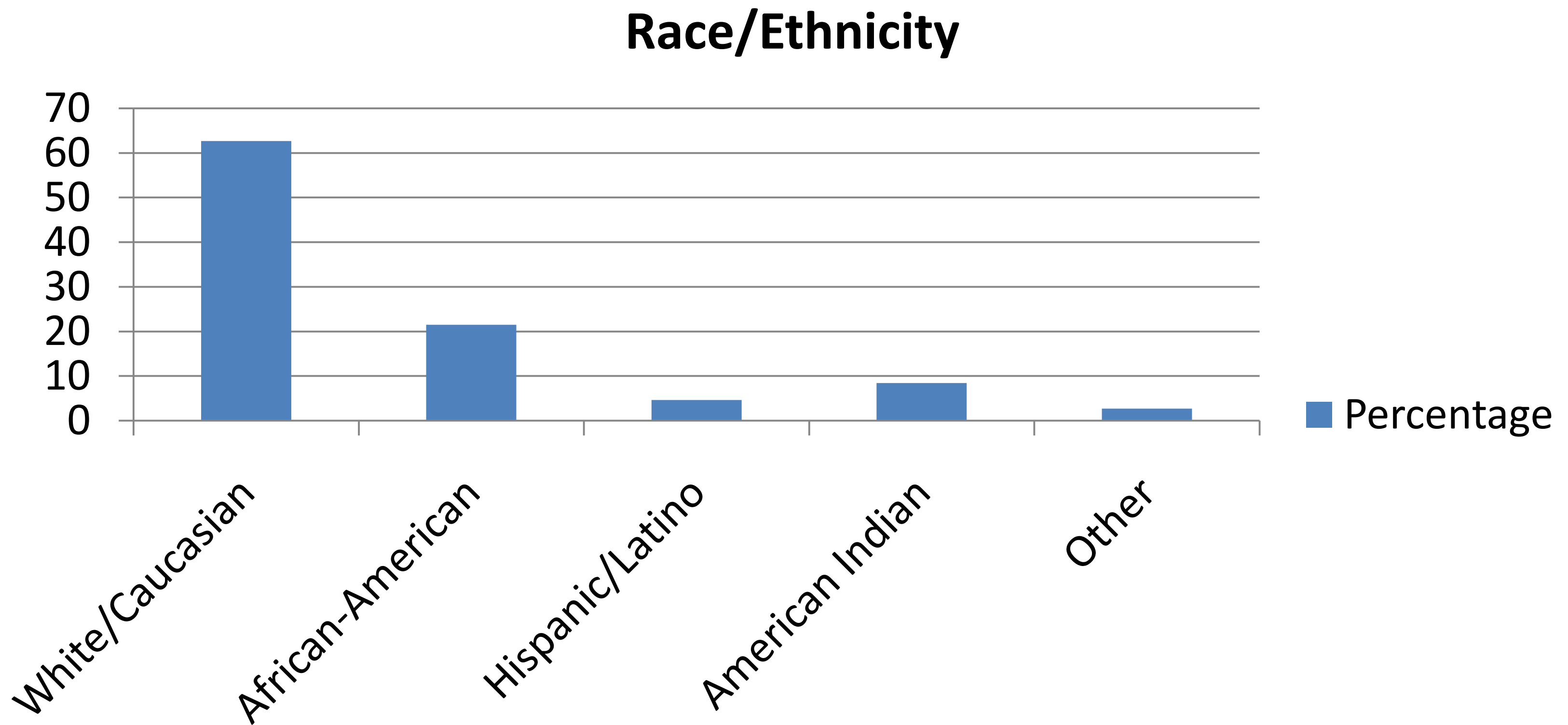
Oklahoma Aging Offender Project

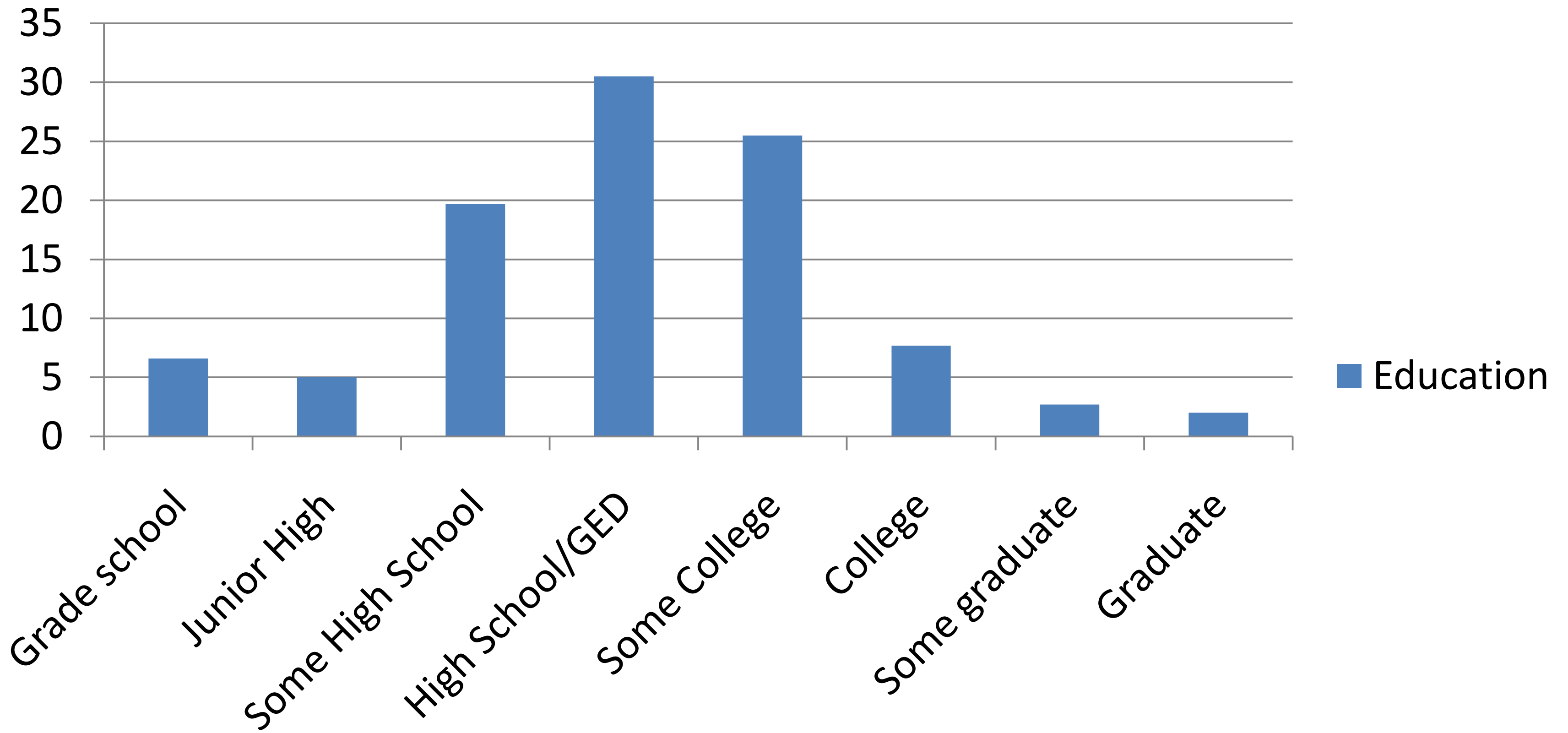
- Pilot investigation involving convenience sample of N = 261 male inmates, aged 45 and older (*M* = 57.59*),* residing in Oklahoma State Prisons
  - IRB approved study
  - Participants identified through OK-DOC with assistance from data management coordinator and final approval to conduct research received by field operations coordinator and individual prison administration (e.g., warden, deputy warden)
  - Announcement(s) posted relative to specific data and time of survey
  - Self-report survey conducted in small group setting
  - OKDOC assisted with identification of participants with low literacy
    - Assisted by trained member of research team with private one-to-one interview
  - All participants read and signed informed consent and debriefed at conclusion

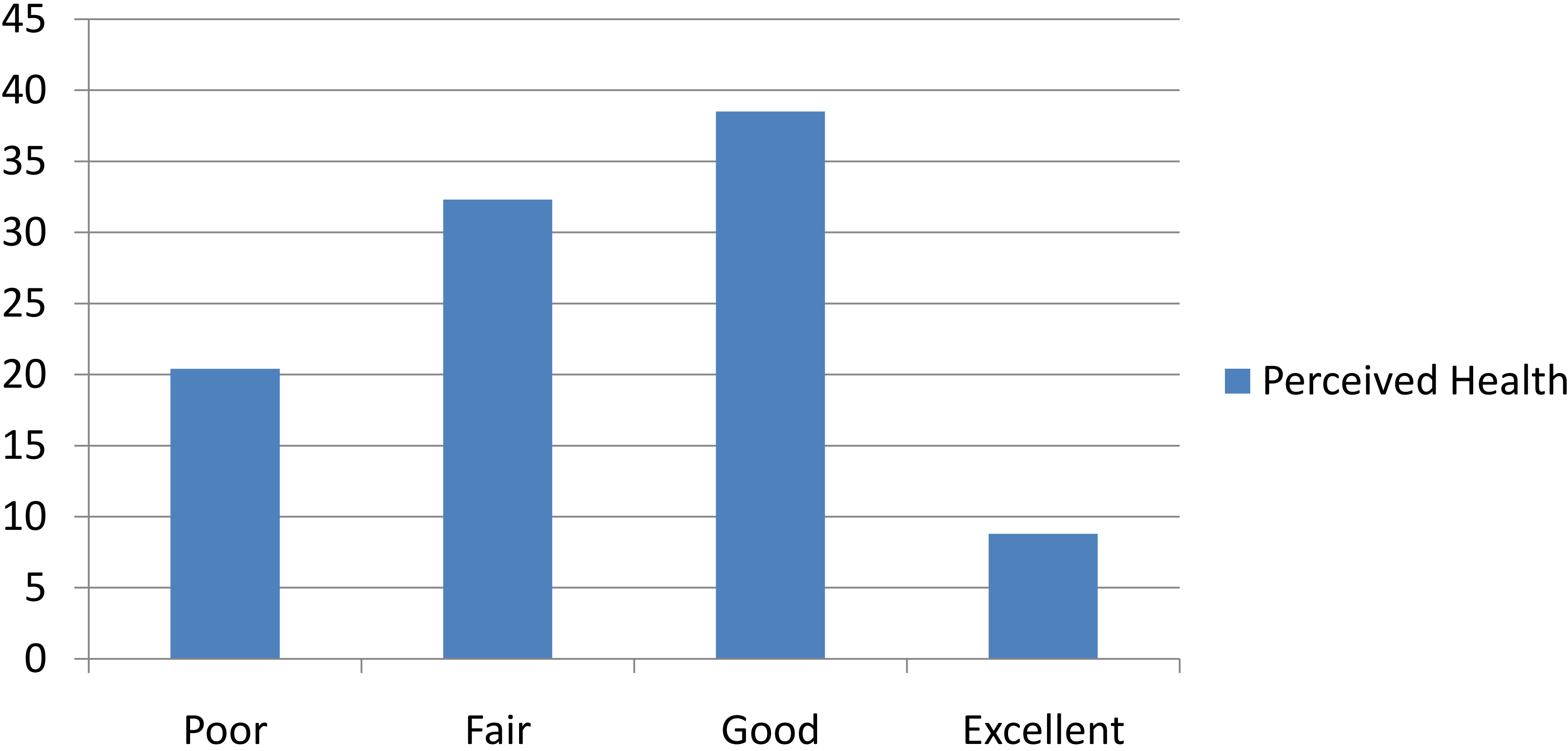
Purpose

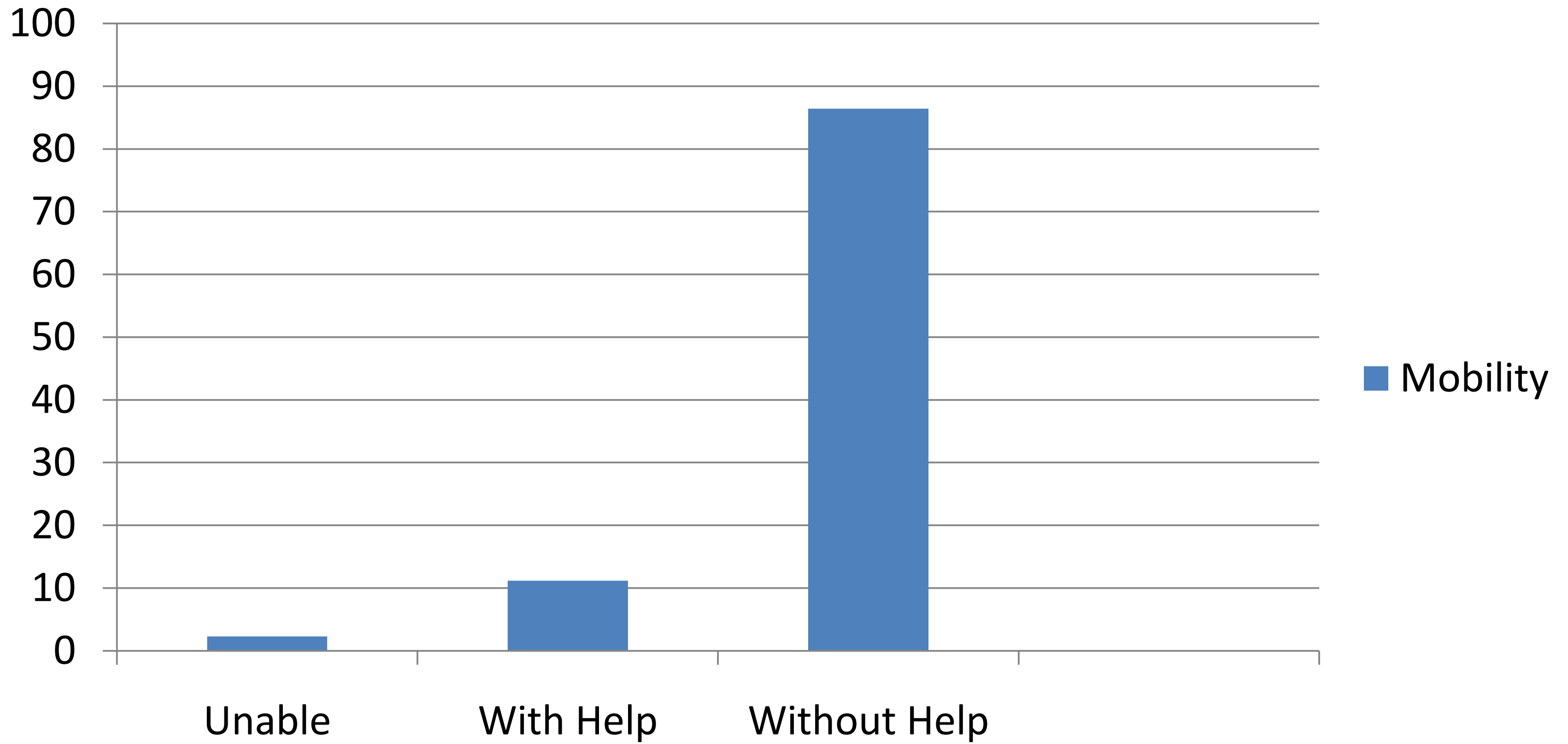
- **Study 1 (Bishop & Merten, 2011)**:
  - To identify key risk indicators of co-occurring health problems
    - Median self-reported health problems in sample was 3 reported conditions
- **Study 2 (Merten, Bishop, & Williams, In-Press)**:
  - Expansion of study 1
  - Key consideration of racial/ethnic differences in self-reported health outcomes relative to emotional/intrinsic indicators well-being

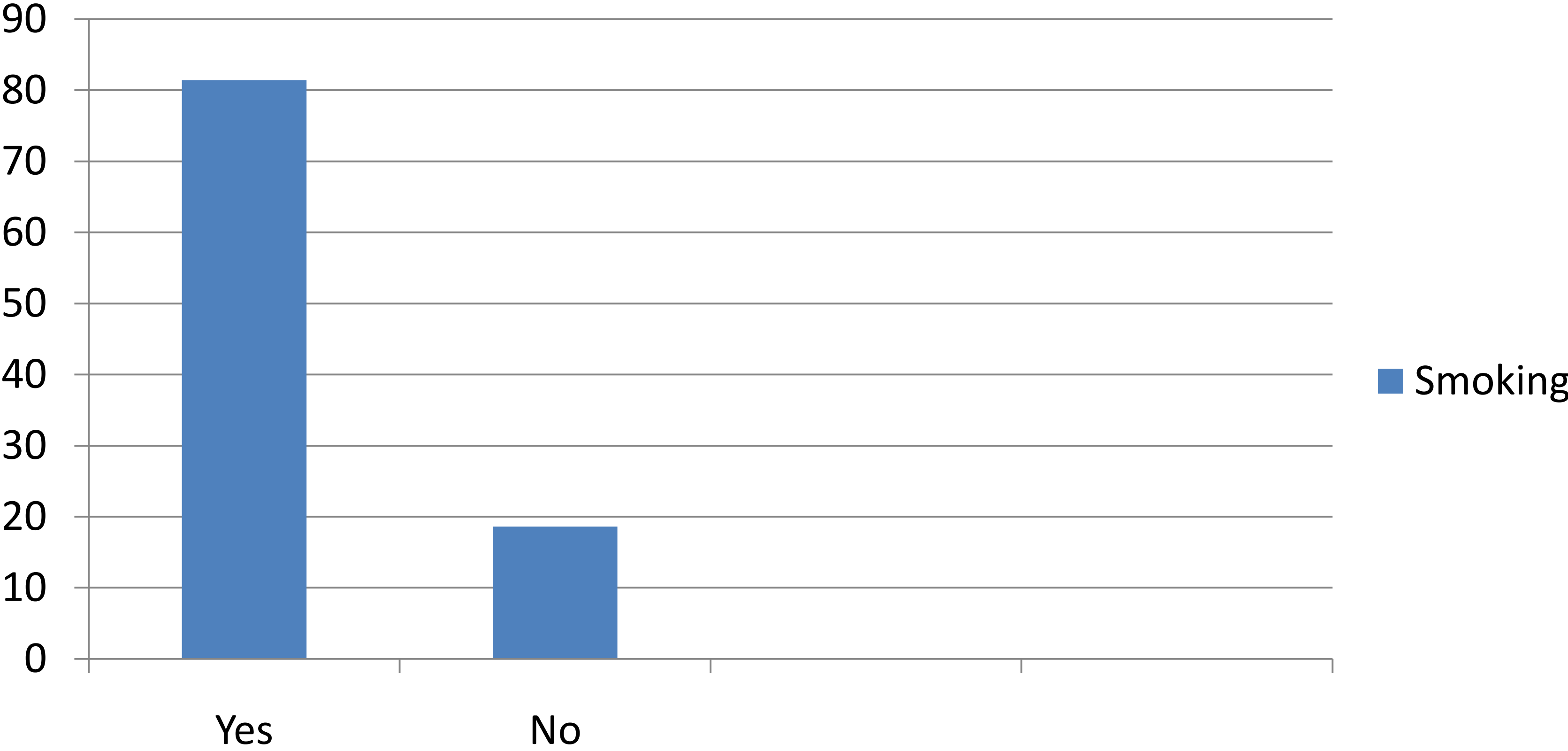
Sample Profile

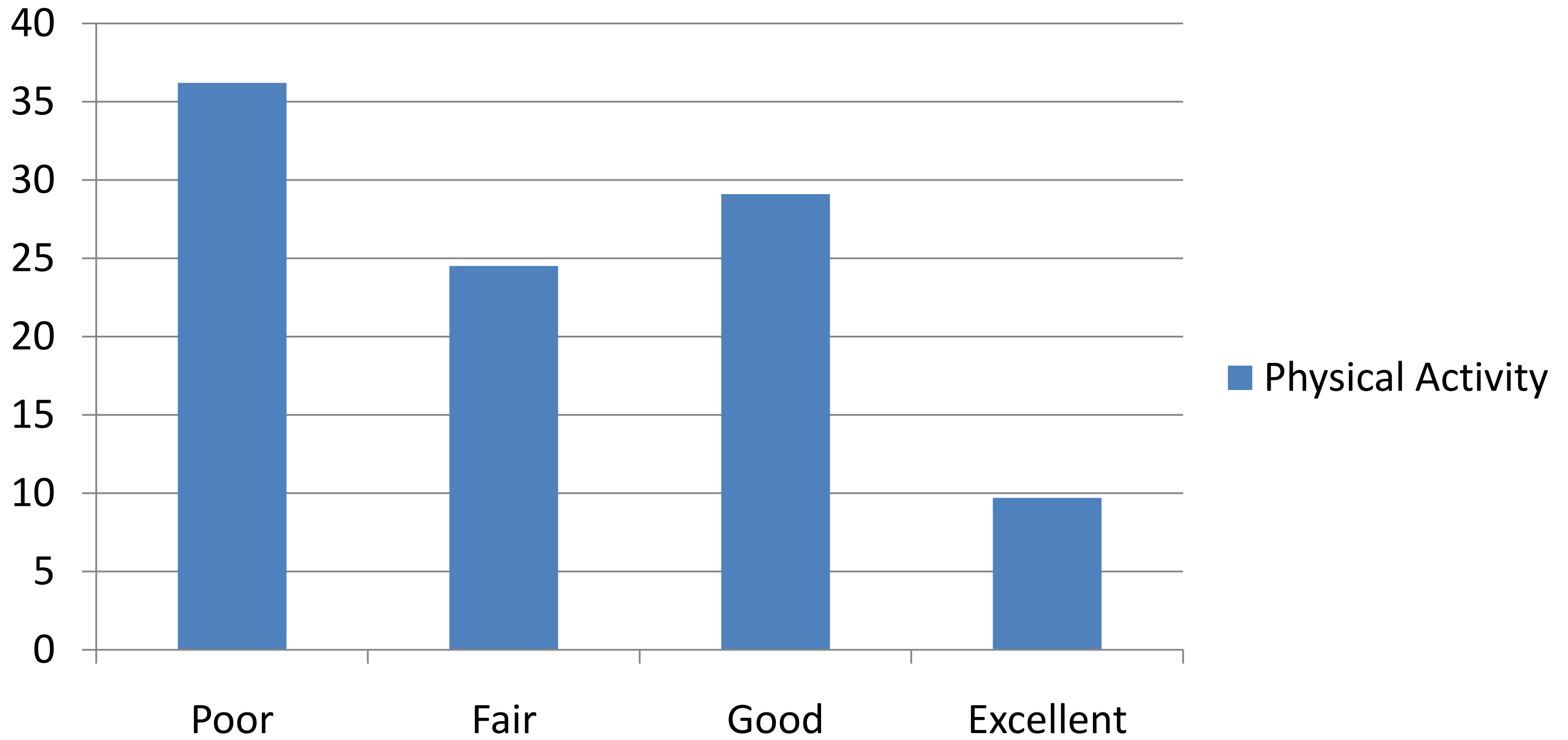


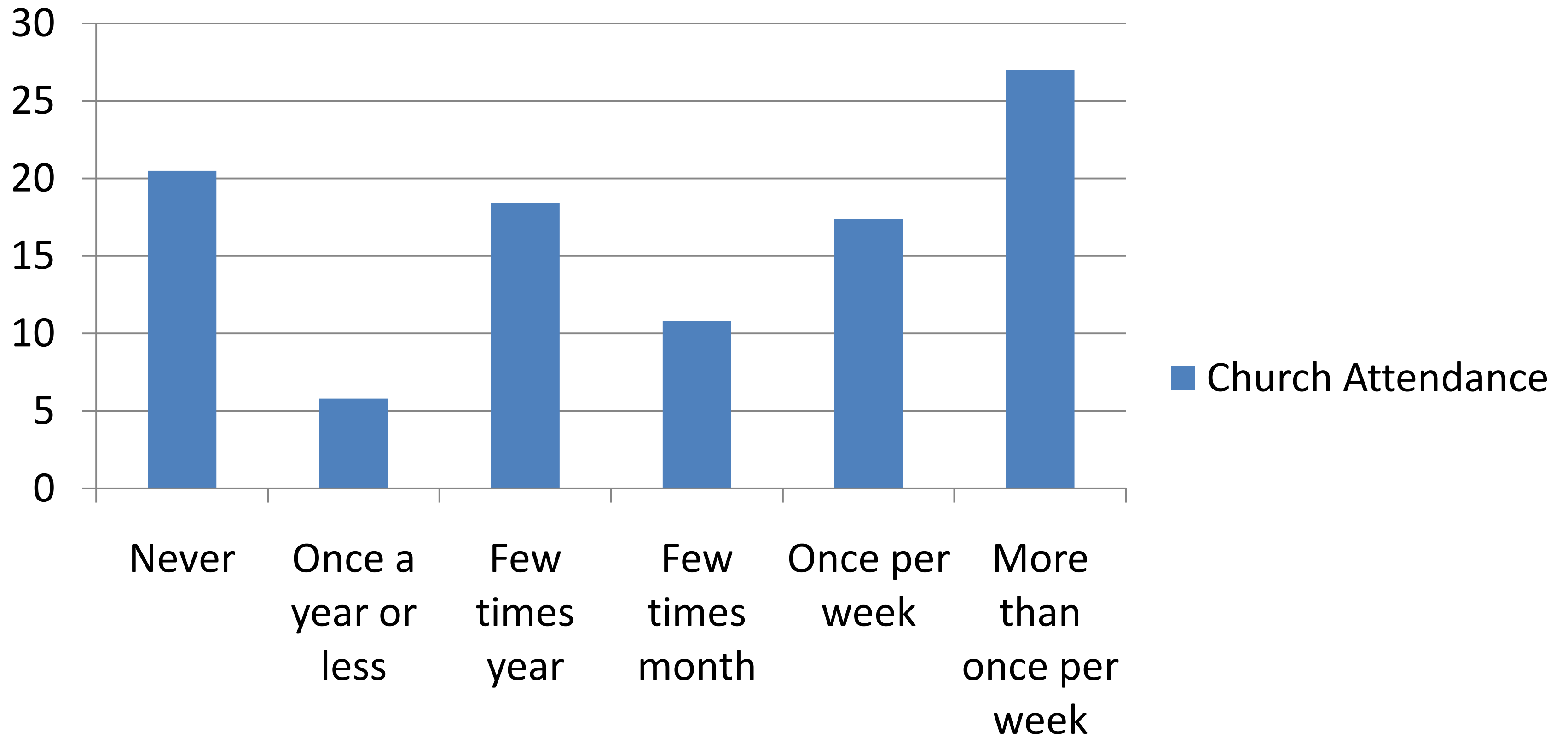

Education
35
30
25
20
15
10
5
0
Grade school
Junior High
Some High School
High School/GED
Some College
College
Some graduate
Graduate
Education


Perceived Health
45
40
35
30
25
20
15
10
5
0
Poor
Fair
Good
Excellent
Perceived Health


Mobility
100
90
80
70
60
50
40
30
20
10
0
Unable
With Help
Without Help
Mobility


Smoking
90
80
70
60
50
40
30
20
10
0
Yes
No
Smoking


Physical Activity
40
35
30
25
20
15
10
5
0
Poor
Fair
Good
Excellent
Physical Activity


Church Attendance
30
25
20
15
10
5
0
Never
Once a year or less
Few times year
Few times month
Once per week
More than once per week
Church Attendance

Identified Risk and Protective Indicators (Bishop & Merten, 2011)

- **Key Risk Indicators:**
  - Education
    - 41% increase
  - Cigarette smoking
    - 182% increase
  - Church Attendance
    - 23% increase
- **Key Protective Indicators:**
  - Perceived health status
    - 62% decrease
  - Mobility
    - 75% decrease
  - Physical activity
    - 44% decrease

Bishop & Merten (2011)

- Protective Factors
  1. Positive health perceptions
  2. Ability to move and get around prison facility
  3. Engagement in physical activity

- Risk Factors
  1. Being better educated
  2. Smoking
  3. Church attendance

Key recommended need: Health literacy programming to diminish potential threat(s) leading to co-occurring health problems as well as enhance positive health perceptions and promote the benefits of physical movement; pastoral care services devised to identify inmates who may be experiencing health complications

Study 2: Merten, Bishop, & Williams (In-Press)

	White (n=162)		African American (n=56)		Native American (n=30)	
	%	*M*	*%*	*M*	*%*	*M*
Inmate emotional health						
Loneliness [1]		15.31		12.95		13.93
Valuation of life [1, 2]		46.87		54.05		49.28
Depressed mood [1]		4.27		2.71		3.45
Health Conditions[a] [1]		3.30		2.61		2.76
High blood pressure	54.04%		60.71%		41.38%	
High cholesterol [1]	39.13%		25.00%		24.14%	
Heart condition	21.12%		10.71%		24.04%	
Currently smoke	84.38%		82.14%		65.52%	
Liver disease	9.94%		5.36%		6.90%	
Diabetes	18.63%		17.86%		27.59%	
Hepatitis	15.53%		5.36%		10.34%	
Hernia	14.29%		7.14%		6.90%	
Prostate problem	19.25%		14.29%		20.69%	
Ulcers	13.04%		3.57%		17.24%	
Obesity	7.45%		7.14%		6.90%	
Asthma	12.42%		12.50%		10.34%	
Emphysema [1, 2]	8.70%		0.00%		10.34%	
Cancer	7.45%		8.93%		3.45%	

	Younger than 55 (N=98)		55 and over (N=163)	
	%	*M*	*%*	*M*
Inmate emotional health				
Loneliness		14.96		14.02
Valuation of life		48.41		48.84
Depressed mood		4.27		3.64
Health Conditions[a] [1]		2.78		3.48
High blood pressure [1]	38.14%		62.35%	
High cholesterol	34.02%		33.95%	
Heart condition	13.40%		22.84%	
Currently smoke [1]	88.66%		77.02%	
Liver disease	11.34%		6.79%	
Diabetes	14.43%		22.84%	
Hepatitis [1]	17.53%		8.64%	
Hernia [1]	7.22%		14.81%	
Prostate problem [1]	9.28%		23.46%	
Ulcers	10.31%		12.35%	
Obesity	10.31%		4.94%	
Asthma	15.46%		11.11%	
Emphysema	4.12%		9.26%	
Cancer [1]	3.09%		10.49%	

Study 2: Key Findings

- Valuation of one's life and feelings of loneliness are associated with depressive affect
- Depressive affect is associated with greater health impairments
- The association between race/ethnicity and self-reported health problems may be explained by how much one values their life and how depressed one may feel in prison
  - This appears most salient among African-American prison inmates

Conclusion

- Health practitioners and policy makers must consider the following:
  1. Need for improving health literacy and health promoting activities among older prisoners
  2. Further consideration of pastoral ministry programming or programs directed at improving emotional or intrinsic well-being
  3. Further inquiry into factors within the correctional environment that may act as a source of “disablement” and contribute to poor health functioning
  4. Greater involvement and education of care providers and staff who have direct interaction with inmates

Future Consideration

- Prison facility design and/or development of “geriatric” or age-appropriate unit or facility
- Comparative differences between men who are currently incarcerated vs. formerly incarcerated
- Enhancement of self-efficacy among inmates via health promoting interventions

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